Veterans Health Administration

*Review of
Alleged Patient Deaths,
Patient Wait Times, and
Scheduling Practices at the
Phoenix VA Health Care System*

ACRONYMS

CBOC	Community Based Outpatient Clinic
CBT	Cognitive Behavioral Therapy
COPD	Chronic Obstructive Pulmonary Disease
CPRS	Computerized Patient Record System
CSTAT	Consultation Stabilization Triage Assessment Team
CT	Computerized Tomography
DBT	Dialectical Behavioral Therapy
ED	Emergency Department
EHR	Electronic Health Record
EWL	Electronic Wait List
FY	Fiscal Year
GAO	Government Accountability Office
HAS	Health Administration Service
HRC	Health Resource Center
HVAC	House Committee on Veterans' Affairs
ICD	Implantable Cardioverter Defibrillator
LPN	Licensed Practical Nurse
NEAR	New Enrollee Appointment Request
OEF/OIF/OND	Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn
OIG	Office of Inspector General
PCP	Primary Care Provider
PDF	Portable Document Format
PET	Positron Emission Tomography
PSA	Prostate-Specific Antigen
PTSD	Post-Traumatic Stress Disorder
PVAHCS	Phoenix VA Health Care System
RSA	Replacement Scheduling Application
SPC	Suicide Prevention Coordinator
VA	Department of Veterans Affairs
VAMC	Veterans Affairs Medical Center
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VistA	Veterans Health Information Systems and Technology Architecture
VSSC	Veterans Health Administration Support Service Center
WIG	Wildly Important Goal

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EXECUTIVE SUMMARY

The VA Office of Inspector General (OIG) reviewed allegations at the Phoenix VA Health Care System (PVAHCS) that included gross mismanagement of VA resources, criminal misconduct by VA senior hospital leadership, systemic patient safety issues, and possible wrongful deaths. We initiated this review in response to allegations first reported to the VA OIG Hotline. We expanded our work at the request of the former VA Secretary and the Chairman of the House Committee on Veterans' Affairs (HVAC) following an HVAC hearing on April 9, 2014, on delays in VA medical care and preventable veteran deaths. Since receiving those requests, we have received other Congressional requests including those submitted by the Chair and Ranking Members of the following Committees and Subcommittees. A complete list of requestors is located in Appendix J.

- House Committee on Veterans' Affairs

- HVAC Subcommittee on Oversight and Investigations

- House Appropriations Committee

- House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies

- Senate Committee on Veterans' Affairs

- Senate Appropriations Committee

- Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies

On May 28, 2014, we published a preliminary report, *Review of Patient Wait Times, Scheduling Practices, and Alleged Patient Deaths at the Phoenix Health Care System – Interim Report,* to ensure all veterans received appropriate care and to provide VA leadership with recommendations for immediate implementation. This report updates the information previously provided in the *Interim Report* to reflect the final results of our review. We focused this report on the following five questions and identified serious conditions at the PVAHCS and throughout the Veterans Health Administration (VHA).

- Were there clinically significant delays in care?

- Did PVAHCS omit the names of veterans waiting for care from its Electronic Wait List (EWL)?

- Were PVAHCS personnel following established scheduling procedures?

- Did the PVAHCS culture emphasize goals at the expense of patient care?

- Are scheduling deficiencies systemic throughout VHA?

Due to the multitude and broad range of issues, we assembled a multidisciplinary team comprising board-certified physicians, special agents, auditors, and health care inspectors to evaluate the many allegations, determine their validity, and assign individual accountability if appropriate. The team interviewed numerous individuals to include the principal complainants, Dr. Samuel Foote, a retired PVAHCS physician, and Dr. Katherine Mitchell, the Medical Director of the PVAHCS Operation Enduring Freedom/Operation Iraqi Freedom/and Operation New Dawn (OEF/OIF/OND) clinic. In addition:

- We obtained and reviewed VA and non-VA medical records of patients who died while on a wait list or whose deaths were alleged to be related to delays in care.

- We reviewed two statistical samples of completed primary care appointments to determine the accuracy of patient wait times based on our assessment of the earliest indication a patient desired care.

- We reviewed over 1 million email messages, approximately 190,000 files from 11 encrypted computers and/or devices, and over 80,000 converted messages from Veterans Health Information Systems and Technology Architecture emails.

The patient experiences described in this report revealed that access barriers adversely affected the quality of primary and specialty care at the PVAHCS. In February 2014, a whistleblower alleged that 40 veterans died waiting for an appointment. We pursued this allegation, but the whistleblower did not provide us with a list of 40 patient names. From our review of PVAHCS electronic records, we were able to identify 40 patients who died while on the EWL during the period April 2013 through April 2014. However, we conducted a broader review of 3,409 patients identified from multiple sources, including the EWL, various paper wait lists, the OIG Hotline, the HVAC and other Congressional sources, and media reports.

OIG examined the electronic health records (EHRs) and other information for the 3,409 veteran patients, including the 40 patients reflected above in PVAHCS's records, and identified 28 instances of clinically significant delays in care associated with access to care or patient scheduling. Of these 28 patients, 6 were deceased. In addition, we identified 17 care deficiencies that were unrelated to access or scheduling. Of these 17 patients, 14 were deceased. We also found problems with access to care for patients requiring Urology Services. As a result, Urology Services at PVAHCS will be the subject of a subsequent report. The 45 cases discussed in this report reflect unacceptable and troubling lapses in follow-up, coordination, quality, and continuity of care.

During our review of EHRs, we considered the responsibilities and delivery of medical services by primary care providers (PCPs) versus specialty care providers (such as urologists, endocrinologists, and cardiologists). Our analysis found that the majority of the veteran patients we reviewed were on official or unofficial wait lists and experienced delays accessing primary care—in some cases, pressing clinical issues required specialty care, which some patients were already receiving through VA or non-VA providers. For example, a patient may have been seeing a VA cardiologist, but he was on the wait list to see a PCP at the time of his death. While the case reviews in this report document poor quality of care, we are unable to conclusively assert that the absence of timely quality care caused the deaths of these veterans.

Supplementing data gathered from the EHR, we also analyzed information, when available, from sources that included Medicare, non-VA health records, death certificates, media reports, and interviews with VA staff. Approximately 23 percent of the patients we reviewed received private sector medical care funded by Medicare or Medicaid, and 35 percent had insurance coverage beyond VA.

We identified several patterns of obstacles to care that resulted in a negative impact on the quality of care provided by PVAHCS. Patients recently hospitalized, treated in the emergency department (ED), attempting to establish care, or seeking care while traveling or temporarily living in Phoenix often had difficulty obtaining appointments. Furthermore, although we found that PVAHCS had a process to provide access to a mental health assessment, triage, and stabilization, we identified problems with continuity of mental health care and care transitions, delays in assignment to a dedicated health care provider, and limited access to psychotherapy services.

As of April 22, 2014, we identified about 1,400 veterans waiting to receive a scheduled primary care appointment who were appropriately included on the PVAHCS EWL. However, as our work progressed, we identified over 3,500 additional veterans, many of whom were on what we determined to be unofficial wait lists, waiting to be scheduled for appointments but not on PVAHCS's official EWL. These veterans were at risk of never obtaining their requested or necessary appointments. PVAHCS senior administrative and clinical leadership were aware of unofficial wait lists and that access delays existed. Timely resolution of these access problems had not been effectively addressed by PVAHCS senior administrative and clinical leadership.

From interviews of 79 PVAHCS employees involved in the scheduling process, we identified the following types of scheduling practices not in compliance with VHA policy. Some schedulers identified multiple inappropriate scheduling practices.

- Thirty staff stated they used the wrong desired date of care, resulting in appointments showing a false 0-day wait time.

- Eleven staff stated they "fixed" or were instructed to "fix" appointments with wait times greater than 14 days. They did this by rescheduling the appointment for the same date and time but with a later desired date.

- Twenty-eight staff stated they either printed out or received printouts of patient information for scheduling purposes. Staff said they kept the printouts in their desks for days or sometimes weeks before the veterans were scheduled an appointment or placed on the EWL.

PVAHCS executives and senior clinical staff were aware that their subordinate staff were using inappropriate scheduling practices. In January 2012 and later in May 2013, the Veterans Integrated Service Network 18 Director issued two reports that found PVAHCS did not comply with VHA's scheduling policy. Our review also determined PVAHCS still did not comply with VHA's scheduling policy. As a result of using inappropriate scheduling practices, reported wait times were unreliable, and we could not obtain reasonable assurance that all veterans seeking care received the care they needed.

The emphasis by Ms. Sharon Helman, the Director of PVAHCS, on her "Wildly Important Goal" (WIG) effort to improve access to primary care resulted in a misleading portrayal of veterans' access to patient care. Despite her claimed improvements in access measures during fiscal year (FY) 2013, we found her accomplishments related to primary care wait times and the third-next available appointment were inaccurate or unsupported. After we published our *Interim Report*, the Acting VA Secretary removed the 14-day scheduling goal from employee performance contracts.

Inappropriate scheduling practices are a nationwide systemic problem. We identified multiple types of scheduling practices in use that did not comply with VHA's scheduling policy. These practices became systemic because VHA did not hold senior headquarters and facility leadership responsible and accountable for implementing action plans that addressed compliance with scheduling procedures. In May 2013, the then-Deputy Under Secretary for Health for Operations Management waived the FY 2013 annual requirement for facility directors to certify compliance with the VHA scheduling directive, further reducing accountability over wait time data integrity and compliance with appropriate scheduling practices. Additionally, the breakdown of the ethics system within VHA contributed significantly to the questioning of the reliability of VHA's reported wait time data. VHA's audit, directed by the former VA Secretary in May 2014 following numerous allegations, also found that inappropriate scheduling practices were a systemic problem nationwide.

Since the PVAHCS story first appeared in the national media, we received approximately 225 allegations regarding PVAHCS and approximately 445 allegations regarding manipulated wait times at other VA medical facilities through the OIG Hotline, from Members of Congress, VA employees, veterans and their families, and the media. The VA OIG Office of Investigations opened investigations at 93 sites of care in response to allegations of wait time manipulations. In particular, we focused on whether management ordered schedulers to falsify wait times and EWL records or attempted to obstruct OIG or other investigative efforts. Investigations continue, in coordination with the Department of Justice and the Federal Bureau of Investigation. While most are still ongoing, these investigations confirmed wait time manipulations were prevalent throughout VHA. As of August 2014, among the variations of wait time manipulations, our ongoing investigations at the 93 sites have, thus far, found many medical facilities were:

- Using the next available date as the desired date to "0-out" appointment wait times.

- Canceling appointments and rescheduling appointments to make wait times appear to be less than they actually were. We substantiated that management at one facility directed schedulers to do this.

- Using paper wait lists rather than official EWLs.

- Canceling consultations (consults) without appropriate clinical review.

- Altering clinic utilization rates to make it appear the clinic was meeting utilization goals.

Wherever we confirm potential criminal violations, we will present our findings to the appropriate Federal prosecutor. If prosecution is declined, we will provide documented results of our investigation to VA for appropriate administrative action. We will do the same if our

investigations substantiate manipulation of wait times but do not find evidence of any possible criminal intent. Finally, we have also kept the U.S. Office of Special Counsel apprised of our active criminal investigations as they relate to the U.S. Office of Special Counsel's numerous referrals to VA of whistleblower disclosures of allegations relating to wait times and scheduling issues.

This report cannot capture the personal disappointment, frustration, and loss of faith of individual veterans and their family members with a health care system that often could not respond to their mental and physical health needs in a timely manner. Immediate and substantive changes are needed. If headquarters and facility leadership are held accountable for fully implementing VA's action plans for this report's 24 recommendations, VA can begin to regain the trust of veterans and the American public. Employee commitment and morale can be rebuilt, and most importantly, VA can move forward to provide accelerated, timely access to the high-quality health care veterans have earned—when and where they need it.

The VA Secretary concurred with all 24 recommendations and submitted acceptable corrective action plans. We will establish a rigorous follow up to ensure full implementation of all corrective actions. The VA Secretary acknowledged that VA is in the midst of a very serious crisis and will use the OIG's recommendations to hone the focus of VA's actions moving forward. The VA Secretary also apologized to all veterans and stated VA will continue to listen to veterans, their families, Veterans Service Organizations, and VA employees to improve access to the care and benefits veterans earned and deserve.

RICHARD J. GRIFFIN
Acting Inspector General

TABLE OF CONTENTS

RESULTS AND RECOMMENDATIONS

Question 1   Were There Clinically Significant Delays in Care?

The patient experiences described in this report revealed that various access barriers adversely affected the quality of primary and specialty care at the Phoenix VA Health Care System (PVAHCS). In the course of patient case reviews, we also identified other quality of care issues unrelated to delays. Patients recently hospitalized, treated in the emergency department (ED), attempting to establish care, or seeking care while traveling or temporarily living in Phoenix often had difficulty obtaining appointments.

In February 2014, a whistleblower alleged that 40 veterans died waiting for appointments. We pursued this allegation, but the whistleblower did not provide us with a list of 40 patient names. From our review of PVAHCS electronic records, we were able to identify 40 patients who died while on the EWL during the period April 2013 through April 2014. However, we conducted a broader review of 3,409 patients identified from multiple sources, including the EWL, various paper wait lists, the OIG Hotline, the HVAC and other Congressional sources, and media reports.

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Clinically Significant Delays

Clinically significant delays were found in the medical and/or surgical care or mental health care of 28 patients, including 6 patients who were deceased, 4 patients with newly diagnosed conditions, 17 patients with chronic conditions, and 1 patient considered to be a risk to the public.

Deceased Patients (Cases 1–5, 27)

Case 1

A man in his late 60s had a history of homelessness, diabetes, head injury, hepatitis, and low back pain. He had been seen at multiple VA health care facilities across the United States during 2011–2013. He presented to the PVAHCS ED with a minor injury and requested a place to stay. He was found to have markedly elevated blood glucose (477 milligrams/deciliter [mg/dl]) and was treated with insulin and intravenous fluids.

The patient stated that he did not want to take insulin, an injectable medication, and was therefore started on metformin, an oral blood sugar-lowering medication. The ED physician requested that he have a follow-up appointment with Primary Care within 24 hours. The patient was not given an appointment to be seen in Primary Care; multiple visits to non-VA EDs ensued, and he was hospitalized at two different non-VA hospitals. A death certificate obtained from the State of Arizona indicates the patient died at a local non-VA hospital 8 weeks after the PVAHCS ED visit.

Given the patient's homelessness and uncontrolled diabetes, hospitalization would have been optimal. In that he was not admitted, a more urgent scheduling effort than a "Schedule an Appointment" consultation (consult) was required.

Case 2

A man in his late 60s had a history of homelessness, hypertension, diabetes, cirrhosis, congestive heart failure, and emphysema. He had been hospitalized at a New England VA Medical Center (VAMC) and at a Texas VAMC. He presented to the PVAHCS ED with 1 week of generalized weakness and diarrhea. He had recently moved to the Phoenix area from New England.

A Schedule an Appointment consult for a new patient primary care appointment was placed on the day of the ED visit and again 2 days later. After an additional 2 days, the patient was hospitalized at a non-VA hospital for abdominal swelling and weakness. Eleven weeks after that admission, he was hospitalized at a different non-VA hospital for hepatic encephalopathy.

More than 3 months after the patient's death, PVAHCS staff attempted to call the patient to schedule a primary care appointment.

Although unlikely to change the overall outcome for this patient with severe liver disease and other medical problems, primary care management could have improved symptom control and assisted with specialty care coordination.

Case 3

A man in his mid-60s had a history of diabetes, hypertension, hyperlipidemia, cigarette smoking, and post-traumatic stress disorder (PTSD). He transferred his care from a Midwest VAMC and registered for care at PVAHCS. The patient's family reported that he was having flu-like symptoms and that they attempted to get him an appointment at PVAHCS several times after registration without success.

Four months after registering at PVAHCS, the patient sought care for flu-like symptoms and shortness of breath at a non-VA medical facility, where he was diagnosed and treated for pneumonia. A computerized tomography (CT) scan performed at that facility revealed a large left pulmonary mass and enlarged lymph nodes suggesting "local spread of malignancy." The patient was advised to follow up with his PCP to have a positron emission tomography (PET) scan.

Two weeks later, the patient called PVAHCS and explained that he had been recently discharged from a local hospital and needed "another test." He was advised to "walk-in," which he did, and was seen that same day. On examination, a provider noted an "enlarged, firm lymph node in the supraclavicular [above the collarbone] area on the left side" and ordered a CT scan of the chest. The CT scan, completed 1 month later, revealed a large left hilar mass and bilateral mediastinal and hilar adenopathy. Four weeks after the CT scan, the patient underwent "diagnostic bronchoscopy with endobronchial biopsy & lavage + axillary needle biopsy." A diagnosis of lung cancer was made, and a PET scan confirmed widely metastatic disease. Arrangements were made to enroll the patient in hospice. The EHR contained no information indicating where the patient died, or whether hospice care was actually provided prior to his death.

There are two concerns in this case. First, the patient never received a primary care appointment as requested when he registered at PVAHCS, although this does not mean that the patient's lung cancer would have been detected sooner. The second concern is that once malignancy was suspected, at least 9 weeks elapsed before a definitive diagnostic procedure was performed.

Given the size and location of the tumor at the time of diagnosis, the delay in care for this patient was unlikely to have had a negative effect on his overall prognosis. However, his care might have been improved if palliative care had been implemented sooner.

Case 4

A man in his late 70s had a history of hypertension, chronic alcohol abuse, and obesity. In late 2011, the patient was seen in the PVAHCS ED for "bronchitis vs early pneumonia." He was not seen again at PVAHCS until the summer of 2013, when he presented to the PVAHCS ED with lower extremity edema. He was found to have deep vein thrombosis, was briefly hospitalized, and discharged home with anticoagulant medications. At the time, a Schedule an Appointment consult was entered for an urgent Primary Care appointment.

The patient was seen again in the ED 2 weeks later for back pain. The treating provider's note included the statement, "Follow up with assigned clinic or primary care physician within 72 hrs [hours] from this emergency room visit today." At that time the patient was noted to be anemic (hematocrit 28 percent; normal is greater than 37).

The patient presented again to the ED 1 month later with a nosebleed, and a nasal balloon was placed. He was seen in the ED 2 days later for removal of the nasal balloon, and at that time, another Schedule an Appointment consult was entered for Primary Care; an appointment "Within 1 week" was requested.

One month later, the patient presented again to the PVAHCS ED with weakness and decreased urine output, and he was admitted to the hospital. He was noted to have a history of uncontrolled hypertension and was considered to be volume depleted. Laboratory testing revealed acute renal injury, hypoalbuminemia (low blood albumin), and nephrotic range proteinuria (large amount of protein in the urine). Following a 1-week hospitalization, he was discharged to a skilled nursing facility for rehabilitation. He died 5 weeks later.

This patient had delayed Primary Care follow-up after several ED visits. With anticoagulation, anemia, hypertension, and kidney disease, earlier

primary care management could have expedited treatment of anemia and hypertension and facilitated coordination of his specialty care.

Case 5

A man in his mid-50s had a history of pancreatitis, three cerebrovascular accidents (strokes), hypertension, and polysubstance abuse. He moved to the Phoenix area from the East Coast in early 2014. He had received treatment at another VAMC as well as from non-VA providers prior to his relocation to Phoenix.

The patient presented to the PVAHCS ED with abdominal pain, was given medications for nausea and pain, instructed to follow up with a PCP "within 72 hours," and discharged home. According to an entry on the Schedule an Appointment consult record, the consult was canceled the next day and a note was put in the EHR documents that a message was left for the patient to call and schedule an appointment.

Ten days later the patient again presented to the ED because of persistent pain and he had run out of pain medication. According to the nursing triage note, "Pt [The patient] states he forgot to take his lisinopril [a blood pressure lowering medication] today." His blood pressure was 209/107 millimeters of mercury (mm Hg). He requested methadone and Percocet [oxycodone and acetaminophen] but was prescribed only a limited supply of oxycodone and a medication for nausea. The plan outlined by the ED physician stated that the patient should follow up with Primary Care within 2 days. The patient died 12 days later at a non-VA hospital. The cause of death given on the death certificate was "multiple prescription medication intoxication."

Despite this patient's need for blood pressure monitoring and treatment, as well as management of other chronic conditions, he never received an appointment with Primary Care.

*Patients With
Newly Diagnos
ed Conditions*

Case 6

A man in his mid-50s presented to the PVAHCS ED with shortness of breath, excessive sweating, thirst, and numbness in both hands. His blood glucose level was markedly elevated (516 mg/dl), and he was prescribed metformin and advised to see his PCP within 1 week. He was not seen by a PCP, ran out of medication, and returned to the ED 1 month later with symptoms of uncontrolled diabetes. His medications were renewed, and a diabetes teaching appointment was made. Twelve weeks later he was seen in Primary Care.

This symptomatic patient with newly diagnosed diabetes was not scheduled to see a PCP for almost 4 months after an ED visit at which significant symptoms and laboratory abnormalities were noted.

Case 7

A man in his late 60s was evaluated in the PVAHCS ED for a subcutaneous cyst on his back and treated with an antibiotic. Eight months later, he was seen in the ED for chest pain. His blood pressure was 180/124 mm Hg, and an electrocardiogram showed an abnormality. After his hypertension was treated and testing showed no myocardial infarction, he was discharged with blood pressure medication and advised to follow up with a PCP within 2 weeks. No Cardiology appointment was made, but a Primary Care appointment was scheduled for 7 months later. A PVAHCS physician who became aware of this patient's situation evaluated him 5 months after the ED visit and entered a referral to cardiology. The patient subsequently underwent coronary artery bypass surgery.

Although this patient had a favorable outcome, the delay in scheduling follow-up care after an ED visit exposed him to unnecessary risk.

Case 8

A man in his early 40s presented to the PVAHCS ED concerned that he might have melanoma, a potentially fatal form of skin cancer. The ED provider note described skin lesions on each arm and the left ankle, "present for about a year, recently getting larger, changing shape and darker…could be melanoma, needs further evaluation."

A referral to general surgery was requested by the ED provider, but this consultation was canceled by a general surgeon the next day with a notation that the patient should be evaluated and treated by dermatology. Approximately 10 months later, the patient was evaluated in Primary Care, and a consult was placed to Dermatology. The lesions were determined to be benign.

Failure of basic consult management and coordination of care could have led to serious consequences had these lesions ultimately been diagnosed as melanoma.

Case 9

A man in his 60s was treated in the past at PVAHCS for substance abuse, depression, and PTSD. After 15 years, he presented to the PVAHCS Mental Health Clinic, and a psychiatrist wrote that he had PTSD, depression, alcohol abuse, and multiple problems with his "primary support system." At that

visit, the patient's blood pressure was 191/102 mm Hg and a repeat measurement was 175/102 mm Hg; a Schedule an Appointment consult for routine Primary Care follow-up was entered. One week later the patient was added to the EWL for a PCP appointment, and an appointment was made for 15 weeks after the Mental Health Clinic visit. The patient was seen again in the Mental Health Clinic 5 weeks after the initial visit, but his blood pressure was not recorded.

This patient's hypertension warranted expeditious evaluation and treatment, which did not occur.

Patients With Chronic Conditions

Case 10

A man in his 40s had a history of hypertension, traumatic brain injury, and alcohol abuse. He reported to the OIG Hotline that he called PVAHCS for an appointment to have his blood pressure checked and was told that an appointment would not be available for 6 months. He stated that 3 months after calling PVAHCS, he awoke with vertigo, nausea, and slurred speech. These symptoms resolved within a day, and he did not seek medical attention for them. After an additional 2 months, he was in an all-terrain vehicle accident and began having more frequent symptoms of slurred speech and dizziness.

When he was seen for his scheduled Primary Care appointment, his blood pressure was 163/107 mm Hg, and he was started on antihypertensive medications, counseled on alcohol use, and asked to follow up in 2 weeks. However, 1 week later he returned to the ED complaining of stuttering and slurred speech, and brain imaging was performed that revealed a large tumor. He subsequently underwent craniotomy and chemoradiation with no apparent recurrence of tumor.

This patient waited 6 months for a PCP appointment, during which time symptoms occurred that were attributed by the patient to hypertension. Although timely Primary Care management might have led to an earlier diagnosis of the patient's brain tumor, his overall prognosis was probably unchanged.

Case 11

A man in his early 60s had a history of alcohol abuse and untreated hypertension. At the end of 2013, he presented to the Phoenix ED complaining of 2 weeks of shortness of breath. He was admitted overnight, diagnosed with "decompensated heart failure," and scheduled for an outpatient echocardiogram. A Schedule an Appointment consult was placed for Primary Care. The echocardiogram was performed 3 weeks later.

He returned to the ED after another 3 weeks with extreme shortness of breath and vomiting, was admitted to the hospital, and soon transferred to the Intensive Care Unit. The result of the recent echocardiogram was not readily available because the interpretation had not yet been entered into the EHR.

After evaluation by cardiology, he was transferred emergently to a non-VA hospital where a defibrillator and pacemaker were placed. The EHR reveals that on the date of that transfer, the echocardiogram was interpreted as showing severely decreased cardiac function (left ventricular ejection fraction, 10 percent).

The Schedule an Appointment consult was closed, and the patient was placed on the EWL with a comment stating that the "wait time is approximately 143 days for a new patient appointment."

This patient had severely impaired heart function identified by echocardiography. Prompt medical management might have prevented his subsequent deterioration.

Case 12

A man in his 70s was found to have an elevated prostate-specific antigen (PSA) and was referred by a PCP to the Urology Service. However, the consult was amended as "needs another psa." A Urology appointment was scheduled for 3 months later, but this appointment was canceled by the Urology Clinic 1 week before the scheduled date because "provider not available"; the appointment was not rescheduled.

The PCP entered a referral for non-VA urology care 4 months after the original request, but this was denied on the basis that "the facility provides this service." After an additional 4 months, the facility closed the Urology Service consult request, indicating "no longer accepting consults." A request for non-VA urology care was again submitted, and the patient was seen by a non-VA urologist more than 11 months after the initial request. Prostate biopsy revealed prostate cancer.

This patient had a prolonged delay between the time his abnormal blood test was noted and a diagnosis was made.

Case 13

A man in his late 60s had an extensive cardiac history, including a myocardial infarction and placement of multiple coronary artery stents at non-VA facilities. After experiencing financial difficulties and unable to afford his medications, he was admitted to PVAHCS after presenting to the

ED complaining of palpitations. Tests revealed no new abnormalities, and he had marked symptomatic improvement after medications were resumed.

During his hospitalization, an outpatient cardiology appointment was scheduled, but that appointment was canceled because "provider sick." The appointment was rescheduled for the following month, but that appointment was canceled due to a "change in profile." The consult was ultimately discontinued as "too old."

Four months after his initial ED presentation, during a routine Primary Care appointment, another Cardiology Service consult was entered. However, the consult was discontinued with the notation "cardiac work-up negative, symptoms due to non-compliance."

One month later, the patient presented to the ED with chest pain and palpitations and was admitted to the hospital. Another Cardiology Service consult was requested and the patient was seen as an outpatient the following month.

This patient with significant cardiac disease experienced repeated delays in establishing follow-up care with Cardiology. Although no negative clinical consequences are certain, appropriate cardiology care may have prevented re-hospitalization.

Case 14

A man in his 60s was found to have a nodular prostate. This finding prompted his PCP to place a referral to the PVAHCS Urology Service. An appointment was made for 3 months later, and the patient was seen and referred to an outside facility for a prostate biopsy.

Approximately 6 weeks later, after the biopsy was completed, the patient delivered a pathology report describing prostate cancer to the PVAHCS Urology Clinic, and a VA urologist called the patient to inform him that surgery would be arranged at a non-VA hospital.

In a complaint received by the OIG Hotline, the patient described a frustrating group of events over the next 2 months in which PVAHCS allegedly had no record of the non-VA referral for the procedure, the VA urologist who called the patient left PVAHCS, outside pathology and/or laboratory reports were misplaced, and multiple messages were not returned from the Patient Advocate's office. In mid-November, the Patient Advocate's office called the patient to state he had been approved for the outside surgical procedure and four follow-up visits. Eight months after the initial referral to Urology, the patient had an uneventful surgery.

This patient with biopsy-proven prostate cancer experienced repeated scheduling delays and poor coordination of care with non-VA providers.

Case 15

A man in his late 50s was seen in the PVAHCS ED for toe pain. Because of an elevated blood glucose level (206 mg/dl), he was considered to possibly have a new diagnosis of diabetes. He was subsequently seen in the Ambulatory Clinic and received foot care.

The patient was seen in Primary Care 3 months after the ED visit and hospitalized after he was found to have markedly elevated blood glucose level (739 mg/dl). The patient reported multiple symptoms consistent with uncontrolled diabetes, including weight loss, excessive urination, and excessive drinking. He was discharged from the hospital on insulin and metformin (an oral blood sugar-lowering medication).

The elapsed time between the patient's ED visit and his initial appointment to be seen in Primary Care was excessive. Had the patient been scheduled more timely to be seen in Primary Care, it is likely that medications, education, and risk-appropriate screenings could have prevented his later inpatient admission.

Case 16

A man in his mid-30s had a history of anxiety and suicidal ideation. He called PVAHCS for an appointment and was placed on the EWL. Five weeks later, he was called by the facility and told he had a Primary Care appointment in another 4 weeks.

The patient had been hospitalized at an East Coast VAMC for 1 week during the prior year for suicidal ideation and anxiety. At discharge, he declined further treatment, saying that he was moving to Phoenix. The East Coast VAMC Suicide Prevention Coordinator (SPC) wrote a note in the EHR indicating that PVAHCS SPC was alerted by a voice mail about this patient, but there was no documentation from the PVAHCS SPC that acknowledged receipt of that message.

The patient was seen in a PVAHCS Primary Care Clinic as scheduled, and a referral was made to the Mental Health Clinic. Three weeks later, the patient was contacted by the Mental Health Clinic to arrange an intake appointment.

For this patient with a history of hospitalization for suicidal ideation and anxiety, continued outpatient mental health treatment was important. The

delay in scheduling an initial Primary Care appointment led to a delayed referral to Mental Health.

Case 17

A man in his 50s had a history of chronic tobacco use, chronic obstructive pulmonary disease (COPD), diabetes, and anxiety. In mid-December 2013, he presented to the PVAHCS ED with symptoms suggestive of an upper respiratory infection and COPD. The patient was treated and discharged with medications. Through a Schedule an Appointment consult, Primary Care follow-up was requested within 1 month.

About 1 month later, the patient returned to the ED because he ran out of his medications. He had not been scheduled to be seen in Primary Care. In early February, he returned to the ED with symptoms suggestive of another COPD flare. About 1 month later, he returned to the ED requesting medication refills. In early May, he was seen for his first scheduled appointment in Primary Care.

This case reveals a missed opportunity to treat a patient with a chronic disease in an outpatient setting and demonstrates why some patients use the ED for "primary care." At least one of the patient's COPD exacerbations may have been averted if the patient had been seen in Primary Care sooner.

Case 18

A man in his late 80s lives in the Midwest for half the year and in Arizona the other half. He receives both private care and VA care, and is registered with and followed by Primary Care at a Midwest VAMC.

In late December 2013, the patient presented to the PVAHCS ED with symptoms suggestive of a urinary tract infection, and blood tests revealed evidence of kidney disease. He was prescribed an antibiotic, and adjustments were made to his anti-hypertension regimen.

In early January 2014, the patient walked in to Primary Care for repeat labs and a blood pressure check, as instructed by the ED physician. His blood pressure was found to be 165/82 mm Hg. He had a new patient appointment pending for about 3 weeks later at PVAHCS. When he arrived for that appointment, he was not triaged, but rather, a licensed practical nurse (LPN) informed him that he cannot have two Primary Care teams (that is, in Phoenix and the Midwest). The patient left after choosing the Midwest VAMC as his home base.

While VHA policy discourages the practice of assigning more than one Primary Care team, it is not prohibited in all circumstances. VHA policy

allows for the assignment of two Primary Care teams when veterans split their time between different residences located in different geographic areas.[1] The patient could have had a Primary Care team assigned at PVAHCS, while maintaining his care in the Midwest.

This was an elderly patient with a change in his blood pressure medication regimen and significantly reduced renal function. The patient, after being on his new regimen for 1 week, had persistent hypertension and might have benefited from a medication adjustment. The patient presented for a scheduled appointment but left after being given misinformation regarding VHA management of veterans who split their residence between two different locations.

Case 19

A man in his late 50s who had a history of methamphetamine abuse presented to PVAHCS in early May 2013 complaining of new blurry vision and was found to have a blood pressure of 224/124 mm Hg. He was evaluated that day by Ophthalmology and referred to Primary Care. The ophthalmologist who saw the patient in the following week attributed his visual changes to hypertension.

Four months after his initial ED visit, the patient went to the ED requesting a refill of medications he had been prescribed a few days earlier at a non-VA hospital. He reported that he had been diagnosed with a stroke there. The ED physician who saw him submitted another consult request for Primary Care follow-up.

In early October, the patient contacted the facility requesting a new Primary Care appointment "as soon as possible." The first successfully scheduled Primary Care appointment was made for 1 month later. In early December, the patient completed an appointment in Primary Care. About a month later, the patient was admitted to a non-VA hospital for a new stroke, which resulted in significant loss of vision in both eyes.

The patient was an amphetamine abuser and had dangerously elevated blood pressure during his initial visit. His wait for Primary Care was excessive, and while waiting, he suffered a stroke. A timelier Primary Care visit could have improved his blood pressure control and allowed for treatment of his substance abuse which could have reduced his risk for stroke.

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[1] VHA Directive 2007-016, *Coordinated Care Policy for Traveling Veterans,* May 9, 2007.

Case 20

A man in his mid-50s was seen in the PVAHCS ED in late
January 2014, 2 weeks after his release from incarceration. He stated that his
blood pressure was 180/120 mm Hg while incarcerated and that he had not
been taking his medications after being released. In the ED, his blood
pressure was 162/128 mm Hg, and his urine tested positive for
amphetamines and cocaine. He was prescribed two medications for his
blood pressure and instructed to follow up with a PCP, even if outside the
VA system, or at an ED if his blood pressure readings remained markedly
elevated.

With blood pressure readings so high in a patient with significant heart
disease, any delay in follow-up and primary care is concerning. The EHR
did not reflect a sufficiently aggressive approach.

Case 21

A man in his early 60s had a history of diabetes, COPD, obstructive sleep
apnea, and obesity. He had been seen regularly at a PVAHCS Primary Care
Clinic from 2007 through 2011. He had no further encounters until early
March 2014 when he presented as a "walk-in" complaining of swelling and
shortness of breath. He said that he had recently lost his private insurance
and no longer had any medication. A nurse noted that his oxygen saturation
was reduced (89 percent; normal is greater than 95 percent). After
consulting with the physician on staff, the nurse advised the patient that she
was going to call Emergency Medical Services so that patient could be
transported to the nearest ED. The patient refused but did agree to drive
himself to the PVAHCS ED.

After an evaluation at the PVAHCS ED, the patient was admitted to the
medicine ward. He was restarted on his medications, pulmonary function
and other tests were scheduled, and a Schedule an Appointment consult was
placed for Primary Care. Six weeks later pulmonary function tests were
performed, revealing significant COPD. Nineteen weeks after
hospitalization, the patient had not been scheduled with a PCP.

Despite discharge instructions indicating a need for Primary Care follow-up
within 2 weeks, this patient with significant pulmonary disease had not been
scheduled for Primary Care.

Case 22

A man in his late 60s was seen at the PVAHCS ED for right knee pain. In
the course of his evaluation, the patient was also found to have a markedly
elevated blood pressure (241/137 mm Hg). The ED provider treated his

hypertension and requested that the patient be seen by Primary Care within a
week. Seven months later, the patient had not been scheduled for a Primary
Care appointment nor had he made other visits to PVAHCS.

This patient's blood pressure elevation warranted treatment in the immediate
weeks after his ED visit, but no treatment was documented for the next
7 months.

Case 23

A man in his early 40s had a history of major depressive disorder, diabetes,
hyperlipidemia, and hypertension. His initial contact with PVAHCS was in
October 2013, when he was hospitalized for a major depressive disorder. At
that time laboratory values indicated very poor diabetes control and marked
cholesterol elevation (total cholesterol, 470 mg/dl; LDL cholesterol,
307 mg/dl). His medical regimen at discharge included drugs for diabetes
and hypercholesterolemia, including insulin, glyburide, metformin, and
atorvastatin.

The discharge summary specified, "please schedule for a new patient
Primary Care appointment." The patient was not scheduled in Primary Care
for 6 months. When he was seen, his diabetes control was even worse and he
had blurred vision.

This patient, with very poorly controlled diabetes and extreme
hyperlipidemia, had substantially delayed care.

Case 24

This patient is a man in his early 40s who registered for care at PVAHCS in
September 2012, and his first primary care appointment was 8 months later.
At that appointment, he revealed a history of hypertension, hyperlipidemia,
severe alcohol abuse, anxiety, and depression. He was later diagnosed with
steatohepatitis. The patient subsequently underwent successful treatment for
alcohol abuse.

This patient with significant mental and physical health issues waited
8 months for initiation of treatment.

Case 25

A man in his 60s presented to the PVAHCS ED in late January 2014 with
chest pain and shortness of breath. He reported that he had recently been
treated at a non-VA hospital for coronary artery disease and had a stent
placed. In the ED, an electrocardiogram showed no abnormalities, and blood
tests were negative for acute myocardial infarction. He was considered to

have "atypical chest pain," and a Schedule an Appointment consult was placed. An appointment for Primary Care was made for 2 months later. When he presented for that appointment, he was sent to the ED, where he was admitted with a cough and shortness of breath. He was subsequently evaluated by a pulmonologist and his symptoms were attributed to gastroesophageal reflux.

This patient with known significant coronary artery disease had a delay in initial primary care that might have exposed him to unnecessary risk.

Case 26

This man in his early 40s has a history of polysubstance abuse, panic disorder, and homelessness.

In early December 2013, he was seen in the ED for a rash, and an ED physician placed a consult for a PCP assignment. Throughout January 2014, the patient repeatedly sought care in the ED, frequently requesting narcotics, and multiple references were made as to the need for "follow-up with PCP." In late January, an ED physician again entered a consult requesting PCP services.

This high-risk patient with polysubstance abuse was utilizing the ED for basic health care needs. As of June 3, 2014, the patient had not been seen in Primary Care.

*Patient Who
Committed
Suicide
(Case 27)*

Case 27

A man in his late 50s had a history of bipolar disorder, alcohol dependence, and four suicide attempts. He moved to Phoenix from Texas where he had been followed by both Mental Health and Primary Care. His last visit with his mental health provider in Texas was in late July 2013, with plans for a follow-up in 4 months, which the patient did not attend.

In early December, the patient registered with PVAHCS and applied for an outpatient medical appointment. He was placed on the EWL 3 days later. In early April 2014, the patient contacted PVAHCS about the status of his appointment and reported he was having "ongoing issues." A medical services assistant informed the patient that he could come into any clinic as a "walk-in."

On two occasions in mid-April, PVAHCS staff unsuccessfully attempted to call the patient to set up a new appointment and left voice messages. In late April, the patient called to schedule an appointment; he was informed that someone would contact him. In early May, the facility made another

unsuccessful attempt to contact the patient and also sent a letter to the patient with the facility's contact information.

Three days later, the patient committed suicide by gunshot. His brother told the suicide prevention social worker that the patient had been depressed for a long time.

This patient was at increased risk of suicide. A timely Primary Care appointment was not available at the time of initial contact, and the patient was placed on the facility's EWL. Better availability of an appointment for this patient might have changed the outcome.

Patient for Whom Risk to the Public Was a Concern

Case 28

This man in his early 60s had a history of schizophrenia. He was released from prison after being incarcerated for 16 years following a conviction for manslaughter. One year later, he registered for care at PVAHCS at a "Stand Down" (a homeless veteran outreach event), and he was given an appointment for primary care for 4 months later. He was seen in Primary Care 2 weeks before his scheduled appointment, and hallucinations and suicidal ideation were discussed. He was referred to Mental Health.

Although it is unclear what PVAHCS knew about his history at the time of registration, this patient was a potential threat to himself and others. He had schizophrenia and a history of violence and was without medication and having auditory hallucinations and suicidal ideation. A timely appointment at the time of registration should have been provided.

Other Quality of Care Issues

In addition to the 28 cases discussed earlier that had clinically significant delays, OIG identified deficiencies unrelated to delays in the care of 17 patients, including 14 who were deceased.

Deceased Patients (Cases 29–42)

Case 29

A man in his early 60s had a history of severe cardiomyopathy (disease of the heart muscle), hypertension, poorly controlled diabetes, hepatitis B, hepatitis C, and tobacco use. An echocardiogram performed in late summer 2013 showed the patient's cardiac function was severely depressed, indicating severe heart failure and increased risk for abnormal heart rhythms and sudden death.

The patient was followed in PVAHCS's Primary Care and Cardiology Clinics. Two days following the echocardiogram, a cardiologist entered a consult to the Tucson, AZ, VAMC's Cardiology-Electrophysiology Service for consideration of an implantable cardioverter defibrillator (ICD) with or without cardiac resynchronization. The patient had an ICD placed

approximately 5 years previously, but it was removed because of
complications caused by either infection or metal allergy.

Two weeks after the consult to the Tucson VAMC was entered, a Cardiology
nurse practitioner at the Tucson VAMC called the patient. During that
conversation, the patient stated that he wanted allergy testing before any new
device was placed.

Five weeks later, an allergy patch test revealed no reaction to metals. The
PVAHCS cardiologist sent a note attached to the consult to the Tucson
VAMC's Cardiology-Electrophysiology Service stating that the patient "can
now be scheduled for CRT-D [cardiac resynchronization therapy with
defibrillator]." The cardiologist recommended that the procedure be done in
the next 4 to 5 weeks.

One month later, the patient was seen by a PVAHCS cardiologist. The
cardiologist added another note to the Tucson VAMC
Cardiology-Electrophysiology consult stating that the patient needed to be
seen for device implantation.

In early 2014, the patient had a routine follow-up appointment at PVAHCS
in Primary Care. One week later PVAHCS was informed of his death.

Medical records from a local non-VA hospital indicated that 3 days prior to
his death, the patient's family witnessed him collapse in his kitchen. Upon
arrival, Emergency Medical Services notes indicated that the patient was
pulseless and in ventricular fibrillation.

According to PVAHCS records, the patient was on an EWL for an
Endocrinology Service consult that had been placed in late spring of 2013 for
management of the patient's poorly controlled diabetes. The patient
reportedly agreed to an appointment 1 month later, but he did not go to that
appointment.

The ICD should have been placed within a few months of the most current
plan. This patient's severe cardiac disease placed him at risk for sudden
death at any time. ICD placement might have forestalled that death.

Case 30

A man in his mid-50s had a history of hypertension and chronic pain due to
degenerative joint disease involving his neck. He was followed by Primary
Care, and his pain management plan consisted of physical therapy and
limited use of hydrocodone. He was awaiting a Neurosurgery evaluation of
his neck to determine if a surgical intervention could help with his pain.

In mid-2013, the patient called his PCP requesting stronger pain medication, as his usual medication was not helping his "torso pain." Two days later, the provider documented that the patient could pick up an alternative pain medication at the outpatient pharmacy. There is no documentation in the EHR that the provider evaluated the patient by phone or in person.

Two days after starting the new medication, the patient presented to the ED complaining of severe abdominal pain. He was noted to have "10/10" (worst possible) abdominal pain, a temperature of 95 degrees Fahrenheit, and a pulse of 111 beats per minute. He was evaluated by an ED physician within 20 minutes. A CT scan of his abdomen, completed 2 hours later, showed a perforated bowel (a hole in the wall of the bowel that can quickly lead to life-threatening infection and/or sepsis). A surgical consult was requested 4 hours after the CT scan, and another hour passed before a surgery resident evaluated the patient. The patient was taken to the operating room for an exploratory laparotomy (a surgery that opens the abdominal cavity) within 2 hours of the surgeon's evaluation. The patient remained on pressors (intravenous medications used to elevate blood pressure in the setting of shock) and ventilator support postoperatively. Two days later, the family removed life support and the patient died.

This patient being treated for chronic neck pain described a new location of pain, and this description should have prompted a telephone or face-to-face assessment. At his final presentation to the ED, hypothermia and tachycardia warranted prompt and intensive interventions. Earlier diagnosis and treatment might have altered the outcome in this case.

Case 31

A man in his mid-60s had a history of prostate cancer, diabetes, PTSD, and morbid obesity. He was followed routinely in Primary Care at PVAHCS.

The patient was diagnosed with prostate cancer at another VA facility in the fall of 2010. He was treated with radiation therapy followed by leuprolide injections.

His last normal recorded PSA was at the "undetectable" level, noted at a 2012 Urology Clinic follow-up appointment. The patient was instructed by the urologist to return in 6 months for an examination and repeat PSA. According to the patient's EHR, that follow-up appointment was canceled by Urology staff 3 months before the appointment was to occur. There was no evidence in the EHR indicating that staff attempted to contact the patient to reschedule this appointment.

Three months after the "canceled" appointment, during a Compensation and Pension examination, another PSA level was ordered. The result showed a

value of 0.90 ng/ml. (In a patient with a history of prostate cancer and a history of post-treatment undetectable PSA levels, any measurable PSA suggests recurrence of disease.) Seven months later, as part of a routine appointment, the patient's PCP ordered laboratory tests, including a PSA. The value was then 98 ng/ml. A Urology Service consult was placed.

Later that month, the patient was seen at the PVAHCS ED complaining of 2 months of back pain. X-rays revealed lytic (bone destructive) lesions in his lumbar spine, presumably from metastatic prostate cancer. Urology evaluated the patient that same day, and treatment was initiated. In early 2014, the patient was admitted to hospice; he died 2 months later.

At one of this patient's canceled Urology Service appointments, providers might have identified or confirmed the patient's rising PSA, which could have prompted an earlier initiation of aggressive treatment.

Case 32

A man in his late 50s was hospitalized at PVAHCS in late 2013 after liver nodules were found on a CT scan obtained at a non-VA hospital. A liver biopsy was required for a definitive diagnosis, and this was anticipated to be done after discharge from PVAHCS. Two Schedule an Appointment consults were entered during that inpatient stay—both for Primary Care and both were routine. Two days after discharge, a post-hospitalization call was made to the patient, but staff were unable to make contact with the patient, as his listed contact information was incorrect. Two additional attempts to reach the patient and discuss biopsy scheduling were also documented.

A week after discharge the patient was seen in the PVAHCS ED. He was under the impression that he was to return that day to be admitted for a liver biopsy. He was sent home and advised to contact his PCP; he was seen in Primary Care 3 days later at an initial visit to establish care.

One week later, the patient was readmitted to PVAHCS for severe groin pain and worsening edema. He was evaluated by the Hematology/Oncology Service the following day, but because of his advanced disease, chemotherapy was not advised. He died 3 days later in the PVAHCS Community Living Center hospice unit.

In the care of this patient, there was significant confusion surrounding when or if the patient would have a liver biopsy. Given his clinical state, when the patient returned to the ED with intractable abdominal pain and probable metastatic disease, an admission for pain control should have been considered. Ultimately, a biopsy was not performed due to impaired blood coagulation, making the risk of bleeding complications too great to safely undergo the procedure.

Case 33

A man in his mid-60s had a history of aortic valve replacement and was being treated with an anticoagulant medication. He also had a history of coronary heart disease, hypertension, and iron deficiency anemia. He was followed routinely at PVAHCS and was admitted from the ED in the summer of 2013 for an abnormality in his bloodwork that suggested his anticoagulant dosage needed adjusting. At that time, he reported symptoms of fatigue and blood in his stool, received iron infusions, and was discharged with plans to get a colonoscopy and upper gastrointestinal endoscopy as an outpatient. The patient was contacted 5 days after discharge to set up an appointment with gastroenterology, but he informed the caller that he planned to get his care "outside the VA." For the following 3 months, the patient's only contact with PVAHCS was with the Anticoagulation Clinic staff.

Six weeks after discharge from the hospital, the patient reported to the Anticoagulation Clinic pharmacist that he had dizziness and a low home blood pressure reading (93/47 mm Hg). The pharmacist advised the patient to hold his blood pressure medications, come to the clinic for an evaluation, and contact his provider. On the following day, the patient's PVAHCS PCP acknowledged receipt of the pharmacist's note. The final note in the EHR was approximately 5 weeks later when the patient's wife called to inform facility staff of his death.

This patient had symptomatic hypotension that was brought to the attention of a PCP. There is, however, no indication that anyone from Primary Care attempted to contact the patient. Though it appears in the record that the patient was getting private medical care, a patient reporting symptomatic hypotension should have been immediately contacted by a staff member to ensure an appropriate evaluation.

Case 34

A man in his mid-60s had a history of tobacco use and persistent cough. He presented to the PVAHCS ED in the spring of 2013 with symptoms suggestive of an acute stroke. He was admitted, and during the hospitalization, a chest X-ray revealed a large density in the right lung. The radiologist recommended a CT scan of the chest for further evaluation of this lesion. The discharge summary from that admission cited the lung abnormality and advised that the patient make an appointment in Primary Care, and obtain a CT scan of his chest in 2 months.

Six weeks later, the patient presented to the ED complaining of shortness of breath. He was admitted to the facility and diagnosed with advanced

non-small cell lung cancer. The patient was discharged to home hospice and died several days later.

This was a patient with a newly described lung mass who required further diagnostic evaluation. If the CT scan could not have been performed during the patient's hospitalization, an acceptable alternative would have been to discharge the patient with a scheduled appointment in radiology. The hospital discharge plan specified that the patient should schedule an appointment in Primary Care in 1–2 weeks and "obtain a CT scan of the chest in two months"; this is an unacceptable follow-up recommendation for a large lung mass in a patient with a history of cough and tobacco use.

Case 35

A man in his late 40s with a history of depression presented to the PVAHCS ED in July of 2013. He had been living on the West Coast, getting private psychiatric care, when he began having paranoid delusional thoughts. He called his parents in Arizona asking for help. They traveled to his home and brought him immediately to the PVAHCS ED.

The patient was evaluated by a mental health nurse in the ED. The patient reported to the nurse that he had been started on sertraline 5 days earlier. Additionally, he commented that 6 years prior, he had been prescribed paroxetine but had to stop taking this medication when he began having suicidal thoughts. He denied any history of suicide attempts and also denied any current suicidal or homicidal ideation. He declined hospital admission but did agree to stay with his parents and report to the Mental Health Clinic the following morning. At approximately 11 a.m. the following morning, the patient committed suicide.

This patient's symptoms at presentation were consistent with a depression-induced psychosis. Given his previous reaction to an antidepressant medication, as well as the fact that he was recently started on another antidepressant, hospital staff should have pursued processes for involuntary admission.

Case 36

A man in his late 60s had a history of multiple medical problems with depression and chronic pain. He was hospitalized at PVAHCS after presenting to the facility's Mental Health Clinic in the spring of 2012. He continued to be followed by Primary Care, with some limited involvement of the Pain Clinic. His last primary care visit was in the spring of 2013 for pain control follow-up; at that time his pain medications were adjusted, his sleeping medication dose was increased, and he was instructed to return in 6 months.

Three days later, the patient presented to the ED complaining of ongoing pain that was unresponsive to treatment. Though the patient denied suicidal or homicidal ideation at this visit, the ED physician documented that the patient stated, "the pain is so frustrating, it might make him suicidal." The patient was described as "despondent" when he left the ED after being given a cervical collar and pain medication.

Several days later, the patient presented unscheduled to the Primary Care Clinic and was evaluated by a registered nurse. He denied suicidal or homicidal ideation. According to the EHR, "Vet states is in 'so much pain right now I could cry'." The nurse documented that she suggested he report to the Mental Health Walk-In Clinic, but the patient declined.

On the same day, the patient called the National Suicide Prevention Hotline. He complained of severe and chronic pain unresponsive to treatment, but no response is recorded regarding questions about suicidal ideation or intent. According to the EHR, the "Veteran stated his doctor is not calling him back." A consult was sent to the local SPC at PVAHCS, but the consult was closed with a comment from the local SPC: "Call not related to SDV [self-directed violence]. Will forward to Veteran's PACT team. Please close consult." Six days later, the patient committed suicide.

Because of his past hospitalization for suicidal ideation, his voicing of ideas about suicide in the ED, and his call to the National Suicide Prevention Hotline, this patient should have been identified and managed as a patient at high risk for suicide.

Case 37

A man in his 60s moved to Phoenix in August 2010 to care for his elderly mother. He reported a history of chronic cough and occupational exposure to asbestos to a PVAHCS provider 2 months later. A chest X-ray showed a suspicious lesion, and the patient underwent a CT-guided lung biopsy in early December. The biopsy did not reveal malignancy, but it was noted that the tissue may not "represent the lesion" and close follow-up was recommended. A request for a CT scan to be done 3 months later was entered, but the scan was never scheduled, and the order was canceled with a comment from the radiology staff to "resubmit if needed."

The patient was seen for a routine appointment 5 months after the biopsy, but there was no documented discussion of the CT scan and the scan was not reordered. The patient was seen 5 months later, and X-rays were obtained to evaluate knee pain. About 3 weeks later, he was seen in the ED with persistent leg pain.

Eleven months after the lung biopsy, a PVAHCS social worker documented a phone call from a non-VA hospital indicating that the patient had a craniotomy and was diagnosed with metastatic malignant melanoma. He subsequently received comprehensive palliative care at the PVAHCS prior to his death 6 months later.

This patient had poor follow-up care following a lung biopsy. Although the cause of this patient's death was metastatic melanoma and may not have been related to the lung mass, management of the mass was inadequate.

Case 38

A man in his late 20s was seen by PVAHCS Mental Health and Primary Care beginning in 2010. He had a history of PTSD, bipolar disorder, and polysubstance abuse. In early 2012, he was hospitalized for suicidal behavior and a psychotic episode related to substance abuse. He completed a sobriety program and was followed by Mental Health every 1 to 2 months for the next several months. His last visit with Mental Health was in the summer of 2012, and his psychiatrist recommended follow-up in "1-2 months, or sooner as needed." The patient did not keep the follow-up appointment scheduled for 6 weeks after that last appointment, and an attempt to contact him was not made until 12 weeks later. The patient contacted the facility 3 days after the missed appointment and spoke with a nurse about a worsening skin lesion. He was instructed to go to the ED for evaluation, but there were no further encounters with PVAHCS documented. He died 5 weeks later, and the death certificate obtained by OIG states that the cause of death was accidental "acute heroin toxicity."

This patient was at high risk given recent suicidal behavior and hospitalization with psychosis. He was lost to follow-up after he did not appear for an appointment. More timely attempts to contact the patient should have occurred.

Case 39

A man in his 30s was first seen at PVAHCS in mid-2011. He had transferred his care from another VAMC, where he had been treated for schizoaffective disorder with disorganized thinking, paranoid ideation, and hallucinations; he also had a history of PTSD. The patient had made three suicide attempts, requiring hospitalization, in the prior 2 years. He was admitted to the inpatient mental health unit at PVAHCS in the spring of 2012 and transferred to a non-VA hospital after assaulting a staff member on the unit.

He presented to the PVAHCS ED 2 months later after calling the crisis line. He reportedly called 911 and said that he was suicidal because he could not afford to stay at his motel. He told the triage nurse that he "hates life and it

is so stressful he doesn't want to be in it." He was evaluated by a mental health consultant, and his risk for suicide was considered to be low. The patient reported that he "would feel okay if he gets some place to live." In the ED, he was treated with new medications (loxapine and mirtazapine) with a plan to follow up with his private mental health provider or the PVAHCS Mental Health Walk-In Clinic. The following day the patient committed suicide.

Because this patient had a history of multiple suicide attempts, psychosis, and an unstable housing situation, an admission to monitor initiation of antipsychotic and antidepressant medications would have been a more appropriate management plan.

Case 40

A man in his 20s had been evacuated from Afghanistan in 2009 because of shrapnel injuries and loss of consciousness. He had a history of seven mental health hospitalizations while in the military and a history of self-injurious behavior. He presented to PVAHCS in September 2012 with anxiety and several weeks later was admitted to a non-VA hospital following a suicide attempt. He was subsequently admitted to the PVAHCS inpatient mental health unit after presenting to the ED complaining of feeling angry all the time. He reported suicidal ideation, thoughts of harming his brother, and his sense that once enraged, he did not know if he could stop himself.

The following day, a team had a conference, to which the patient presented as upset. His mother stated that the patient told his brother that "all I would have to do when I get out is point a gun at a cop and they would shoot me. I won't have to kill myself." The patient's mother expressed concerns regarding the safety of the patient. Documentation noted the patient "is not exhibiting signs of SI/HI [suicidal or homicidal ideation] or medication withdrawal. Veteran's mother verbalized she was unwilling to petition [pursuit of involuntary admission] him at this time." He was discharged. Two days later, he was found dead in his apartment of a possible overdose on medication.

There was not a delay in care, but this case raised a quality of care concern. In the context of his presentation the day before and at the conference, his prior mental health history, and the fact that he had not been stabilized on medication, it would have been prudent to either observe or stabilize the patient for a longer period, or for the providers to pursue a petition of involuntary admission, if the patient was unwilling to stay.

Case 41

A man in his 70s had a history of significant dementia. The case management notes stated, that for a period of time the veteran lived "off the grid," with no electricity or telephone at his residence. He was followed in a PVAHCS Primary Care Clinic since 2008, at which time he had not been seen by a medical provider for over 4 years. The patient was seen several times in 2008 with his case manager present but then only for an ED visit in May of 2009, at which time he opted not to wait after being triaged for "flu like" symptoms.

The medical record noted that the patient had been scheduled for three appointments in 2010 and 2011, all of which were canceled by the clinic staff without any notation explaining the reason for cancelation. In addition, there is no documentation that attempts were made to reschedule these canceled appointments. A death certificate obtained from the State of Arizona indicated that the patient was found dead in April 2014. The cause of death was listed as "hypertensive and arteriosclerotic cardiovascular disease."

In a patient with such severe cognitive impairment, his remote and isolated living conditions would have made his care management challenging; however, it is concerning that three appointments were scheduled and subsequently canceled by PVAHCS staff without a documented effort to reschedule. Such a pattern would likely discourage any patient from relying on this facility for his or her health care, but in a patient with such significant cognitive impairment, it is unlikely that he could have initiated the process of rescheduling these canceled appointments.

Case 42

A man in his mid-50s had a history of hypertension, stroke, chronic hepatitis C, and alcohol and polysubstance abuse disorders. His first presentation to the VA system was when he visited the PVAHCS ED with a complaint of dizziness. He was prescribed medications for nausea and dizziness and discharged. The plan was for the patient to follow up with Primary Care within 1 week.

The patient was admitted to the PVAHCS Substance Abuse Residential Rehabilitation Treatment Program 3 weeks later. He completed the treatment program after approximately 1 month and was discharged, taking only blood pressure medications. A suicide risk assessment completed prior to discharge found the patient's suicide risk to be "low or nil." Discharge instructions included that the patient was "to go to eligibility to get a Primary Care physician assigned for further follow up." Three days after discharge,

an appointment to establish care with a PCP was made for 12 weeks later, but the patient committed suicide 2 weeks before the appointment.

Although any relation to the patient's death is unlikely, this patient should have had follow-up established with a PCP or mental health provider sooner than the 12 weeks that were planned.

Other Patients

Case 43

A man in his mid-60s had a history of asthma and COPD. He presented to the PVAHCS ED after having been recently discharged from a non-VA hospital with several medications that needed to be filled. A Schedule an Appointment consult was placed that requested Primary Care follow-up "within one week." Two weeks later, the patient was hospitalized at another non-VA hospital for pneumonia. Three months later, he was again hospitalized for an asthma exacerbation.

He presented to PVAHCS Primary Care approximately 1 week later as a "walk-in," seeking to have his prescriptions from an outside hospitalization filled. At that time, he received both prescriptions as well as a new patient appointment for 10 days later. The patient completed that appointment and is currently followed as an outpatient.

With the history of asthma and COPD as well as a recent hospitalization, this patient should have received primary care follow-up soon after his initial ED visit. It is possible that earlier management and monitoring within Primary Care may have prevented subsequent hospitalizations.

Case 44

A man in his mid-50s had a past history of hyperlipidemia. He registered for care at PVAHCS in the spring of 2012, requesting a routine appointment in Primary Care. The patient was given an appointment for 4 months later. In mid-June, the appointment was canceled by the "clinic" and not rescheduled. The patient was not made aware of the cancelation and he reported that he showed for the appointment only to discover it had been canceled. There is no evidence in the EHR that the patient was offered another appointment time. At the end of 2013, the patient reported to an outside ED with chest pain and was taken the following day to the cardiology lab for left heart catheterization with stent placement.

A week later, the patient reported to a PVAHCS Primary Care Clinic requesting medications and cardiology follow-up at PVAHCS. The patient was seen by a physician that day, and at that time, a consult for cardiology was placed, as the patient could not afford to "pay out-of-pocket" for a post-procedure cardiology office visit.

The patient also reported that when he submitted all the medical bills from his outside hospital care to the PVAHCS business office, he was denied reimbursement, as "he was not enrolled in a Primary Care Clinic within the VA."

The delay between the patient's registration and initial request for care and an actual appointment was excessive, and when that appointment was inexplicably canceled, PVAHCS staff did not attempt to reschedule the patient. In addition, managing the patient's post-procedure cardiology follow-up and reimbursing him for life-saving interventions at an outside facility failed to happen in a timely and coordinated manner.

Case 45

A man in his late 60s was followed in a PVAHCS Primary Care Clinic. He had a history of diabetes, hypertension, COPD, coronary artery disease, PTSD, depression, and gastroesophageal reflux. He underwent a barium swallow X-ray at a non-VA facility, and 2 days later, home telemetry recorded a blood pressure of 82/67 and that "he's been terrible sick the past two day since he had his barium swallow … he's had a terrible headache, chest pain, abdominal pain and constipation." The patient and his wife presented to his PCP as instructed and were advised to "push fluids, 7 cups water daily," as the patient's wife admitted his fluid intake had been low. The patient's temperature was not taken, no abdominal exam was recorded, and no diagnostic studies were obtained. Two days later, the patient's wife took him to a non-VA hospital where he was febrile and admitted for urosepsis.

The quality of care concern in this case relates to an incomplete evaluation of an ill hypotensive patient, including the lack of a temperature recording or examination of the abdomen. Earlier treatment could have been initiated if an appropriate evaluation had been conducted.

Access to Mental Health Care at PVAHCS

Although we found a process to provide ready access to mental health assessment, triage, and stabilization had been in place at PVAHCS, we identified issues with continuity of care, care transitions, delays in assignment to a dedicated psychiatrist/mental health nurse practitioner in the outpatient mental health clinic, and impaired access to specific types of evidence-based psychotherapies. Mental health leadership had been addressing these issues at the time of our April–May 2014 visits to the facility.

Access,
Continuity of
Care, and
Provider
Assignment

For several years, PVAHCS has increasingly used a mental health consultation stabilization triage assessment team (CSTAT) to address access for mental health patients. The CSTAT essentially serves as a daily walk-in clinic. New patients presenting for assessment, patients discharged from the hospital, and patients in need of a follow-up appointment but who could not get a timely appointment with their assigned provider in the mental health outpatient clinic, were told to go to CSTAT. On one hand, sending patients to a CSTAT clinic can provide ready and potentially critical access to mental health care, especially for outpatients in need of timely assessment and/or stabilization interventions, and can enhance timely follow-up when a mental health outpatient service is short-staffed. However, when a facility becomes reliant on a CSTAT-like clinic to increasingly provide daily routine or ongoing mental health services because of diminished access to the regular outpatient mental health clinic, issues with provider continuity, care transitions, and provider assignment arise.

One issue raised during our interviews was that if a new mental health patient could not be seen for a scheduled appointment with an assigned mental health provider in a mental health clinic, they would be seen in CSTAT instead. If provider availability was still an issue, additional follow-up appointments would occur in CSTAT until assignment to a provider could be accommodated. Although patients could readily access mental health care, actual assignment to a provider might not occur or could be delayed several months. Some new patients might receive a timely initial visit but not a full comprehensive multidisciplinary evaluation until a few months later. In addition, since CSTAT appointments were not with a particular provider, at each CSTAT visit, patients might see different clinicians, an arrangement that lacks continuity of care and the inherent benefits of being assessed and treated by a consistently assigned provider and treatment team.

Two additional concerns expressed were: (1) when a mental health provider leaves the facility, the process has been to send the provider's former patients to CSTAT instead of redistributing or reassigning the patients among existing mental health outpatient clinicians, and (2) transfer patients are sent for walk-in appointments instead of being scheduled for regular appointments.

Further, if an assigned patient's provider did not have availability for a patient to be seen for follow-up in the clinician's recommended time frame, the patient might also be sent to CSTAT, again raising continuity of care issues.

Although CSTAT enabled patients to be seen, broader qualitative issues, such as continuity of care and delayed assignment to a dedicated mental

health provider, are not addressed by overreliance on this alternative clinic structure.

Care Transitions

Patients discharged from the inpatient Mental Health Service, especially but not exclusively those without an assigned Mental Health provider, were often sent to CSTAT for their 14-day follow-up appointment, which is required by VHA policy.[2] CSTAT, by design, was a walk-in clinic to provide ready access. However, because it was a walk-in clinic, depending on the patient volume and acuity, the day a recently discharged patient presented for follow-up, the patient might experience a several hour wait to be seen.

Patients recently discharged from inpatient mental health care are at increased risk, which in part is the rationale for VHA's goal to maintain at least phone contact with these patients within 7 days of discharge and face-to-face contact within 14 days of discharge. A concern raised during an interview was that some recently discharged patients would become frustrated and opt to leave CSTAT before being seen by a clinician because of long waits in this walk-in clinic. Though certainly better than a situation where access is not available, the arrangement is not ideal when compared with having a traditional scheduled appointment with an assigned provider in a mental health clinic.

Changes Instituted by the Chief of Psychiatry

Since coming to PVAHCS in October 2013, the new Chief of Psychiatry successfully recruited 13 additional mental health-prescribing clinicians to the facility within a 7-month period and has begun reorganizing the service. Nine of the new providers are presently on board (several we interviewed in early June had started within the prior 2–3 months), one was due to start the first week in June, and three were in the credentialing process. The influx in new psychiatrists has provided an ability to assign patients to a mental health provider and an availability of new and established patient appointments.

As part of a reorganization process, starting in April 2014, the facility has begun implementing a team-based model whereby each day the walk-in clinic will be arranged around teams comprising three to four prescribing clinicians (psychiatrists and nurse practitioners), one psychologist, one social worker, and nursing staff. Each of the new teams were rolled out in 2-week intervals. In place of CSTAT, each team has been assigned a clinic day during which clinicians will see both new patients with scheduled appointments in addition to walk-in patients. The new patients and walk-in patients (who do not already have an assigned Mental Health provider) who are seen that day will then become assigned to one of that team's providers and be followed by that provider in his or her regular Mental Health Outpatient Clinic. As of July 10, 2014, all five teams were operational with

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[2] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.

some prescribing providers covering 2 days and use of a *locum tenens* (temporary) physician as part of the Friday team. Newly hired providers who came on board in mid-July were to complete the teams allowing one distinct team of providers per day. The new structure should help provide both enhanced access and continuity of care.

Delayed Access to Individual and Specialized Psychotherapy Services

VHA has disseminated different evidence-based psychotherapies during recent years including cognitive behavioral therapy (CBT) and acceptance and commitment therapy for depression, cognitive processing therapy and prolonged exposure therapy for PTSD, and dialectical behavioral therapy (DBT) for issues with regulation and modulation of emotions.

Within the general mental health clinic there are CBT-based groups for depression, anxiety, and mindfulness that were described to us as "tier 1" groups. These groups meet for 4 weeks, and patients can participate in these groups more than once. PVAHCS has fairly ready access to these groups. The anger management group, which begins every other month; the CBT coping skills group, which begins every 5 weeks; and the pathfinders group ("DBT lite") comprising three 5-week modules, were described to us as "tier 2" groups. Reportedly, these groups are geared toward stabilizing patients to a level at which they would be ready for individual psychotherapy if indicated and desired. Intensive DBT therapy group, which runs from 6 to 12 months in duration, and individual psychotherapies were described as "tier 3" groups.

Several clinicians and clinic staff reported that depending on the circumstances, access to tier 2 groups might be delayed at least 2 months, while access to individual psychotherapy and the intensive DBT group was impaired and involved prolonged, several-month-long waits. Some clinicians expressed frustration that patients referred for individual or intensive therapies were screened using rigorous threshold criteria and deemed inappropriate for these therapies. Psychology leadership reported that some patients referred for these therapies are not stable enough for the level of intensity. Psychology leadership also reported that by 2011, the division had lost a significant number of clinical staff and was not allowed by the prior PVAHCS director to fill the vacancies. As of early June 2014, Psychology leadership reported 11 vacancies for which 9 candidates had been selected and were pending offer acceptance, credentialing, privileging, and/or on-boarding.

We obtained a list of patients waiting for individual therapy or specialized mental health therapy services. These services are unrelated to PVAHCS facility leadership performance evaluation metrics. The list contained 171 patient names with the longest wait dating back to November 2013. In early May 2014, the facility had begun working to provide services to these patients through the Non-VA Medical Care program. In June 2014, we

reviewed patient EHRs. None of the patients on the list were deceased. We found some of the patients on the list were being seen internally at the PVAHCS for the requested individual or specialized therapy. A few were being seen by an outside vendor. Some of the patients had either declined or opted to wait to receive therapy internally rather than through Non-VA Care.

For the majority of patients, however, Non-VA Care consults had been authorized, but appointments had not yet been scheduled. Of the 128 patients for whom the EHR indicated authorization but scheduling of an appointment via TriWest was still pending, status updates via the TriWest portal indicated that for 96 patients, the authorizations were erroneously sent directly to the patients instead of to TriWest.[3] A few of these patients used this "vendor of choice" authorization and initiated Non-VA Care with a provider of choice in the community. Among the other 32 patients, 9 authorizations sent to TriWest were either never received or loaded by the TriWest staff into its system; 8 of the patients had completed initial appointments or had upcoming appointments as of July 9, 2014; 8 other patients had not yet been scheduled by TriWest with a provider; and 7 patients declined appointments/services when contacted by TriWest.

Upon discovery in early July that authorizations had been sent to patients instead of directly to TriWest or had not been received by TriWest, PVAHCS purchased care leadership promptly informed fee basis management so its staff could re-upload or re-send authorizations immediately in order not to further delay care.

Suicides

OIG physicians reviewed the EHRs for 77 patients who committed suicide from January 1, 2012, to May 2014. Chronic pain conditions and relational discord were issues in several cases. Table 1 summarizes the findings.

Table 1. Veterans on PVAHCS EWL

Suicides	Physician Reviewed	Delays in Care	Clinically Significant Delays	Other Quality of Care Issues
77	77	9	1	5

Source: VA OIG

A clinically significant delay was identified for one patient related to primary care. Details of this case were described in a previous section of this report. Quality of care issues and non-clinically significant delays were related to Mental Health, Primary Care, and the ED.

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[3] In 2013, TriWest Healthcare Alliance was awarded a 5-year contract by VA to administer the VA Patient-Centered Community Care program to serve nearly half of the veterans eligible for care in the country.

According to the most recent PVAHCS Governing Council Quarterly Suicide Prevention Report, from October 2013 to May 2014, 27 suicides were known to the suicide prevention coordinator (SPC). According to the PVAHCS Governing Council Quarterly Suicide Prevention Report, among these patients, 48 percent were followed by a PCP at the facility, 37 percent were seen by the mental health service, 18.5 percent had chronic pain issues, and 29.6 percent had contact with a clinic or program (for example, Audiology) at the facility within 30 days of death. Twenty-six percent of the patients were not under VA care (that is, they were seen exclusively outside of VA).

The Council's report recommended an action plan that included:

- Hiring a family services coordinator with specialized training in marital and family therapy and two additional family services clinicians with specialized training in marital and family therapy, as PVAHCS does not presently have a clinician specialized in marital and family therapy and family services programs are beginning to be implemented at some other VAMCs to provide couples and family counseling, OEF/OIF/OND family support, and suicide prevention education.

- Mandatory suicide prevention training for employees that is tracked and expanding the VHA SAVE[4] training at orientation from 15 minutes to 1 hour.

- Completion of safety plans for all patients seen in mental health, not just those rated moderate risk or above.

- Suicide risk assessments to be completed on all patients seen by a social worker in the ED.

Conclusion   Patients at PVAHCS experienced access barriers that adversely affected the quality of primary and specialty care provided for them. They frequently encountered obstacles when they or their providers attempted to establish care, when they needed outpatient appointments after hospitalizations or ED visits, and when seeking care while traveling or temporarily living in Phoenix. The cases discussed in this report reflect unacceptable and troubling lapses in follow-up, coordination, quality, and continuity of care.

Although we found that a process to provide access to mental health assessment, triage, and stabilization was in place at PVAHCS, we identified problems with the continuity of mental health care and care transitions, delays in assignment to a dedicated provider, and limited access to psychotherapy.

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[4] Training developed by VHA on steps in suicide prevention. The acronym stands for: Signs of suicidal thinking, Ask questions, Validate the person's experience, Encourage treatment, and Expedite getting help.

In addition, we found substantial problems with access to care for patients requiring Urology Services. Urology Services at PVAHCS will be the subject of a subsequent OIG report.

Recommendations

1. We recommended the VA Secretary direct the Veterans Health Administration to review the cases identified in this report to determine the appropriate response to possible patient injury and allegations of poor quality of care. For patients who suffered adverse outcomes, the Phoenix VA Health Care System should confer with Regional Counsel regarding the appropriateness of disclosures to patients and families.

2. We recommended the VA Secretary require the Phoenix VA Health Care System to ensure the continuity of mental health care, improve delays in assignments to a dedicated provider, and expand access to psychotherapy services.

3. We recommended the VA Secretary require the Phoenix VA Health Care System to reevaluate and make the appropriate changes to its method of providing veterans primary care to ensure they provide veterans timely and quality access to care.

4. We recommended the VA Secretary direct the Veterans Health Administration to establish a process that requires facility directors to notify, through their chain of command, the Under Secretary of Health when their facility cannot meet access or quality of care standards.

Management Comments   The VA Secretary concurred with our findings and recommendations and stated that VHA would implement Recommendations 1, 2, and 3 by August 2015 and that VHA had already implemented Recommendation 4. The Secretary's entire verbatim response is located in Appendix K.

OIG Response   The VA Secretary's planned corrective actions are acceptable. We will monitor VA's progress and follow up on the implementation of our recommendations until all proposed actions are completed. Based on VA's actions, we consider Recommendation 4 closed.

Question 2   Did PVAHCS Omit the Names of Veterans Waiting for Care From Its Electronic Wait List?

Veterans Waiting for Care

PVAHCS did not include all veterans on its EWL. As a result, we identified serious conditions at PVAHCS that resulted in delays, some significant, in veterans' access to health care services. As of April 22, 2014, we identified about 1,400 veterans waiting to be scheduled for a Primary Care appointment and who were appropriately included on the PVAHCS EWL. However, we also identified over 3,500 additional veterans who were waiting to be scheduled for an appointment. Those 3,500 veterans were not on the EWL as of April 2014; most were on what we determined to be unofficial wait lists.

According to VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures,* (Appendix G), the EWL is the official VHA wait list for outpatient clinical care appointments. The EWL is used to list patients waiting to be scheduled or waiting to be assigned a PCP. The EWL tracks new patients with whom the primary care or specialty care provider does not have an established relationship, such as the patient has not been seen before in the clinic at that facility.[5] The EWL usually consists of newly registered, newly enrolled, or new specialty care consult requests for patients waiting for their first scheduled appointment in a particular clinic. Facilities can establish EWLs for multiple clinics within their facility. No other wait list formats (paper, electronic spreadsheets, or others) are to be used for tracking requests for outpatient appointments.

Unofficial Wait Lists

PVAHCS had over 3,500 individual veterans who were waiting to be scheduled for an appointment and were not on the EWL. We identified these veterans from the New Enrollee Appointment Request (NEAR) list, Helpline paper printouts, Schedule an Appointment consults, consults closed without clinical review, and unprocessed enrollment applications. Some of the over 3,500 individual veterans were on multiple lists discussed in the following sections.

VHA measures new patient wait times from the date a scheduler creates an appointment in the Veterans Health Information Systems and Technology Architecture (VistA), which becomes the appointment create date, with the date the appointment is completed. If an appointment cannot be scheduled due to lack of capacity, the veteran is added to the EWL. The date the scheduler adds the veteran to the EWL becomes the start date in lieu of the appointment create date. Consequently, the length of time these 3,500 veterans will actually wait for appointments prior to being scheduled

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[5] A clinic refers to a primary care service or specialty care service within a medical center, such as a primary care clinic, mental health clinic, and urology clinic.

or added to the EWL will never be accurately reflected in VA wait time data because PVAHCS staff had not yet scheduled their appointments or added them to the EWL. Until that happens, the reported wait time for these veterans does not start. These veterans were at risk of being lost in PVAHCS's scheduling processes and thus never obtaining their requested or necessary appointments.

NEAR List

The NEAR list, a computer-generated report, identifies newly enrolled veterans who requested an appointment during the enrollment process. There were approximately 1,800 enrolled veterans on the PVAHCS's NEAR list who indicated they wanted a Primary Care appointment but were not yet scheduled for one and were not on the EWL. Of the approximately 1,800 veterans, nearly 1,700 had been on the NEAR list longer than 30 days.

The Health Administration Service (HAS)—an administrative service at PVAHCS that provides support to the patient processing activities, such as enrollment, eligibility verification, and scheduling—did not use the NEAR list to contact veterans for an appointment. Therefore, it became a *de facto* unofficial wait list because of the inordinate amount of time veterans spent on the list before the facility scheduled the veterans' appointments or placed them on the EWL. In addition, veterans' wait times spent on the NEAR list prior to being scheduled for appointments or added to the EWL were not captured in VA wait time data. HAS supervisors stated they were unaware of the existence of the NEAR list until April 2014. However, they should have been aware of the NEAR list because VHA policy and multiple other documents that were available to PVAHCS management and staff discussed the NEAR list.

- A January 2009 VHA NEAR training guide indicated the NEAR list is available and provided information to enable staff to manage new enrollee appointment requests and their placement on the VistA EWL.

- A Veterans Integrated Service Network (VISN) 18 site visit in May 2013 recommended that PVAHCS develop appropriate training materials and train staff on the use of the NEAR list.

In addition, Mr. Lance Robinson, Associate Director, sent an email in April 2014 to Ms. Sharon Helman, the Director of PVAHCS, and others stating that a management analyst knew about the NEAR list after the VISN team left in May 2013 but failed to continue to run it and utilize it. The management analyst sent an email to Dr. Darren Deering, Chief of Staff; and the Assistant Chief of HAS, in response to the email from Mr. Robinson. The management analyst copied Mr. Robinson; Ms. Michelle Bagford, Associate Chief Nurse; and the Chief of HAS.

*Email From a
Management
Analyst,
May 2, 2014*

*I am behind in e-mail and I would like to clarify the statement
below.*

I did not fail to continue to run it [the NEAR list]. *I looked at it a
few times when I first got here and spoke to* [the former Assistant
Chief of HAS] *about it. . . . I also recall that it came up after the
VISN Team left and I told* [the former Assistant Chief of HAS] *that it
had come up in conversation with them and* [the former Assistant
Chief of HAS] *said she was going to talk to Eligibility about it.*

*Helpline Paper
Printouts*

We identified about 600 screen shot paper printouts from the PVAHCS
Helpline representing newly enrolled veterans who called the Helpline to
request primary care appointments but were not scheduled for appointments
or on the EWL. The 600 printouts consisted of:

- Compiled printouts from March through April 2014 (530)

- Printouts found in a drawer in a Primary Care Clinic in June 2014 (70)

The supervisor of eligibility and enrollment—a service within HAS—told us
that his staff entered veterans' enrollment form information into VistA,
creating an electronic record for the veterans. Instead of scheduling an
appointment at the time of enrollment, staff provided the newly enrolled
veteran with the phone number to the PVAHCS Helpline—also a service
within HAS—to call and request an appointment.

According to HAS personnel, when a veteran called the Helpline to schedule
an appointment, staff from the Helpline collected patient demographics of
the veteran and then printed a screen shot. From approximately
February 2013 through March 2014, the Helpline staff printed the screen
shots containing this information directly to printers in HAS's data
management services. HAS personnel from outpatient services periodically
collected the screen shot printouts from data management and were supposed
to be adding the veterans to the EWL. HAS personnel told us there were
often delays before adding the veterans from the printouts to the EWL. This
occurred because they did not pick up the printouts every day, and there were
only a few staff assigned regularly to add these veterans to the EWL.
Although this printout process started around February 2013, HAS staff did
not begin to fully use the EWL until around April 2013. HAS staff placed
only 1 veteran on the EWL in March 2013, 93 veterans in April 2013, and a
little over 850 veterans in May 2013.

HAS personnel told us that because the printouts contained personally
identifiable information, they destroyed them after they either scheduled the
veterans' appointments or placed the veterans on the EWL. Because staff
destroyed the printouts over the course of time this process was in place, we

could not identify those veterans affected by this process or confirm that they were eventually placed on the EWL or provided an appointment.

From the end of March through April 2014, a HAS employee created a daily Portable Document Format (PDF) of compiled printed screen shots and emailed them to responsible outpatient services' personnel. We obtained those PDF screen shots, which included approximately 550 individual veterans. We determined that 530 of those veterans were not on the EWL as of April 2014 and were still waiting to be scheduled for an appointment.

The following example highlights the problem experienced by one of the veterans who was included in the PDF screen shot printouts we identified. A veteran emailed the OIG Hotline on May 14, 2014, and said he enrolled at PVAHCS. According to the veteran's electronic record, he enrolled on April 3, 2014. At the time he enrolled, he was told by PVAHCS staff he was going to be put on the EWL. He called the medical facility again in May to check on his status, and HAS staff told him they placed him on the EWL on May 6, 2014. The staff member suggested it would be another 3 to 4 months before the veteran would be seen. This veteran's wait time was unaccounted for during this 1-month period from April to May 2014.

In June 2014, a scheduler provided us with about 200 additional paper printouts that identified veterans who called the Helpline around December 2013. She received these printouts from a coworker who found the printouts in a drawer in a Primary Care Clinic. Upon review, the scheduler determined that about 70 of the 200 veterans were not scheduled for an appointment and were not on the EWL. According to the scheduler, she subsequently added the veterans to the EWL in June 2014.

Schedule an Appointment Consults

Pending Schedule an Appointment consults represented 307 veterans referred to primary care, but the facility had yet to schedule their appointments or add them to the EWL as of April 2014. The wait time for patients with pending consults begins when schedulers create the appointments or place the veterans on the EWL. This means the wait time for these veterans prior to being scheduled or added to the EWL was not captured in VA wait time data.

PVAHCS ED physicians and inpatient services providers used Schedule an Appointment consults in an attempt to ensure that veterans who did not have a PCP would have a follow-up appointment scheduled post-discharge. These consults were sent to notify HAS staff of a veteran without a PCP in need of a Primary Care appointment. According to HAS staff, if a consult was noted as routine, they would add the veteran to the EWL. If a consult was noted as urgent, they would send it to a provider for review.

We were told by a HAS employee that no one reviewed Schedule an Appointment consults from approximately August 2013 through December 2013. Although we could not confirm this statement, our review of emails determined there was a significant backlog of 1,300 pending Schedule an Appointment consults as of December 2013.

A meeting with a veteran's family resulted in Dr. Deering realizing the facility did not have an adequate plan to ensure patients leaving the ED obtained timely follow-up appointments. The following excerpt is from a December 14, 2013, email from Dr. Deering to Dr. Christopher Burke, Chief of Primary Care Services; Dr. Timothy Wright, Chief of the Emergency Department; the Nurse Manager of the Emergency Department; Dr. James Felicetta, former Chief of Medical Services; and the Chief of HAS. Mr. Robinson and Ms. Nancy Claflin, Nurse Executive, also received the email.

*Email From
Dr. Deering,
December 14, 2013*

I just spent about 45 minutes with a veteran's family who is very upset.

Their father was discharged from the ER [Emergency Room] *on September 28th and the ER Doc* [doctor] *requested a one-week f/u* [follow-up] *with a PCP.*

A "scheduled an appointment" consult was placed in CPRS [Computerized Patient Record System].

The veteran died on November 30th.

Someone called the family on Dec 6th to schedule the appointment.

They feel that we were negligent in his care and that earlier intervention would have prolonged his life.

They have a copy of his records including the 'schedule an appt' [appointment] *consult that wasn't addressed for 2 months.*

.   .   .   .

My intent is that I need you, as leaders of the ER, Primary Care, and HAS to come together and develop a plan about how we can make sure that patients who are leaving the ER get a follow-up and that the information is communicated to the veteran in a timely manner. Please work on this and let us know what is needed to make this happen or what your plan is by Dec 30th. Although it may not have made a difference in the outcome of this patient, it is a process that needs to be hardwired before it does impact someone.

On December 19, 2013, Dr. Hamed Abbaszadegan, Chief of Clinical Informatics, sent the following email to Dr. Robbi Venditti, staff physician, discussing new patient scheduling and noting that the Schedule an Appointment consult was a broken process. He also copied a number of other clinical staff, including Dr. Burke, Dr. Wright, Dr. Deering, and Ms. Bagford.

*Email From
Dr. Abbaszadegan,
December 19, 2013*

This week the inspector general was here regarding the issue of new patient scheduling (those without a PCP). Ironically, there has been some side conversation regarding this issue this week as well…The consult called "Schedule an Appointment" has >1300 open consults in a pending stage, most coming from the ED. I feel we have a broken process that can be improved. Thus, I am requesting to improve/change this process. I will personally represent informatics to help find a solution to new appointments which is tied to access as well as quick (1-2 week) post-ED visits.
Thoughts?

We found no evidence that PVAHCS developed a plan to ensure that patients leaving the ED received a follow-up appointment.

*New Patient
Backlog
Redistribution*

In October 2012, HAS data management staff identified new patient appointments in Primary Care that were scheduled later than December 1, 2012. Some of these appointments were scheduled for almost a year in the future. This represented a backlog of 2,501 appointments. The goal at the time was to redistribute this backlog of new patient appointments among the PCPs and reschedule these veterans for earlier appointments. HAS data management staff divided the list of 2,501 patients among 43 providers. Twenty-eight providers at the main facility were assigned over 1,800 patients, with the remainder assigned to providers at the clinics. Most providers received about 67 new patients.

Despite the effort to redistribute the veterans to other providers with the intent of getting an earlier appointment, we determined 544 of the 2,501 veterans had not received Primary Care appointments as of March 31, 2014. We reviewed 200 of the 544 veterans who had not received an appointment. According to our review of the veterans' EHRs, 143 of the 200 veterans (72 percent) appeared to still be waiting for Primary Care appointments. The other 57 veterans were no longer waiting for care from PVAHCS because they had moved out of the area, could not be reached, decided they no longer wanted VA care, or had died.[6] On June 17, 2014, we provided the names of the 544 veterans to Mr. Steve Young, Interim PVAHCS Director, for review and appropriate action with these veterans.

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[6] These deaths were included in the case reviews addressed under Question 1.

*Urology
Consults
Closed*

According to Urology staff, from May 2013 through September 2013, two urologists left PVAHCS and only one was replaced. This left PVAHCS's Urology Service with two urologists and a nurse practitioner.

Urology staff told us they informed PVAHCS management of access and staffing issues starting in August 2013. In January 2014, to address the Urology Service's concerns about providing care to patients with a minimal number of providers, the ability of PVAHCS providers to write new outpatient Urology consults was disabled. In addition, PVAHCS administratively closed 344 pending Urology consults for 339 individual veterans on 2 separate days without first identifying how the veterans would receive needed care. Following is a January 13, 2014, email Dr. Venditti sent to Dr. Deering that acknowledged the disabling of consults to Urology Services.

*Email From
Dr. Venditti,
January 13, 2014*

As of last week all outpatient consults for GU [General Urology] *were disabled. On Friday 250 active and pending consults were discontinued. These two actions should eliminate and/or reduce the extra demands placed on the current GU staff. (This left appr.* [approximately] *136 scheduled Veterans through March and appr. 136 scheduled veterans that did not have a real appointment.)*

One item on the action plan is to determine who/how the cancelled Veterans are reviewed for ongoing medical needs.

We reviewed 115 veterans whose consults were closed and determined 68 veterans (59 percent) did not receive a Urology appointment. Of those, eight veterans either transferred to another facility or said they no longer wanted urology care at PVAHCS, three veterans had died,[7] two veterans were in hospice care, and one veteran had a chart review completed and was determined to not need care. The remaining 47 veterans (41 percent) eventually received Non-VA Care Urology appointments but waited an average of 167 days for those appointments (ranging from 21 to 396 days). On June 17, 2014, we provided the names of these veterans to Mr. Young for review and appropriate follow-up action with those veterans. Due to the substantial problems with access to care for patients requiring Urology Services at PVAHCS, Urology Services will be the subject of a subsequent OIG report.

*Unprocessed
Enrollment
Applications*

On June 6, 2014, Dr. Katherine Mitchell, the Medical Director of the PVAHCS OEF/OIF/OND Clinic, provided the OIG with a folder of 69 individual VA enrollment applications. Dr. Mitchell stated that the veterans whose applications were in the folder had not been processed for enrollment. The unprocessed enrollment applications were from veterans

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[7] These deaths were included in the case reviews addressed under Question 1.

who enrolled at a PVAHCS outreach effort in late 2013. However, PVAHCS still had not processed their enrollment information over 6 months later. We reviewed the enrollment forms to determine how the applicants answered the question on the form of whether they wanted care. Based on the applicants' answers, we determined 36 individuals did not want care, 18 wanted care, and 15 did not answer that question. On June 9, 2014, we provided the forms to Mr. Young's office for PVAHCS's review and appropriate follow-up action with these veterans.

EWL Data Entry Issue

In April 2014, VHA's national data in the Veterans Health Administration Support Service Center (VSSC) showed fewer than 300 veterans waiting for care on PVAHCS's EWL. However, we found that actually about 1,400 veterans were waiting for care, according to PVAHCS's VistA EWL report. The EWL data obtained from PVAHCS's VistA system listed a much higher number of veterans than the EWL data we obtained from the VSSC. VHA staff identified a data entry issue that prevented the total number of veterans that were actually on the PVAHCS EWL from being reflected in the national EWL data.

We were unable to determine when PVAHCS first became aware that the national EWL data was not capturing all veterans on the wait list. On April 22, 2014, the Chief of HAS told us he was aware the number of veterans on PVAHCS's EWL showed more than what was reported in national data. According to national information technology support, on April 30, 2014, PVAHCS submitted an information technology trouble ticket, and the data entry issue was fixed the next day.

As shown in Figure 1, national data did not reflect the same number of veterans waiting on PVAHCS' EWL prior to correcting the data entry issue. As of May 1, 2014, the national data reported about 1,400 veterans—the same as the PVAHCS's EWL.

Figure 1. Veterans on PVAHCS EWL
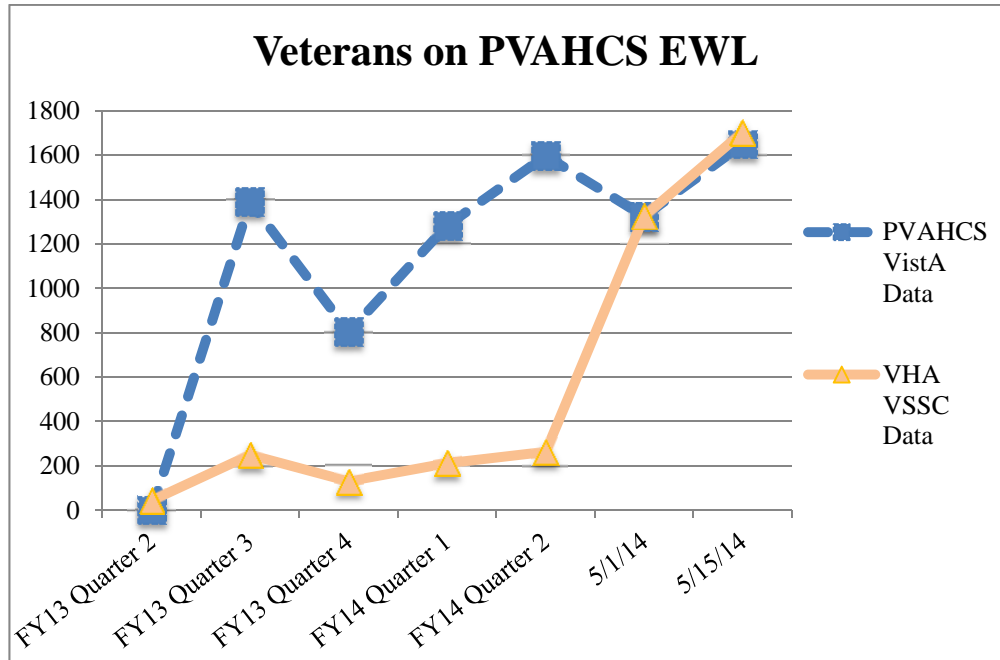
Source: PVAHCS EWL data obtained from VistA and VHA national EWL data obtained from VSSC

Because PVAHCS's EWL was not accurately reflected in the national EWL data, the time period during which those veterans were on PVAHCS's EWL was not captured in VHA wait time data. Accurate wait list information is necessary to provide VHA with the information it needs and the ability for early identification of access issues and determination of the right mix and number of resources needed.

Deceased Veterans on the EWL

A PVAHCS employee told us that coworkers may have changed death dispositions of veterans who died while on the EWL, causing the veterans to reappear on the EWL. In addition, four of the schedulers interviewed stated they were also aware of deceased veterans that they had previously removed from the EWL (because they were told the veterans were deceased) who later reappeared on the EWL.

Certain audit controls within VistA were not enabled, which limited our ability to determine whether any malicious manipulation of the VistA data occurred. At our request, VA enabled this audit trail capability at PVAHCS and nationwide. We identified nine veterans whose EWL record indicated a "Date of Death Error." We were able to review seven of nine veterans' records that had been identified as altered after VA turned on the VistA audit trail function on April 24, 2014. For those seven veterans, the VistA audit trail showed "Postmaster" as the user name. These actions were processed as an electronic action that removed the death disposition and added "Date of

Death Error" to the records. This occurred because there was no date of death recorded in the veteran's record by PVAHCS. The Postmaster automated routine deletes an EWL "Death" disposition if there is no date of death in the veteran's record and enters the reopen reason as "Date of Death Error" as an electronic control to prevent errors in reporting deaths.

PVAHCS local policy, which refers to deaths inside the facility, states schedulers should notify Decedent Affairs[8] or the Administrative Officer of the Day about a veteran's death. According to a Decedent Affairs employee, upon verification of death, Decedent Affairs should record the veteran's date of death in the electronic records. We found at least one example in which a scheduler noted a veteran's death in VistA, but Decedent Affairs did not record the veteran's date of death in the electronic records until about 3 months later. Because the Postmaster automated routine deletes an EWL "Death" disposition if there is no date of death entered in the veteran's record, we believe it is imperative that staff timely notify Decedent Affairs, and Decedent Affairs staff timely verify and record veteran deaths in VistA.

New Enrollee Scheduling Process

We concluded that the scheduling processes for new enrollees used at PVAHCS contributed to access delays. Prior to February 2013, when new patients to PVAHCS requested an appointment, PVAHCS staff referred them to eligibility and enrollment staff to verify eligibility. The eligibility and enrollment staff scheduled a primary care appointment for the veteran, regardless of the available time frame for an appointment. A prolonged period between the appointment request and the available appointment date was not unusual. Figure 2 depicts the typical scheduling process at the PVAHCS prior to February 2013.

Figure 2. PVAHCS Scheduling Process Prior To Using the EWL
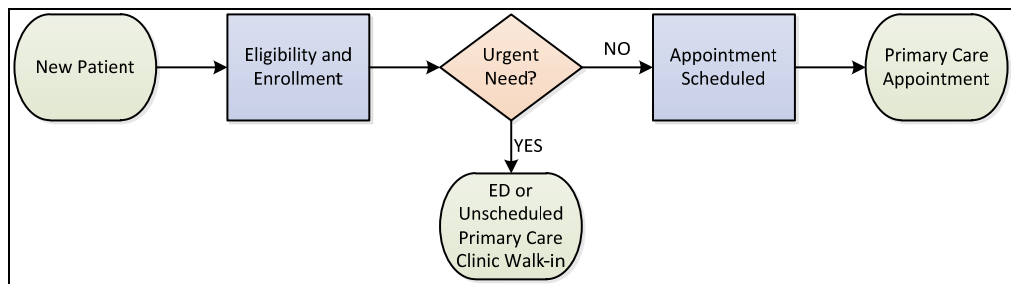
Source: VA OIG analysis of PVAHCS scheduling processes

As part of the restructuring and clinic clean-up process, the Chief of HAS issued a memo requesting the removal of scheduling responsibilities from a list of individuals. This list included eligibility and enrollment staff as well as Helpline staff. As a result, the process to obtain an appointment became

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[8] Decedent Affairs staff at PVAHCS are responsible for verifying a veteran's death and inputting the veteran's date of death in the electronic records.

more complicated for the veteran. Instead of scheduling an appointment for
a newly enrolled veteran or adding them to the EWL, eligibility and
enrollment staff gave the veteran the Helpline phone number to call to
schedule an appointment. The Helpline, in turn, printed screen shots
representing veteran appointment requests directly to printers in HAS data
management services instead of actually scheduling the appointment. HAS
personnel from outpatient services collected the screen shot printouts from
data management to place the veterans on the EWL, and eventually contact
the veteran to schedule an appointment. Figure 3 depicts the scheduling
process at PVAHCS following those changes.

Figure 3. PVAHCS Scheduling Process After EWL
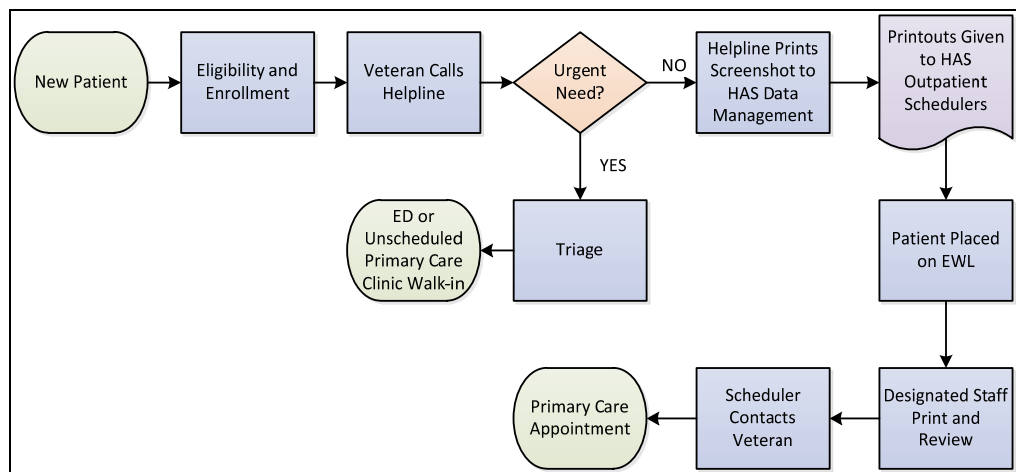
Source: VA OIG analysis of PVAHCS scheduling processes

Ultimately, new patient primary care appointment requests from enrollment,
Helpline, ED, or inpatient providers were funneled to only about three staff
responsible (sometimes more staff during overtime work) for adding veterans
to the EWL and contacting the veterans to schedule an appointment. This
change in process resulted in delays in veterans receiving appointments.

**Management
Awareness**

PVAHCS senior management was aware of the existence of access delays, as
well as many of the documents that we identified as unofficial wait lists. The
following email excerpts provide further insight into what was known and
when.

**Email From
Ms. Helman to
Dr. Deering,
July 2, 2012**

*I would like for Dr. Piatt to provide us with an action plan by next
Monday for all the cbocs [sic] and next steps that need to be taken to
start getting Veterans in.*

*I want him to address staffing, weekend/evening clinics, blocked
admin [administrative] time, etc. This is not just a 'staffing fix'.*

The plan needs to have short term and long term fixes.

*As I mentioned Friday, this wait (a year long in some clinics) is
unacceptable and we need to have a plan in place that we are
striving towards so that the* [sic] *we all support and move in the
same direction.*

Dr. Burke sent an email to Dr. Deering discussing concerns with the
reasonableness of the standards and the rate of veterans receiving an
appointment within 14 days looking better than it truly was.

*The Electronic Waiting List (EWL) is supposed to be used when we
cannot get a new pt* [patient] *appointment within 90 days. Therefore,
the fact that we currently have an EWL (with 1000+ pts on it)
suggests that we cannot get a new patient appointment within
90 days. So how can we get a new patient appointment within
14 days? And how can we do it at a 50% rate? Or 40%? Or 30, or
20, or even 10%? It makes no sense.*

Occasionally a pt will cancel an appt [appointment] *and this will
open up a sooner slot, but this cannot account for 50% of our new
pts. There are a couple of possibilities for why our numbers look
better than they truly are:*

- *We are purposely not pulling patients off the EWL until or unless
  we know we can get them an appointment within 14 days.*

- *Our EWL is so inefficiently managed that the clerical folks are
  not able to keep up with it and there are hundreds of future new
  pt appts sitting empty because they have not been able to move
  pts into those appts quickly enough.*

*I have asked HAS if clerks have been told to selectively NOT book
appts beyond 14 days in order to make us look good and was told no.
So my best guess is that the management of the EWL is so poor that
even though there are hundreds of open new pt appt slots between
now and 90 days, the clerical staff responsible for pulling pts off the
EWL and booking those appts is only, at any given time, booking
appts in the next ~30 days. The result is that a lot of the appts are
actually booked out <14 days, giving the appearance that our access
is better than it truly is.*

*If the clerical folks (the "appointment people" as Dr. Corrie might
call them) actually got on the ball and started filling all the available
appts between now and 90 days from now, our access numbers (as
reflected by the 14 day metric) would start to look worse.*

*So when you ask what happened to cause our 14 day number to drop
from 50% to 35%, the answer is that the clerical folks started being
more efficient and effective in pulling folks off the EWL.*

*All we have done in Primary Care is triple the number of daily new
pt slots. Unfortunately we have no control over the daily demand for
new pt appts. To get a true representation of our new pt access we
need to fill every new pt appt between now and 90 days before we
use the EWL.*

*Unfortunately, while this will dramatically shrink our EWL (it might
even eliminate it) it will also point out the fact that we continue to
have significant new pt access problems.*

*Email From
Management
Analyst
March 7, 2014*

A management analyst sent an email to Mr. Robinson and Dr. Deering, and
copied the Chief of HAS, Dr. Venditti, and Dr. Abbaszadegan. It was
subsequently forwarded to Ms. Helman. This was in response to an email
from Ms. Susan Bowers, former VISN 18 Director, regarding VHA's
concern about inappropriately closing open consults, stating VHA has "zero
tolerance" for consults open over 90 days. When forwarding Ms. Bowers'
message to certain PVAHCS staff, Mr. Robinson asked what the effect was
of establishing EWLs if clinics cannot schedule a new patient within 90 days.
In response to Mr. Robinson's email, the management analyst expressed her
concerns.

Is there the appropriate number of staff to manage an EWL?

*… I do not feel we can start an EWL in an area unless we know for
sure that the clinic capacity really is out 90 days.*

*… Unfortunately, in my humble opinion, I think some of the "pain"
staff are feeling in dealing with this is all the incorrect practices that
have been occurring: consults not being received, future
appointments not being made or placed into Recall; and there has
been a great deal of "blind scheduling" (appts* [appointments] *are
made w/o* [without] *any contact with the pt [patient]) going on at
this Facility for some time. Any of the latter, would on the surface
appear to make scheduling easy and quick, but for what should be
obvious reasons, is not only the wrong thing to do to our patients but
is against the Directive.*

*Email From
Dr. Burke,
March 13, 2014*

A physician at the VA Pacific Islands Health Care System emailed Dr. Burke
to ask how PVAHCS was able to get new patient wait times down to 7 days
from 238 days. The VA Pacific Islands Health Care System was
experiencing a similar scheduling problem with their EWL for new patients.
Dr. Burke sent this email to one of his PVAHCS colleagues:

> *Wonderful. Not sure how to answer this. Can I just say smoke and
> mirrors?*

**Phoenix
Veteran
Outreach**

The day after the publication of our May 28, 2014, *Interim Report*, PVAHCS
requested the VA's Health Resource Center (HRC) contact veterans waiting
for care. Outreach efforts of HRC were based on the 1,700 veterans' names
we provided to VHA at the time of our *Interim Report*, as well as additional
veterans PVAHCS identified from its own review. After identifying
duplicate entries, veterans with no telephone numbers, and deceased
veterans, HRC determined that 2,881 veterans needed to be contacted. Out
of 2,881 contacts, 11 veterans needed crisis or emergency services,
146 veterans requested appointments within 7 days, and 722 veterans
requested appointments within 30 days. The remaining 2,002 veterans
requested appointments within 90 days, already had an appointment, had
transferred to another VA medical facility, requested not to be contacted, or
the HRC was not able to contact them. A detailed summary of the results of
the Phoenix outreach is in Appendix D.

Conclusion

PVAHCS maintained what we determined to be unofficial wait lists, and
used inappropriate scheduling processes, which delayed veterans' access to
health care services. We identified over 3,500 additional veterans who were
waiting to be scheduled for appointments. Those 3,500 veterans were not on
the EWL as of April 2014; most were on what we determined to be
unofficial wait lists. PVAHCS management was aware of many of the
documents that we identified as unofficial wait lists and that access delays
existed in PVAHCS. Senior PVAHCS administrative and clinical leaders
did not effectively address these access problems.

Recommendations

5. We recommended the VA Secretary review all existing wait lists at the
    Phoenix VA Health Care System to identify veterans who may be at
    risk because of a delay in the delivery of health care and provide the
    appropriate medical care. We provided this recommendation to the
    former VA Secretary in the *Interim Report*.

6. We recommended the VA Secretary take immediate action to ensure
    the Phoenix VA Health Care System reviews and provides appropriate
    health care to all veterans identified as being on unofficial wait lists.
    We provided this recommendation to the former VA Secretary in the
    Interim Report.

7. We recommended the VA Secretary ensure all new enrollees seeking
    care at the Phoenix VA Health Care System receive an appointment

within the time frames directed by Veterans Health Administration policy.

8. We recommended the VA Secretary ensure the Phoenix VA Health Care System timely process enrollment applications.

9. We recommended the VA Secretary ensure the Phoenix VA Health Care System follows VA consultation guidance and appropriately reviews consultations prior to closing them to ensure veterans receive necessary medical care.

10. We recommended the VA Secretary ensure the Phoenix VA Health Care System staff timely verify and record veteran deaths in the Veterans Health Information Systems and Technology Architecture.

Management Comments   The VA Secretary concurred with our findings and recommendations and stated that VHA would implement Recommendations 7, 8, 9, and 10 by August 2015 and that VHA had already implemented Recommendations 5 and 6. The Secretary's entire verbatim response is located in Appendix K.

OIG Response   The VA Secretary's planned corrective actions are acceptable. We will monitor VA's progress and follow up on the implementation of our recommendations until all proposed actions are completed. Based on VA's actions, we consider Recommendation 5 closed. We will close Recommendation 6 when VHA provides us documentation it contacted the veterans we identified as being on unofficial wait lists and provided to VHA after June 4, 2014. Also, in response to problems we identified with the consult process at the PVAHCS, Urology Services will be the subject of a subsequent report.

Question 3   Were PVAHCS Personnel Following Established Scheduling Procedures?

Inappropriate Scheduling Practices

From interviews with 79 HAS staff involved in the scheduling process,[9] we identified multiple types of scheduling practices not in compliance with VHA policy. Many of these scheduling schemes are described in the April 2010 *Memorandum on Inappropriate Scheduling Practices* issued by the then-Deputy Under Secretary for Health for Operations and Management. The stated purpose of the memorandum was to identify and eliminate VHA's use of inappropriate scheduling practices to improve scores on clinical access performance measures. Manipulating the desired date, using the Clinic Appointment Availability Report to identify and reschedule appointments with wait times greater than 14 days, and using paper printouts were frequently mentioned by schedulers as common practice at PVAHCS.

Desired Date Manipulation

Schedulers used the incorrect desired date of care, which resulted in manipulated wait times of established patient appointments. VHA policy states the patient defines the desired date without regard to schedule capacity. Schedulers must not alter the desired date to reflect an appointment date the patient acquiesces to for lack of appointment availability. According to VHA data of completed FY 2013 established patient appointments, PVAHCS veterans ostensibly had a 0-day wait time in 66 percent of Primary Care appointments.

We asked 40 Primary Care schedulers and supervisors how they determined the veteran's desired date when scheduling an appointment, and only 10 schedulers said they used the date the patient wanted to be seen as the patient's desire date. The remaining 30 stated they based the desired date on the provider's availability or next available appointment date. This deviation from VHA's scheduling policy resulted in appointments showing a false 0-day wait time. For example, schedulers would access the scheduling program, find an open appointment, and ask the veteran if that appointment would be acceptable. They would then back out of the scheduling program and enter the open appointment date as the veteran's desired date of care. This makes the wait time reflect 0 days for an established patient. Ten of the 30 schedulers said they had been taught to determine when the next available appointment is and use that as the purported desired date.

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[9] This included 68 Primary Care schedulers and supervisors, 2 data management analysts, 7 Helpline staff, the Chief of Outpatient Services, and the Assistant Chief of HAS.

*Email From
Dr. James Felicetta,
Former Chief of
Medical Services,
October 16, 2012*

Dr. Felicetta sent an email to Dr. Theresa Nieman, a staff physician, and copied Dr. Deering and the Chief of HAS. This message was in response to the physician protesting increasing specialty clinic appointment slots by 10 percent without additional staff to schedule patients in a timely and correct manner. It identifies Dr. Felicetta's concerns in meeting performance standards and suggests ways to meet the 14-day standard.

> *Teri, you're correct that there can be no reprieves, because we really do want to meet the national performance standard. Please work as closely as you can with HAS to make sure they NEVER use the next available scheduling function; that is a killer on the 98% performance standard. Always give them* [patient] *a time frame for when any patient, new or established, is to be seen; one month, two months, etc. That date then becomes the desired date, which hopefully you can hit within 14 days; it's actually a 28-day range, because the appointment can be before or after the desired date. Be sure to discharge as many patients as you possibly can from clinic; don't accumulate them. Screen those incoming consults very aggressively so that a number of them do not have to be seen face-to-face.*

*Clinic
Appointment
Availability
Report*

Supervisors told schedulers to review the Clinic Appointment Availability Report in VistA and to review appointments they scheduled with wait times greater than 14 days. According to one scheduling supervisor's directions to staff, the report was a tool used to determine clinic access issues by looking at appointments made greater than 14 days, and it was the responsibility of the scheduler to correct any scheduling errors. We interviewed 34 schedulers and supervisors familiar with the Clinic Appointment Availability Report, and 11 told us that they "fixed" or were instructed to "fix" appointments on the report.

Schedulers did this by rescheduling the appointment for the same date and time but with a later desired date. This practice can reduce or "0-out" the reported wait time. Schedulers said they felt pressure or were expected to ensure their appointments on their Clinic Appointment Availability Report showed less than a 14-day wait time. Scheduling supervisors told us the report was used to correct scheduling errors. However, one scheduling supervisor said he instructed schedulers to change the desired date to under 14 days.

*Overwriting
Appointments*

Seven of the 11 staff noted above described a process they used to overwrite existing appointments to reduce the reported wait times. Schedulers created a new appointment for the same date and time as the existing appointment. This eliminated the existing appointment and allowed the scheduler to overwrite the prior desired date to one that is closer to the appointment date. The create date of the appointment is effectively reset, thus reducing the

reported wait time. Schedulers stated their supervisors instructed them to "address" or "fix" the appointments on the Clinic Appointment Availability Report, and the schedulers used this overwrite process to reduce the reported wait times.

Holding Appointment Requests

PVAHCS HAS staff—including Primary Care schedulers, data management staff, and Helpline staff—admitted that around the time the EWL first started at PVAHCS, the standard process in Primary Care Clinics was to hold paper printouts of patients seeking an appointment. VHA policy states that no other wait list formats (paper, electronic spreadsheets, and so on) are to be used for tracking requests for outpatient appointments. We asked 55 HAS staff about printouts and 28 stated they either printed out or received printouts of patient information for scheduling purposes, representing appointment requests. For example, if a veteran called or walked into a Primary Care Clinic seeking an appointment, schedulers captured their information, took a screen shot, and printed it out instead of scheduling an appointment or placing the patient on the EWL.

Of these 28 schedulers, 20 said they handed the printouts off to someone else or held them until someone came to pick them up. Staff said they kept the printouts in their desks for days or sometimes weeks before the veterans were scheduled an appointment or placed on the EWL. One scheduler said she compiled them for about 2 to 3 months. Our review of emails found that in April 2013, a management analyst asked a scheduler if she had any paper printouts she was holding for the EWL. The scheduler responded that she had roughly 200. According to the Northwest Community Based Outpatient Clinic (CBOC) supervisor, the Northwest CBOC Primary Care Clinic was still using this paper printout process in May 2014.

In February 2014, Dr. Burke sent an email to Dr. Deering with concerns that PCP schedules were sparsely scheduled.

Email From Dr. Burke, February 5, 2014

[The Chief of HAS] *is aware. Every so often I look at random PCP schedules to see how far out they are scheduled with new pts* [patients] *and I have consistently found that in the timeframe of T+30* [within 30 days] *to T+90* [within 90 days] *days they are very sparsely scheduled. I bring it up with HAS and they tell me they are working on it, are offering overtime for clerks to work weekends scheduling pts off EWL, are enlisting the team MSA's, etc. For our part (the provider end of things) we have asked PCP's to see additional new pts and have communicated this information to* [a management analyst] *who has updated each PCP's Vista grid indicating when the new pts are to be scheduled, thus allowing the clerks doing the scheduling to know where to book the pts, but the actual booking of the appts* [appointments] *is a clerical function for which we depend on them. At times* [the Chief of HAS] *has*

*mentioned pushback from PCPs but this is a copout because the new
pt slots are open for EVERY clerical/HAS person to book.*

Because VA's recorded wait times for new patients begins at the time the
scheduler creates the appointment or places the veteran on the EWL, wait
time data do not capture the wait time that occurs when schedulers hold
veterans' appointment requests. In addition, this practice introduces high
and unnecessary risks that veterans seeking an appointment may be forgotten
and not provided the access to needed care. HAS personnel told us that
because the printouts contained personally identifiable information, they
destroyed these printouts after they added the veteran to the
EWL. Therefore, we could not identify those veterans, confirm that they
were ever provided an appointment, or determine their wait times. This
practice also occurred in other clinics as described in the following email.

*Email From a
Scheduler to Chief
of Outpatient
Services,
December 20, 2012*

Earlier this morning [a Licensed Practical Nurse] *from Orthopedics
Clinic, came in to the MSA* [Medical Support Assistant] *area in front
of the Specialty Clinic looking for paperwork that was supposed to
be faxed. She asked* [a MSA]*, new MSA, to look through a drawer at
the desk that, up until Monday December 17th, was occupied by* [a
departed MSA]*. When opening the drawer, the new MSA noticed
stacks of consults, patient schedules and cancelation lists were
shoved in the drawers. There was old rotten food in the drawers-
some stuck to the consults. There were consults for the Orthopedic
Clinic dating back to September 2012 in the drawer along with other
stacks of patient paperwork. We are currently looking through the
consults to see if these patients have been scheduled.*

**PVAHCS
Management
Aware of
Scheduling
Practices**

In January 2012, VISN 18 issued a scheduling report finding that facilities
throughout the VISN did not comply with VHA policy. The report described
issues at PVAHCS that included the incorrect use of desired dates and failure
to appropriately place patients on the EWL. The report recommended the
PVAHCS Director ensure a veteran's desired date is accurately recorded as
the date on which the veteran or provider wants the patient to be seen and
ensure the veteran is entered on the EWL when appropriate.

In April 2013, Ms. Bowers expressed concerns to Ms. Helman that her
facility staff were not following VHA scheduling directives. In addition,
Ms. Bowers stated that PVAHCS leadership did not appear to disseminate
the previous communication regarding scheduling best practices to all front
line staff and supervisors.

According to the VISN 18 Executive Officer, VISN 18 conducted another
site visit in May 2013 as part of a review of scheduling practices at facilities
not currently meeting the minimum score for same-day appointment
availability. The review found scheduling requirements were not fully

implemented as prescribed in VHA policy, including using a systematic process for the identification and avoidance of inappropriate scheduling activities and full implementation of the EWL. The VISN team also noted that their review of PVAHCS was limited by strict oversight from the Assistant Chief of HAS.

VISN 18 staff required PVAHCS to submit monthly progress updates beginning in August 2013. On July 7, 2014, PVAHCS was still not in full compliance with the scheduling policy. Specifically, according to VISN 18 staff, PVAHCS had not completely trained their clerks or established EWLs in the clinics.

Training   According to VHA policy, all staff must complete required training prior to obtaining access to VistA scheduling. This did not occur at PVAHCS. VHA requires schedulers to complete a mandatory EES-010 VHA Schedulers Training Curriculum. The training consists of four courses that the employee must complete prior to receiving access to scheduling capabilities in VistA. We analyzed training records of schedulers assigned to Primary Care Clinics and determined only about 53 percent of the schedulers at PVAHCS completed the entire EES-010 VHA Schedulers Curriculum as of May 22, 2014. Although scheduler training is critical, the training provides little value if facility leadership does not ensure schedulers perform scheduling procedures in accordance with VHA policy.

Conclusion   PVAHCS personnel did not always follow established VHA scheduling practices. Some schedulers acknowledged they manipulated appointment dates by using prohibited scheduling practices because of pressure to meet wait time goals imposed by leaders at VHA and PVAHCS. In addition, nearly half of the primary care schedulers at PVAHCS had not completed the entire VHA Schedulers training curriculum. As a result of using inappropriate scheduling practices, reported wait times were unreliable and the actual wait times were unknown to key stakeholders, to include veterans seeking health care.

Recommendations

11. We recommended the VA Secretary ensure the Phoenix VA Health Care System establish an internal mechanism to perform routine quality assurance reviews of scheduling accuracy.

12. We recommended the VA Secretary ensure all Phoenix VA Health Care System staff with scheduling privileges satisfactorily complete the mandatory Veterans Health Administration scheduler training.

*Management
Comments*   The VA Secretary concurred with our findings and recommendations and
stated that VHA would implement Recommendations 11 and 12 by
August 2015.   The Secretary's entire verbatim response is located in
Appendix K.

OIG Response   The VA Secretary's planned corrective actions are acceptable.   We will
monitor VA's progress and follow up on the implementation of our
recommendations until all proposed actions are completed.

Question 4   Did the PVAHCS Culture Emphasize Goals at the Expense of Patient Care?

Overstated Accomplishments

Despite obvious access issues at PVAHCS, Ms. Helman claimed successful improvements in access measures during FY 2013.   In Ms. Helman's FY 2013 self-assessment of her Senior Executive Performance Agreement, she claimed the following significant improvements in access to care.

> *. . . I drove tremendous improvement in primary care access in FY 13.   At the beginning of the FY, I identified a severe facility weakness in access.   I realigned priorities and resources and developed a Wildly Important Goal (WIG) to engage staff and increase access. My leadership to achieve WIG of improving access was realized in the dramatic improvement in multiple measures. 7 days for Avg* [average] *3rd Next Available appointments for new and existing patients was the facility metric. For new patients, the facility began with an Avg 3rd Next Available improved 1400% from 338 days to 22 days.   WIG resulted in multiple PACT* [Patient Aligned Care Team] *improvements from FY12 to FY13 including: 70.0% of patients were seen within 7 days to 86%; 24.1% of patients received a same day appointment with their PCP to 49%. . . . In new patients receiving an appointment within 14 days of create date I improved from 32% in FY12 to 50% in FY13.*

This self-assessment addressed portions of the five critical elements that VA's Performance Review Board considered in determining Ms. Helman's performance rating.   As a result of her rating, Ms. Helman received a 1.5 percent pay increase from $169,900 to $172,449 and a performance award of $8,495.   During our review, VA rescinded the 1.5 percent pay increase and performance award of $8,495.

Emphasis on Director's "Wildly Important Goal"

In 2013, Ms. Helman established a "Wildly Important Goal" (WIG) effort to improve access to Primary Care. According to PVAHCS, the problem to be resolved was that in FY 2012, 2,700 new patients were waiting to access care. The WIG was to have all PCPs have a third-next available appointment of 7 days or less for all patients in Primary Care. The third-next available appointment was selected as a measure for the WIG, as it is commonly used in the private sector to measure access.   It is used because the first two available appointment slots may represent openings created by patients canceling appointments and does not always represent true availability.

HAS management displayed WIG posters prominently throughout the facility to show each clinic's success or failure in meeting the WIG.   The following email questioned the validity of a WIG chart showing the decline of new patient appointments in April 2013.

*Email From an
Administrative
Assistant,
June 12, 2013*

The administrative assistant sent this email because he questioned why a veteran who requested to see a PCP on May 17, 2013, had not been scheduled as of June 10, 2013. He was told the veteran was placed on the EWL on April 8, 2013. The email was sent to a number of staff, to include the Chief of HAS.

> *. . . I also thought it was interesting that a very large chart on the wall in Room D641 shows a steady decline in the number of days to schedule New Patient Appointments. The latest information posted (April 2013) shows the average wait times for a new patient appointment is 36.8 days.* [Veteran's name removed]*, a 60% service-connected Veteran, has been waiting over 60 days for new patient appointment. Not really noteworthy compared to wait times at the beginning of the year until one considers the latest reported wait time. Why the variance?*
>
> *Has access to new patient appointments significantly diminished since April?*

The administrative assistant ends his email by giving this warning.

> *Granted, I only have the two (1.25) examples to go off of, but the above raises questions regarding validity of the methodology to calculate the reported numbers. Given the importance of the Access WIG to the facility's leadership, I do believe it prudent to examine that methodology before the Medical Center Director reports these numbers to a non-PVAHCS entity that may also see a disparity.*

To achieve the WIG, inappropriate scheduling processes and practices were used prevalently throughout PVAHCS. For example, a scheduler stated that nurses and providers instructed them to cancel patient appointments in an effort to open up appointment slots in order to keep the third-next available appointment slot within the 7-day goal. Following is an August 12, 2013, email string from Dr. Burke to a management analyst requesting third-next available data to update the Primary Care Clinic's WIG score sheets and highlights the importance of the goal and its link to physician pay.

*Email From
Dr. Burke
August 12, 2013*

> [Dr. Burke]: *Can you please get me the 3rd next available data for the weeks of July 22, 29, Aug* [August] *5, and 12? Before he left,* [name removed] *had been sending the weekly data to me and I need to update my score sheets. Thanks.*

After the management analyst replied that she would follow up, Dr. Burke provided the following response.

[Dr. Burke]: *Thanks. This is very important not only for the WIG but also because primary care physician's performance pay is based, in part, on their 3rd next available.*

Another email excerpt in which Dr. Burke responded to a staff physician expressing concerns with his performance pay and access score of 0 out of 10 follows.

*Email From
Dr. Burke,
January 9, 2014*

I will be in the clinic tomorrow morning so I will try to find you. There were 2 goals for access, both heavily weighted (along with PACT related stuff, access was a big priority last year). One goal was a facility goal of getting at least 40% of new pt [patient] *appts* [appointments] *completed within 14 days of appt create date. It was worth 10 points and believe it or not we actually met that one, barely. The other access goal was an individual goal of 3rd next available follow up appt slot of <7 days, average weekly value during the 4th quarter (July, August, and Sept), also worth 10 pts* [points]*. You can see what your (and other Diamond Clinic providers) 3rd next available was on the poster boards in the clinic. Unfortunately you did not average <7 days so you did not meet that goal.*

In July 2013, Ms. Helman communicated to all staff the "extraordinary" progress made towards the goal of having all PCPs having a third-next available appointment of 7 days or less. She stated that many of the Primary Care teams reached this goal. Subsequently, Ms. Helman changed the WIG to focus on the percentage of new patients in Primary Care who are seen within 14 days, to be in line with VISN and VHA goals and metrics. Specifically, the new WIG was set as, "By September 30th, more than 40 percent of our new patients in Primary Care will be seen within 14 days of the date that their appointment is created." Ms. Helman told staff they were currently at 36.7 percent, which was up from 32 percent just a few months prior.

*Third-Next
Available
Purportedly
Improved From
338 Days to
22 Days*

On her FY 2013 self-assessment, Ms. Helman claimed the third-next available appointment for new patients in Primary Care improved from 338 days to 22 days. PVAHCS officials could not provide data to support that the third-next available appointment ever averaged 338 days for Primary Care. Facility officials provided an internal report that indicated improvements from an average of 231 days to an average of about 24 days until the third-next available appointment for new patients. We determined the claimed reductions in the third-next available appointment were related to two facility actions.

- From October 2012 to November 2012, the third-next available dropped from 231 days to about 129 days. This occurred because the facility began its new patient backlog redistribution for each physician to cancel new patient appointments that were beyond 90 days and provide those veterans with an earlier appointment.

- From February 2013 through May 2013, the third-next available dropped from 111 days to about 18 days. During this period, the facility transitioned to using the EWL in Primary Care, and schedulers admitted to holding new patient appointment requests instead of scheduling the appointments.

In addition, providers could achieve a low number of days until their third-next available appointment by not using available appointment slots. An excerpt of an email from Dr. Burke to Dr. William White regarding access issues and the ratio between providers' third-next available appointment and their current backlog follows. Dr. Burke described to Dr. White what the third-next available measure and backlog represents. Dr. Burke also provided Dr. White his providers' figures on their third-next available appointment and their current backlog, and concluded the following.

*Email From
Dr. Burke,
February 4, 2013*

. . . In looking at this we can see that [7 providers] *do pretty well.* [Provider 8] *clearly is an outlier in both 3rd next available and backlog, reflecting pretty poor access.* [Provider 9] *has a long 3rd next available delay and a fairly long backlog.* [Provider 10] *also has a pretty big backlog for only having a 3rd next available of 3 days, but this may reflect a large number of new pts* [patients] *in her schedule. In the case of* [Provider 11] *(and especially* [Provider12]*), their 3rd next available is deceiving because it would suggest that pts can get appts* [appointments] *within 1-2 days, but their backlog suggests that they are carving out appts. I know* [Provider 12] *has given his team instructions on how to schedule pts but when I looked back at the last month I found that the majority of the 8:00* [a.m.] *slots are not being used, and that raises a red flag. Also it appears that he may not be using the last appt of the day regularly either. Please know that the Pentad is looking at this closely as well and they are aware what the numbers suggest. Can you (discreetly) share this with your providers?*

By August 2013, when the facility had its lowest average third-next available appointment of about 12 days, it also had about 1,200 veterans on the EWL waiting to be scheduled for an appointment. Figure 4 illustrates PVAHCS's reported improvements in the average third-next available appointment for new patients. PVAHCS's WIG target was 7 days.

**Figure 4. Average Days Until Third-Next Available Appointment
for New Patients**
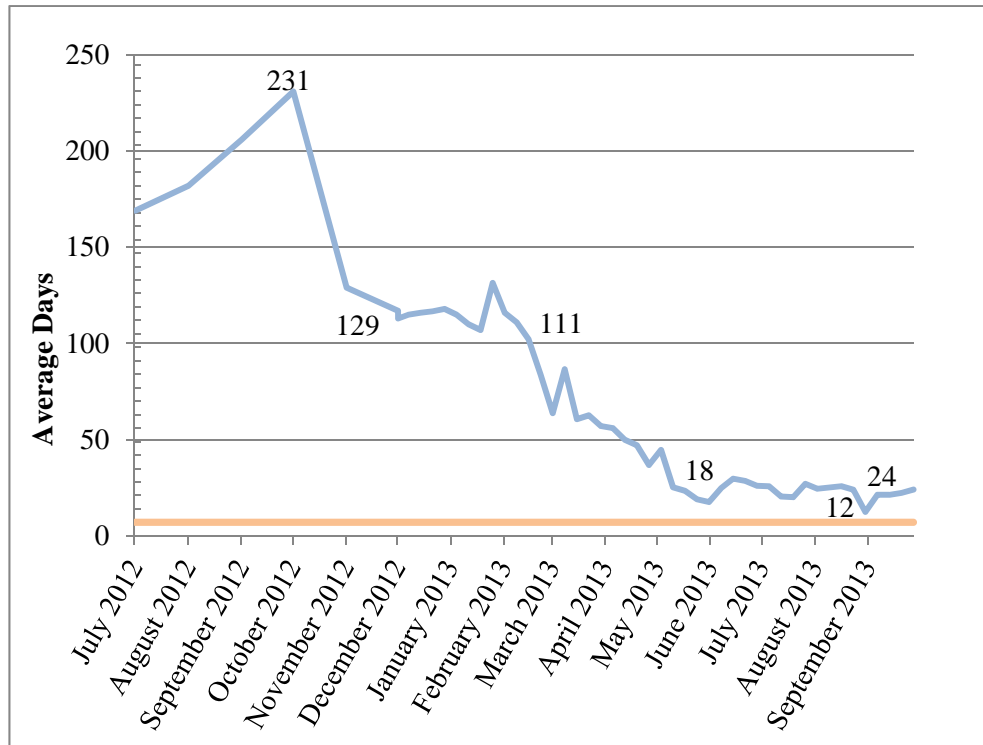
Source: PVAHCS

*Patient
Appointments
Purportedly
Completed
Within 7 Days
of Desired Date*

Ms. Helman claimed 86 percent of all primary care patients were seen within 7 days of the patient's desired date. According to PVAHCS, this was based on the facility's performance in June, July, and August 2013. We reviewed a statistical sample of all primary care appointments completed during these 3 months to determine the earliest indication a patient requested care. Our results estimated only about 59 percent of all Primary Care appointments were completed within 7 days of the patient's desired date. This analysis considered only those veterans who completed appointments and did not include those veterans who were still waiting for an appointment. Most of the wait time discrepancies occurred because schedulers used the incorrect desired date of care.

*New Patient
Appointments
Purportedly
Completed
Within 14 Days*

Ms. Helman claimed 50 percent of new patients received a Primary Care appointment within 14 days in FY 2013. According to PVAHCS, this was based on the facility's performance in August 2013. We reviewed a statistical sample of new patient Primary Care appointments completed during August 2013 to determine the earliest indication a patient desired care. We estimated only about 16 percent of new patients received a Primary Care appointment within 14 days. We also reviewed a statistical sample of new patient Primary Care appointments completed during all of FY 2013 and

estimated only about 13 percent of new patients received a Primary Care appointment within 14 days. This analysis considered only those veterans who completed appointments and did not include those veterans who were still waiting for an appointment. Most of the wait time discrepancies occurred because of delays between the veteran's requested appointment date and the date the appointment was created.

Ethics Consultation Review of the WIG

On April 18, 2012, Ms. Helman spoke at a PVAHCS Chiefs and Supervisors monthly meeting and stated that she wanted everyone to be very ethical. While serving as the Director of Edward Hines Jr. VA Hospital, Ms. Helman recalled hearing Hines providers telling clerks not to schedule veterans. She heard staff telling veterans that they would have to call back because they could not book an appointment within a couple of weeks. Ms. Helman also talked about hearing about unethical behavior involving Medicaid and Medicare while she was the acting director for the Spokane VA medical facility. She said that no one reported it to the OIG or VISN Director because they were fearful for their jobs. Ms. Helman ended her talk saying she did not want an environment like that. Also, she said that if she tells anyone to do something that goes against policies, directives, rules, or laws, they should tell someone about it.

On July 3, 2013, the PVAHCS Director's office sent an email to all PVAHCS staff that publicized extraordinary progress made towards the WIG of having a third-next available appointment within 7 days. In an email on the same date, which later was forwarded to Ms. Helman and Dr. Deering, a PVAHCS program analyst challenged the ethics of calling the WIG a success.

Email From a Program Analyst, July 3, 2013

I have to say, I think it's unfair to call any of this a success when Veterans are waiting 6 weeks on an electronic waiting list before they're called to schedule their first PCP appointment. Sure, when their appointment is created, it's [sic] *can be 14 days out, but we're making them wait 6-20 weeks to create that appointment.*

That is unethical and a disservice to our Veterans.

Even when we were scheduling 8-24 weeks out, at least we could provide ancillary services and they could try coming in as a walk-in to slip into a no-show/cancellation slot. Without a PCP assigned, and that first appointment scheduled out, new or re-establishing Veterans are totally out of luck without going through the Emergency Department or C-STAT [Consultation Stabilization Triage Assessment Team]*. I would appreciate it if you passed my sentiments along to Ms. Helman.*

Each facility must establish a local ethics program, led by the facility director, who appoints an Integrated Ethics Program Officer as the day-to-day head of the local program. An ethics consultation meeting was held on July 11, 2013. The attendees discussed the need to provide more information to veterans. They concluded that:

- Important information had been excluded from the July 3, 2013, email, and as a result, it did not provide all of the information necessary for veterans and staff members to make informed decisions.

- By failing to provide all of the information, veterans may believe they will be seen as a new patient sooner than is currently feasible.

The ethics consultation report recommended publishing both the wait time successes and the number of patients on the current EWL for new patient appointments to all PVAHCS staff. The report also recommended that HAS develop a clear process for educating veterans regarding enrollment and accessing health care during the wait time until their new patient appointments. The goal of the third recommendation was to provide reasonable expectations to veterans for obtaining new patient appointments. Ms. Helman received the report and recommendations. Our review of emails found that PVAHCS stated it developed a New Veteran Orientation booklet to address recommendations 2 and 3.[10] However, according to an email from Ms. Claflin, PVAHCS did not publish the number of veterans on the EWL at that time because the EWL was still being implemented in various clinics.

PVAHCS Work Environment

While conducting our work at PVAHCS, OIG staff and the OIG Hotline received allegations of mismanagement, inappropriate hiring decisions, sexual harassment, and bullying behavior by mid- and senior-level managers at this facility. We interviewed or received OIG Hotline complaints from 26 current and former staff who specifically reported issues of harassment, bullying, improper use of resources, reprisal, and general fear of losing their jobs. Staff in more than one department called the culture "toxic."

Many of these hostile work environment issues reported to us related to facility management, human resources, and the Chief of HAS. The staff made statements indicating these individuals were aggressive and demeaning toward employees and managed through intimidation, fear, and retaliation. We could not substantiate the allegations because most were anecdotal and based on third-party conversations.

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[10] We did not see this booklet during our site visits at PVAHCS and cannot verify whether the contents addressed recommendation 2 and 3.

The following is an abbreviated email from an LPN sent to Ms. Helman, Dr. Deering, and Mr. Robinson on December 12, 2013, concerning poor treatment of veterans.

Email From LPN, December 12, 2013

I have been an LPN at the Thunderbird CBOC since July of this year. I was previously employed at the Northwest CBOC.

I have seen some things at this clinic done by the staff that have disturbed me greatly, some of whom are in leadership roles. I would hope that the things that I have witnessed here will not only be disturbing to you as well, but hopefully enough to merit investigating. I have seen, specifically related to my sister team, walk in patients deliberately made to wait in the lobby for at least 2 hours, as "punishment" for not scheduling an appointment. (This was told to me directly by the team nurse assistant [name removed]*, while laughing about it.) I have seen patients come in for RN* [Registered Nurse] *appointments with our Team Leader,* [name removed]*, and after waiting for nearly two hours to be seen by her, leave the clinic without being seen because they had to wait for so long. Meanwhile, during the time that the patient was waiting,* [name removed] *was in her Nurse Assistants office discussing costumes to wear to an upcoming retirement party, which I witnessed.*

. . . I have also reported this behavior not only to my current Nurse Manager at the time, but also to 3 other Nurse Managers, and nobody will take any responsibility for investigating it. In fact, once I did report these things to my Nurse Manager, she then spoke to my team leader about it, which then began a wide array of harassment towards me from her, which I also reported.

. . . I have submitted my letter of resignation effective 12/13/13 due to the feeling of being in a hostile work environment with no recourse. I also can no longer sit by and watch our Veterans be treated in the manner in which they are at this facility. It's very unfortunate to me that this can occur in this day and age and nobody will do anything about it. Please look into it. This is not OK.

Ms. Helman sent an email the same day to Dr. Deering and Mr. Robinson saying not to send this out to anyone until they decided together on how to address the issue.

Federal Employee Viewpoint Survey

In late April through June 2013, the Office of Personnel Management asked Federal employees to provide input to the 2013 Federal Employee Viewpoint Survey to influence change at their agencies. The Federal Employee Viewpoint Survey is a tool that measures employees' perceptions of whether,

and to what extent, conditions that characterize successful organizations are present in their agencies. The survey included 10 leadership questions, 13 agency questions, and 9 satisfaction questions. For 26 of those 32 questions, PVAHCS employees were less positive compared with the overall results of VA and VHA employees. [11] Table 2 provides three examples in which PVAHCS employees were less positive with their leadership's performance.

Table 2. Federal Employee Viewpoint Survey Results

My organization's leaders maintain high standards of honesty and integrity.			
	Positive	Neutral	Negative
VA	49.3%	24.9%	25.8%
VHA	49.6%	25.0%	25.4%
PVAHCS	43.6%	23.8%	32.6%
How satisfied are you with the policies and practices of your senior leaders?			
VA	40.2%	29.7%	30.1%
VHA	40.8%	29.8%	29.4%
PVAHCS	35.7%	27.9%	36.4%
I have a high level of respect for my organization's senior leaders.			
VA	50.3%	24.4%	25.3%
VHA	50.5%	24.5%	25.0%
PVAHCS	45.5%	24.5%	30.0%

Source: 2013 Federal Employee Viewpoint Survey

Conclusion   PVAHCS's emphasis on goals resulted in a misleading portrayal of veterans' access to patient care. Despite Ms. Helman's claims of successful improvements in access measures during FY 2013, we found those accomplishments were inaccurate and unsupported.

Recommendations

13. We recommended that upon the completion of the investigation the VA Secretary confer with appropriate VA staff and determine whether administrative action should be taken against management officials at

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[11] The definitions for the Positive, Neutral, and Negative responses vary in the following ways across the response scales used in the survey. Positive: Strongly Agree/Very Satisfied and Satisfied/Very Good and Good; Neutral: Neither Agree nor Disagree/Neither Satisfied nor Dissatisfied/Fair; Negative: Disagree and Strongly Disagree/Dissatisfied and Very Dissatisfied/Poor and Very Poor.

the Phoenix VA Health Care System and ensure that action is taken where appropriate.

14. We recommended the VA Secretary ensure the Phoenix VA Health Care System include an employee satisfaction measure and a veteran satisfaction measure in the Phoenix VA Health Care System management's performance plans and facility goals.

Management Comments

The VA Secretary concurred with our findings and recommendations and stated that VHA would implement Recommendation 13 after completion of all external reviews and Recommendation 14 by March 2015. The Secretary's entire verbatim response is located in Appendix K.

OIG Response

The VA Secretary's planned corrective actions are acceptable. We will monitor VA's progress and follow up on the implementation of our recommendations until all proposed actions are completed.

Question 5   Are Scheduling Deficiencies Systemic Throughout VHA?

Inappropriate scheduling practices are a systemic problem nationwide. We identified multiple types of scheduling practices that did not comply with VHA's policy. VHA missed opportunities to hold senior headquarters and field facility leadership responsible and accountable for implementing action plans that addressed compliance with scheduling procedures. Then in May 2013, the Deputy Under Secretary for Health for Operations Management waived the FY 2013 annual requirement for facility directors to certify compliance with the VHA scheduling directive, further reducing accountability over wait time data integrity and compliance with appropriate scheduling practices. Additionally, the breakdown of the ethics system within VHA also contributed significantly to the questioning of the reliability of wait time data in the scheduling system.

Allegations of Inappropriate Scheduling Practices Found Nationwide

Since the PVAHCS story first appeared in the national media, we have received approximately 225 allegations regarding PVAHCS and approximately 445 allegations of similar issues regarding wait times at other VA medical facilities through the OIG Hotline, from Members of Congress, VA employees, veterans and their families, and the media. The VA OIG Office of Investigations has opened investigations at 93 sites of care in response to allegations of wait time manipulations. In particular, we focused on whether management ordered schedulers to falsify wait times and EWL records, or attempted to obstruct OIG or other investigative efforts. Investigations are being worked in coordination with the Department of Justice and the Federal Bureau of Investigation. Our investigations confirmed that wait time manipulations are prevalent throughout VHA. Among the variations of wait time manipulations our ongoing investigations, as of August 2014, at the 93 sites have, thus far, found many medical facilities were:

- Using the next available date as the desired date to "0-out" appointment wait times.

- Canceling appointments and rescheduling them to make wait times appear to be shorter than they actually were. To date, we substantiated that management at one facility directed schedulers to do this.

- Using paper wait lists rather than official EWLs.

- Canceling consults without appropriate clinical review.

- Altering clinic utilization rates to make it appear the clinic was meeting utilization goals.

Wherever we confirm potential criminal violations, we will present our findings to the appropriate Federal prosecutor. If prosecution is declined, we will provide documented results of our investigation to VA for whatever administrative action they deem appropriate. We will do the same if our investigations substantiate manipulation of wait times but do not find evidence of any possible criminal intent. Finally, we have also kept the U.S. Office of Special Counsel apprised of our active criminal investigations as they relate to the U.S. Office of Special Counsel's numerous referrals to VA of whistleblower disclosures of allegations relating to wait times and scheduling issues.

We identified multiple types of scheduling practices that did not comply with VHA policy and a number of types of scheduling schemes in use throughout VHA. Many of these schemes were detailed in the then-Deputy Under Secretary for Health for Operations and Management *Memorandum on Inappropriate Scheduling Practices* (April 2010), included in this report at Appendix H. The memorandum stated that in order to improve scores on assorted access measures, certain facilities have adopted the use of inappropriate scheduling practices that were not in line with patient-centered care. The following examples are schemes we identified.

Scheduling Scheme #1

Schedulers accessed the scheduling program, found an open appointment, and asked the veteran if that appointment would be acceptable. They then backed out of the scheduling program and entered the open appointment date as the veteran's desired date of care. This made the wait time of an established patient 0 days.

Scheduling Scheme #2

Schedulers described a process with the Clinic Appointment Availability Report (or similar report) that supervisors used to identify individual schedulers whose appointments exceeded the 14-day goal. Scheduling supervisors told schedulers to review these reports and correct any appointments with wait times greater than 14 days. At one location, a scheduler told us each supervisor was provided a list of schedulers who exceeded the 14-day goal. To keep their names off the supervisor's list, schedulers automatically changed the desired date to the next available appointment, thereby showing no wait time.

Scheduling Scheme #3

Staff deleted consults without full consideration of the effect on patients. They deleted or canceled provider consults without adequate reviews by clinical staff in an effort to reduce their backlog of consults.

Scheduling Scheme #4

Multiple schedulers described a process they used that essentially "overwrites" appointments to reduce the reported wait times. Schedulers made a new appointment on top of an existing appointment of the same date and time and for the same veteran. This removed the existing appointment date but did not record a canceled appointment. This action allowed the scheduler to overwrite the prior desired date and appointment create date with a new desired date. This adjusted the create date to the current date of

entry and the desired date to the date of the appointment, thus reducing the reported wait time.

Scheduling Scheme #5

Staff created patient appointments without notifying the patient. This is commonly referred to as blind scheduling and creates a high likelihood that the patient will be a no-show for their appointment.

Scheduling Scheme #6

Facilities used paper wait lists or other manual systems to track veterans waiting for care instead of using the EWL. This action delayed adding the veteran to the EWL or scheduling their appointment, thus not capturing the veteran's entire wait time in VA data.

VHA Access Audit Identified Scheduling Issues

At the direction of the former Secretary, VHA conducted an Access Audit from May 12, 2014, through June 3, 2014. The audit was to determine whether allegations about inappropriate scheduling practices were isolated instances of improper practices or if broader, more systemic problems exist. VHA's Access Audit had a number of audit limitations, such as independent verification of results, time limitations, and lack of establishing leadership and staff accountability. However, despite these and other limitations, VHA's audit also found that inappropriate scheduling practices were a systemic problem nationwide.

The audit was conducted in two phases. Phase One covered VA medical centers and large CBOCs serving at least 10,000 veterans. Phase Two covered additional VA facilities, including PVAHCS. Combined, the two phases covered 731 total facilities, including 140 parent facilities. Ultimately, VA chose to suspend Phase Two data collection after initial assessments restated high consistency with the findings of Phase One. The following are VHA's Access Audit findings.

- Efforts to meet needs of veterans (and clinicians) led to an overly complicated scheduling process that resulted in a high potential to create confusion among scheduling clerks and front-line supervisors.

- Meeting a 14-day wait time performance target for new appointments was simply not attainable given the ongoing challenge of finding sufficient provider slots to accommodate a growing demand for services. Imposing this expectation on the field before ascertaining the resources required and its ensuing broad promulgation represented an organizational leadership failure.

- The concept of "desired date" is a scheduling practice unique to VA, and difficult to reconcile against more accepted practices such as negotiating a specific appointment date based on provider availability or using a "return to clinic" interval requested by providers.

- Thirteen percent of scheduling staff interviewed indicated they received instruction (from supervisors or others) to enter in the "desired date" field

a date different from the date the veteran had requested. At least one instance of such practices was identified in 76 percent of VA facilities.

- Eight percent of scheduling staff indicated they used alternatives to the EWL or VistA package. At least one of such instance was identified in 70 percent of facilities.

- Findings indicate that in some cases, pressures were placed on schedulers to use inappropriate practices in order to make wait times (based on desired date and the wait lists) appear more favorable. Such practices are sufficiently pervasive to require VA to reexamine its entire performance management system and, in particular, whether current measures and targets for access are realistic or sufficient.

- Staffing challenges were identified in small CBOCs, especially where there were small counts of providers or administrative support.

White House Review of VA's Access to Care

On June 27, 2014, the White House published its review of the issues affecting access to timely care at VA medical facilities. The review uncovered layers of problems that led to extended wait times for veterans to get medical care, including a "corrosive culture," and little transparency or accountability. The report highlighted five significant issues that needed to be addressed by VA leadership.

- The 14-day scheduling standard is arbitrary, ill-defined, and misunderstood. The manner in which this unrealistic goal was developed and deployed has caused confusion in reporting and, in some cases, may have incentivized inappropriate actions.

- VHA needs to be restructured and reformed. It currently acts with little transparency or accountability with regard to its management of the VA medical structure. The VHA leadership structure often is unresponsive and unable to effectively manage or communicate to employees or veterans.

- A corrosive culture has led to personnel problems that are seriously affecting morale and by extension, the timeliness of health care. VHA's extensive field structure is exacerbated by poor management and communication structures, a corrosive culture of distrust between some VA employees and management, a history of retaliation toward employees raising issues, and a lack of accountability.

- VA's failures have generated a high level of oversight. It must be more agile and responsive in transparently addressing all legitimate oversight requirements. There have been a number of problems identified and recommendations made by the OIG, the Government Accountability Office (GAO), the Office of Special Counsel, Congress, and others. VA has not followed through on sufficiently addressing those problems or implementing those recommendations.

- The technology underlying the basic scheduling system used by VA medical facilities is cumbersome and outdated. However, with regard to increasing access to care, the software of the scheduling system is secondary to the need for additional resources to actually schedule, such as physical space; appropriately trained administrative support personnel; and doctors, nurses, and other health professionals.

VHA Resistance to Change

VHA has resisted external review findings. Since July 2005, OIG published 20 oversight reports on VA patient wait times and access to care, and VA has been resistant to change. For example, VHA did not concur with recommendations from the 2007 OIG report *Audit of the Veterans Health Administration's Outpatient Waiting Times* to comply with its own policy to create appointments within 7 days or revert to calculating the wait times of new patients based on the desired date of care. VHA disagreed with OIG's observations that VHA ignores the medical provider's desired date for new patients, thereby understating actual wait times. In the 2008 OIG report *Audit of Alleged Manipulation of Waiting Times in Veterans Integrated Service Network 3,* VHA did not concur with the report's conclusions and all nine recommendations. The Under Secretary at the time stated that the issues OIG reported reflected the need for policy solutions that VHA was already addressing. Therefore, singling out VISN 3 and holding it accountable was counterproductive. The 20 OIG reports are listed in Appendix F.

Even when VHA concurred with our recommendations and submitted an action plan, medical facility directors did not always implement VHA's program directives and policy changes.

For example, VA's recent Accelerating Access to Care Initiative is a critical part of increasing access to care through the use of Non-VA Care. In August 2009, OIG reported that VHA improperly paid 37 percent of outpatient fee claims, resulting in an estimated $225 million in overpayments and $52 million in underpayments in FY 2008 and an estimated $1.1 billion in overpayments and $260 million in underpayments over a 5-year period.[12] Also, serious weaknesses in the processes for authorizing outpatient fee care resulted in 80 percent of services lacking proper justification or authorization. We recommended that VHA revise and publish fee policies that establish clear requirements for how medical facilities should justify and authorize outpatient fee care. The then-Acting Under Secretary for Health concurred with the recommendation agreeing the current policies should be updated, with clarifying direction that better reflects current organizational responsibilities.

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[12] *Audit of Veterans Health Administration's Non-VA Outpatient Fee Care Program* (Report No. 08-02901-185, August 3, 2009)

However, nearly 2½ years after our 2009 report on the Fee Care Program, we reported PVAHCS mismanaged fee care funds and experienced a budget shortfall of $11.4 million, which was 20 percent of the health care system's FY 2010 fee care program funds.[13] One cause of the shortfall was the lack of effective authorization procedures, the same problem we reported in 2009. In fact, the facility processed about $56 million in fee claims without adequate review to ensure services were medically necessary.

VHA's awareness of scheduling issues provided it with an opportunity to abolish the systemic culture of inappropriate scheduling practices. However, as it did with prior audit recommendations, VHA did not hold senior field facility leaders responsible or accountable for ensuring compliance with scheduling procedures.

VHA Waived Compliance Certification

VHA Directive 2010-027, dated June 9, 2010, required annual certification (through the VISN Director to the Director of Systems Redesign in the Office of the Deputy Under Secretary for Health for Operations and Management) of full compliance with the content of this directive. Initial certifications were due 6 months following issuance of the directive and then annually thereafter.

As part of the directive, facilities are required to ensure completion, using VISN-approved processes and procedures, of a standardized yearly scheduler audit of the timeliness and appropriateness of scheduling actions and of the accuracy of desired dates. They are also required to ensure that identified deficiencies in competency or performance, identified by the annual scheduler audit, are effectively addressed.

However, in May 2013, the Deputy Under Secretary for Health for Operations Management waived the FY 2013 annual requirement for facility directors to certify compliance with the VHA scheduling directive, further reducing accountability over wait time data integrity and compliance with appropriate scheduling practices. According to VHA's Director of Systems Redesign, who was present when the decision was made, there was significant resistance from medical facility directors to certify compliance with the directive. The facility directors were concerned about certifying results that may be later found inaccurate by the OIG. VHA decided that medical facility directors would instead complete a self-review using a standardized scheduling process checklist.

In total, there were 128 facility responses. There were 19 scheduling items on the checklist. The 19 items included identifying and avoiding inappropriate scheduling activities, checking the EWL daily and acting on

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[13] *Review of Alleged Mismanagement of Non-VA Fee Care Funds at the Phoenix VA Health Care System* (Report No. 11-02280-23, November 8, 2011)

requests received, and creating appointments in response to consult requests using VistA to link the consult to the scheduled appointment. PVAHCS reported it was in compliance with these three items. The remaining 127 facilities reported the following.

- Facilities (114) reported compliance with identifying and avoiding inappropriate scheduling activities.

- Facilities (110) reported compliance with checking the EWL daily and acting on requests received.

- Facilities (105) reported compliance with creating appointments in response to consult requests using VistA to link the consult to the scheduled appointment.

Ethical Lapses   VHA's IntegratedEthics® model, implemented in VHA Handbook 1004.06, dated August 29, 2013, includes three core functions of integrated ethics: (1) ethics consultation, (2) preventative ethics (which is essentially training and issue awareness), and (3) ethical leadership. Although the current handbook is dated Summer 2013, these three core functions date back to at least 2007 in the primer discussed below as well as the earlier 2009 handbook. The principles discussed in this section derive from VHA's IntegratedEthics® program documents. A lapse in any of the three core functions of the ethics model, especially leadership as it influences the organization's culture and the behavior of individuals, invites ethical failures.

To help VA's senior and middle management provide ethical leadership, VHA's National Center for Ethics in Health Care published a primer entitled *Ethical Leadership: Fostering an Ethical Environment & Culture* in 2007.

The primer provides this summary of an ethical leader's responsibilities.

Leaders in the VA health care system have unique obligations that flow from VA's commitment to providing health care to veterans . . . born of the nation's gratitude to those who have served in its armed services.

- *As public servants, VA leaders are specifically responsible for maintaining the public trust, placing duty above self-interest, and managing resources responsibly.*

- *As health care providers, VA leaders have a fiduciary obligation to meet the health care needs of individual patients in the context of an equitable, safe, effective, accessible, and compassionate health care delivery system.*

- *As managers, leaders are responsible for creating a workplace culture based on integrity, accountability, fairness, and respect.*

The primer also discusses the importance that leaders "understand their influence on the organization's ethical environment and culture." Leaders can "inadvertently encourage or endorse unethical behavior despite their best intentions and even without being aware they are doing so. This can happen in any of several ways, such as the following:

- "When leaders set unrealistic or unattainable goals they invite employees to game the system or misrepresent results. When leaders fail to take into account organizational barriers to achieving performance expectations, they may inadvertently set up situations in which the only way to "succeed" is by engaging in behavior that employees know is wrong. In such cases, employees are likely to become cynical, especially when they believe that those who are lauded for their performance have compromised their integrity in order to get there."

- The failure "to link performance incentives to ethical practice" sets the stage for ethical lapses. "Lopsided incentives can leave employees feeling pressured to do whatever it takes to "make the measure" even when doing so raises ethical concerns. Leaders need to incentivize ethical practices just as they incentivize other behaviors."

- "When leaders care more about good performance numbers than accurate performance numbers, focus on accreditation requirements as simply a compliance burden," or "issue orders that are impossible to fulfill, . . . they send messages that have powerful effects in shaping the organization's environment and how staff members perceive the organization, their place in it, and the behaviors that are valued."

- "Many messages to employees focus on specific performance expectations. But leaders who have a personal commitment to ethics make it clear that they care not only that the results are achieved, but also *how*. If a leadership directive is expressed in absolute terms or too forcefully, it can create a strong incentive for staff to "game the system," or to withhold or even misrepresent information, i.e., "fudge the numbers." "

The systemic underreporting of wait times resulted from many causes, to include the lack of available staff and appointments, increased patient demand for services, and an antiquated scheduling system. The ethical lapses within VHA's senior leaders and middle managers also contributed to the unreliability of reported access and wait time issues, which went unaddressed by those responsible. As one symptom of the ethics leadership problem, the Chief Ethics Officer for Health Care Ethics position, along with other positions, was removed from VHA's National Leadership Board in a reorganization in 2011.

Replacing VHA's Scheduling System

Since approximately 2000, VA has made a number of unsuccessful efforts to replace VHA's VistA scheduling system. In 2009, for example, VA canceled the Replacement Scheduling Application (RSA) project. A March 2009 memo from the Under Secretary for Health to the Acting Assistant Secretary for Information and Technology stated that the RSA project had not developed a single scheduling capability it could provide to the field nor was there any expectation of delivering a capability in the near future. The memo also stated that after more than 5 years and a cost of more than $75 million, the RSA failed to deliver a useable product because of ineffective planning and oversight.

In August 2009, we published the OIG report, *Review of the Award and Administration of Task Orders Issued by the Department of Veterans Affairs for the Replacement Scheduling Application Development Program (RSA)* (Report No. 09-01926-207, August 26, 2009). RSA was a multiyear project to replace the system VHA used to schedule medical appointments for VA patients. Lacking defined requirements, an information technology architecture, and a properly executed acquisition plan, RSA was at significant risk of failure from the start. We suggested that VA needed experienced personnel to plan and manage the development and implementation of complex information technology projects effectively. We also suggested that a system to monitor and identify problems affecting the progress of projects could support VA's leadership in making effective and timely decisions to either redirect or terminate troubled projects.

Since the cancelation of the RSA project, VA has continued to seek solutions to replace its current scheduling system. In December 2011, VA posted a Request for Information for market research purposes to help VA develop requirements and an acquisition strategy. Throughout 2012, VHA and VA's Technology Acquisition Center reviewed responses from industry and determined it needed more information. In May 2013, VA decided to conduct an America Competes Act Prize Competition. The winners were notified in November 2013 (four prizes at a cost of $3 million). In FY 2013, VA awarded a $5 million contract to assist the VA project manager, a $1.06 million acquisition support contract, and a $5 million Test and Evaluation Contract to create test environments for the prize competition. To date, no solicitations have been issued for a replacement scheduling system.

While VHA's VistA scheduling system is old and cumbersome, the culture of staff manipulating data is VHA's primary scheduling issue. If managed effectively, a replacement scheduling system may enhance patient scheduling operations.

Recommendations

15. We recommended the VA Secretary initiate a nationwide review of veterans on wait lists to ensure that veterans are seen in an appropriate time, given their clinical condition. We provided this recommendation to the former VA Secretary in the *Interim Report*.

16. We recommended the VA Secretary direct the Health Eligibility Center to run a nationwide New Enrollee Appointment Request report by facility of all newly enrolled veterans and direct facility leadership to ensure all veterans have received appropriate care or are shown on the facility's Electronic Wait List. We provided this recommendation to the former VA Secretary in the *Interim Report*.

17. We recommended the VA Secretary establish veteran-centric goals and eliminate current goals that divert focus away from providing timely quality care to all eligible veterans.

18. We recommended the VA Secretary take measures to ensure use of "desired date" is appropriately applied.

19. We recommended the VA Secretary provide veterans needed care in a timely manner and minimize the use of the Electronic Wait Lists.

20. We recommended the VA Secretary require facilities to perform internal routine quality assurance reviews of scheduling accuracy of randomly selected appointments and schedulers.

21. We recommended the VA Secretary initiate a process to selectively monitor calls from veterans to schedulers and then incorporate lessons learned into training or performance plans.

22. We recommended the VA Secretary conduct a review of the Veterans Health Administration's Ethics Program to ensure the Program's operational effectiveness, integrity, and accountability.

23. We recommended the VA Secretary initiate actions to update the Veterans Health Administration's current electronic scheduling system and ensure milestones and costs are monitored.

24. We recommended the VA Secretary ensure that the Veterans Health Administration establishes a mechanism to ensure data representing VA's national performance are validated by an internal group that has direct access to the Under Secretary for Health.

Management Comments

The VA Secretary concurred with our findings and recommendations and stated that VHA would implement Recommendations 17–23 by September 2015, and that VHA had already implemented Recommendations 15, 16, and 24. The Secretary's entire verbatim response is located in Appendix K.

OIG Response The VA Secretary's planned corrective actions are acceptable. We will monitor VA's progress and follow up on the implementation of our recommendations until all proposed actions are completed. We will not close Recommendation 15 until VHA provides us national data on the number of veterans currently on wait lists to include data on how long the veterans have been on the wait lists. We will not close Recommendation 16 until the OIG completes our ongoing audit of the Health Eligibility Center to ensure the data put forth by the Health Eligibility Center are valid. We consider Recommendation 24 closed based on VA's actions.

Appendix A   Background

Phoenix VA Health Care System

PVAHCS serves veterans in central Arizona through its main medical facility, the Carl T. Hayden VA Medical Center in Phoenix, AZ. Veterans can be seen at one of the medical center's four primary care clinics.

PVAHCS also has affiliated health care clinics in the communities of Phoenix, Surprise, Gilbert, Payson, Show Low, and Globe.

- The Thunderbird VA Health Care Clinic in Phoenix serves veterans from the communities of North/Central Phoenix, Glendale, Peoria, Scottsdale, Avondale, Sun City, Goodyear, and Surprise.

- The Northwest VA Health Care Clinic in Surprise serves veterans from the communities of El Mirage, Glendale, Peoria, Sun City, Sun City West, Surprise, Wickenburg, and Wittman.

- The Southeast VA Health Care Clinic in Gilbert serves veterans on the east side of the valley including the communities of Ahwautukee, Apache Junction, Casa Grande, Chandler, Coolidge, Florence, Mesa, Superior, and Queen Creek.

- The Payson VA Health Care Clinic in Payson is a contract clinic offered to veterans through a partnership with Health Net Federal Services. The clinic serves veterans in the greater Payson area.

- The Show Low VA Health Care Clinic in Show Low serves veterans in the communities of Show Low, Strawberry, Pine, Payson, Lakeside, Pinetop, Vernon, Concho, St. Johns, Snowflake, Taylor, Springerville, Eagar, Holbrook, Alpine, Greer, and Whiteriver.

- The Globe-Miami VA Health Care Clinic in Globe serves veterans in the surrounding area.

Figure 5 is a map of the locations of the PVAHCS clinics.

Figure 5. PVAHCS Community Clinics
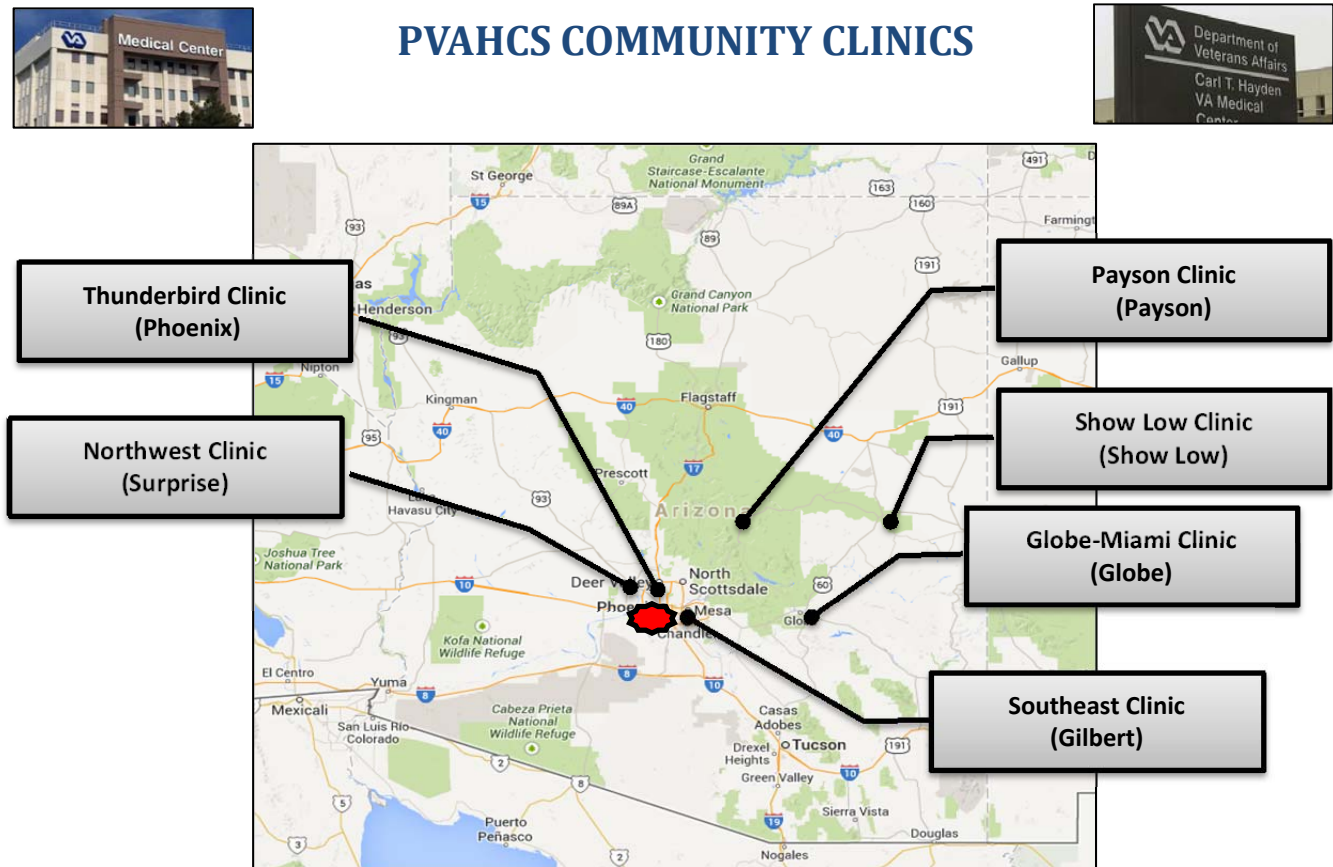
Source: Google Maps

Tracking Wait Time Data

In February 2002, the then-Deputy Under Secretary for Health sent a memo to the VHA Deputy Chief Information Officer for Health requesting the development of an EWL to track the demand for services at VA medical facilities. The memo indicated that existing wait time measures reflected the experience of veterans already in the system but did not capture the wait time experience of new veteran enrollees or patients without a scheduled appointment. At the time, "ad hoc" written lists of new veteran enrollees waiting to be entered in the scheduling system were known to exist. The memorandum attempted to formalize an EWL in VistA to more consistently and accurately reflect demand across VHA.

In November 2002, the EWL package and Phase I enhancement was released. At the time of release, there had been no VHA software to list and track patients waiting for clinic appointments, primary care team assignments, or PCP assignments. The EWL was intended to assist VA

medical facilities in managing veterans' access to outpatient health care and
assist clinics in identifying patients in need of appointments.

In the outpatient setting, patients are assigned a primary care team and
provider who are responsible for delivering care, coordinating health care
services, and serving as the point of access for specialty care. This is
accomplished through VistA. When a patient cannot be assigned to a
primary care team or position, the software asks if the patient should be
placed on the EWL. Wait list reports assist in the management of patients
awaiting a primary care team or provider assignment.

The goal of the EWL is to provide care to the patient as quickly as possible.
The EWL:

- Keeps track of appointments, clinics, and providers associated with
  patients on the various EWLs

- Records and updates patient eligibility information and service-connected
  status

- Runs background programs to determine changes in the veteran's
  service-connected percentage and service-connected priority, as well as
  changes to appointments, clinics, and personnel that affect EWL patients

- Sends messages to assigned mail groups to notify them of such changes

- Produces reports on demand regarding EWL-related activities

Appendix B Scope and Methodology

Scope

We conducted this review from April through July 2014. We reviewed allegations at PVAHCS that included gross mismanagement of VA resources, criminal misconduct by VA senior hospital leadership, systemic patient safety issues, and possible wrongful deaths. We initiated this review in response to allegations first reported to the VA OIG Hotline. We expanded our work at the request of the former VA Secretary and the Chairman of the HVAC following an HVAC hearing on April 9, 2014, on delays in VA medical care and preventable veteran deaths.

Methodology

Due to the multitude and broad range of issues, we assembled a multidisciplinary team comprising board-certified physicians, special agents, auditors, and health care inspectors. To address our review objectives, we reviewed applicable laws, regulations, policies, procedures, guidelines, and studies. Our review at PVAHCS included the following actions.

- We interviewed over 200 staff, most with direct knowledge of patient scheduling practices and policies. This included scheduling staff, data analysts, supervisors, patient care providers, management staff, and whistleblowers who reported allegations of wrongdoing.

- We interviewed the principal complainants, including Dr. Samuel Foote (retired PVAHCS physician) and Dr. Katherine Mitchell (Medical Director of the PVAHCS OEF/OIF/OND clinic).

- We collected and analyzed voluminous reports and documents from VHA information technology systems related to patient scheduling and enrollment.

- We obtained and reviewed VA and non-VA medical records of patients who died while on a wait list or whose deaths were alleged to be related to delays in care.

- We reviewed performance standards, ratings, and awards of senior PVAHCS staff.

- We reviewed complaints to the OIG Hotline on delays in care, as well as those complaints shared with us by Members of Congress or reported by the media.

- We reviewed prior reports relevant to these allegations, including administrative boards of investigations or reports from VHA's Office of the Medical Inspector.

- We reviewed over 1 million email messages, approximately 190,000 files from 11 encrypted computers and/or devices, and over 80,000 converted messages from VistA email.

During the review, we visited the PVAHCS main campus and three large primary care clinics located at the community-based outpatient sites. The review teams used interviews to determine whether PVAHCS personnel followed established scheduling procedures.

Since the PVAHCS story first appeared in the national media, we received approximately 225 allegations regarding PVAHCS and approximately 445 allegations of similar issues regarding manipulated wait times at other VA medical facilities through the OIG Hotline. We received additional allegations from Members of Congress, VA employees, veterans and their families, and the media. The VA OIG Office of Investigations opened investigations at 93 sites of care in response to allegations of wait time manipulations. In particular, we focused on whether management ordered schedulers to falsify wait times and EWL records, or attempted to obstruct OIG or other investigative efforts. Investigations continue, in coordination with the Department of Justice and the Federal Bureau of Investigation. These investigations, while some are still ongoing, confirmed that wait time manipulations are prevalent throughout VHA. Among the variations of wait time manipulations, our ongoing investigations, as of August 2014, at the 93 sites have thus far found many medical facilities were:

- Using the next available date as the desired date to "0-out" appointment wait times.

- Canceling appointments and rescheduling them to make wait times appear to be less than they actually were. We substantiated that management at one facility directed schedulers to do this.

- Using paper wait lists rather than the EWL.

- Canceling consults without appropriate clinical review.

- Altering clinic utilization rates to make it appear the clinic was meeting utilization goals.

Wherever we confirm potential criminal violations, we will present our findings to the appropriate Federal prosecutor. If prosecution is declined, we will provide documented results of our investigation to VA for whatever administrative action they deem appropriate. We will do the same if our investigations substantiate manipulation of wait times but do not find evidence of any possible criminal intent. Finally, we have also kept the U.S. Office of Special Counsel apprised of our active criminal investigations as they relate to U.S. Office of Special Counsel's numerous referrals to VA of whistleblower disclosures of allegations relating to wait times and scheduling issues.

Patient Lists

During this review, OIG was provided with numerous lists of PVAHCS patients. These patient lists were retrieved by OIG staff while onsite at PVAHCS; obtained from the PVAHCS Quality Management office and related activities; and obtained from external sources such as OIG's Hotline, the HVAC, other Congressional sources, and media reports. Furthermore, late in the course of this inspection, we found problems with access to care for patients requiring Urology Services. As a result, Urology Services at PVAHCS will be the subject of a subsequent report. In all, OIG examined the EHRs and other information for 3,409 veteran patients identified from the various lists.

Case Reviews: EWL, PVAHCS Physician List, HVAC List, Hotline List, Media List, Institutional Disclosure List, NEAR List, and Suicides

OIG physicians reviewed the care provided to patients identified on the following lists.

- EWL—deceased patients between April 2013 and April 2014
- Former PVAHCS physician list
- HVAC list
- Hotline referrals up to June 1, 2014
- Media list
- Institutional Disclosure List for disclosures made in calendar years 2012 and 2013
- Deceased patients on the NEAR list after January 1, 2012
- Suicides after January 1, 2012

Institutional disclosures include discussions of events not associated with substantial harm. For example, PVAHCS would disclose that a patient's temperature was taken using an oral probe without a protective cover, a minor surgical procedure had to be interrupted because of a power failure, or an X-ray was performed on the wrong patient.

Case Reviews: Schedule an Appointment Consult List and Paper Wait List

Providers at PVAHCS used the Schedule an Appointment consult mechanism to refer patients for care to other providers, usually in Primary Care. For this purpose, a Schedule an Appointment consult was often used. OIG staff performed preliminary reviews for the 2,426 patients on both the Schedule an Appointment consult list and the "Paper Wait" list using a review tool developed by senior physicians.

When a delay in patient care was identified, an in-depth EHR review was conducted. This review included researching previous inpatient admissions, reviewing ED visits, admissions at other VA facilities, VA registration data, and correspondence between a patient and PVAHCS. Reviewers used clinical judgment to determine whether, in their opinion, an identified delay could have translated into a harmful outcome or a potentially harmful outcome. When such a situation was identified, the EHR was flagged for an in-depth physician review ("second-level physician review").

Overall, 13 reviewers, selected based on their medical training and patient care experience, performed this initial screening. The reviewers were supervised by a physician.

Reviewers referred 341 of the 2,426 patient EHRs for physician review. This second-level review involved reexamination of the available information in the VA EHR, along with a review of any pertinent non-VA treatment records that would help in making an informed assessment regarding the effect of the delay on the veteran's health care. For many of these secondary evaluations, case review meetings were conducted with senior physician staff to present complex cases and formulate a consensus.

Case Reviews for Mental Health

OIG inspectors obtained a list from the PVAHCS's former SPC of all patient suicides from May 23, 2010, through May 6, 2014, known to the facility and reported to the VA's Center of Excellence for Suicide Prevention in Canandaigua, NY. OIG physicians (including two psychiatrists) reviewed the EHRs of 77 patients on the list who committed suicide between January 1, 2012, and May 6, 2014. Thirty of the 77 suicides initially were not known to the SPC but later came to the attention of the SPC from the PVAHCS Quality Management office.

OIG inspectors also obtained a spreadsheet of 171 PVAHCS patients on a wait list for psychotherapy services from the Director of Psychology at the PVAHCS. PVAHCS reported that most of the patients on the list were referred for psychotherapy to non-VA providers. These referrals were made in early May 2014 through the TriWest contract. OIG clinician inspectors and an OIG psychiatrist reviewed the EHRs for all patients on the list in order to ascertain an updated status for pending psychotherapy consults. For patients authorized for Non-VA Care through TriWest but still awaiting an appointment per the EHR, we obtained updates as of July 9, 2014.

We interviewed the Director of the VA Center of Excellence for Suicide Prevention, the PVAHCS' former SPC, a facility suicide prevention case manager, the Chief of Primary Care at the PVAHCS, the Chief of the Psychiatry Department, the Director of Psychology Services, the Section Chief for Outpatient Psychiatry, nine psychiatric providers in the Jade/Opal clinic, three psychologist providers in the Jade/Opal clinic, a clinical social worker in the Jade/Opal clinic, five of the clinic's registered nurses, two nursing assistants, a home telehealth nurse, and three of the Jade/Opal clinic's medical support assistants.

Records

Patient records were reviewed in VA's Compensation and Pension Record Interchange database that includes the EHR. Also, as needed, images and additional data were downloaded from VA's Computerized Patient Record System (CPRS).

Several patients in cases reviewed herein opted for Non-VA Care at critical junctures. As needed, we obtained the relevant private sector medical records and interviewed caregivers and family members. For all deceased patients reviewed in a second-level physician review, we obtained death certificates from Maricopa County and the State of Arizona, whom we would like to acknowledge for their cooperation and expedience in meeting our request.

Government Standards

Our assessment of internal controls focused on those controls relating to our review objectives. The Office of Audits and Evaluations, the Office of Healthcare Inspections, and the Office of Investigations completed this independent, joint review in accordance with the Council of the Inspectors General on Integrity and Efficiency's *Quality Standards for Inspection and Evaluation* (January 2012).

Appendix C   Statistical Sampling Methodology

We selected two random samples of primary care appointments completed at PVAHCS. Both samples were evaluated to determine the reported wait times based on our assessment of the earliest indication a patient desired care.

Populations

We sampled two populations. The first sample's population consisted of 26,382 primary care appointments for new and established patients that were completed during June through August 2013. The second population consisted of 12,341 primary care appointments for new patients during FY 2013 including 1,352 completed in August 2013.

Sampling Design

We selected a simple random sample of 80 appointments from the first population described above. We stratified the second population into eight strata and reviewed a sample of 226 appointments. We stratified the sample based on the month the appointment was completed (August or not August) and based on whether the veteran was ever on the EWL, received a Schedule an Appointment consult, or both.

Weights

We calculated estimates in this report using weighted sample data. Sampling weights were computed by taking the product of the inverse of the probabilities of selection at each stage of sampling.

Projections and Margins of Error

We used a 90 percent confidence interval and the midpoint of our estimates for our projections. The margins of error and confidence intervals are indicators of the precision of the estimates. If we repeated this audit with multiple samples, the confidence intervals would differ for each sample, but would include the true population value 90 percent of the time.

Table 3 provides our projections and margins of error.

Table 3. Projections and Margins of Error

Category	Sample Estimate (Percent)	Margin of Error (Percent)	90% Confidence Interval Lower 90%	90% Confidence Interval Upper 90%	Sample Size
New/Established Patient Appointments Completed in 7 Days of Desired Date	58.8	9.2	49.5	68.0	80
New Patient Appointments Completed in 14 Days of Create Date (FY 2013)	13.4	8.7	4.8	22.1	226
New Patient Appointments Completed in 14 Days of Create Date (August 2013)	16.1	7.9	8.3	24.0	107

Source: OIG Analysis

Appendix D   Phoenix Outreach Campaign, Health Resource Center

VA | **U.S. Department of Veterans Affairs**

DEPARTMENT OF VETERANS AFFAIRS
Health Resource Center
3401 SW 21st St., Building 9
Topeka, KS 66604

June 30, 2014

In Reply Refer To: Director/00

Mr. Steven Young
650 E Indian School Road
Phoenix, AZ 85012

Mr. Young-

We were proud to support your facility in identifying Veteran's needs for potential care. Our outbound call campaign has completed, however, there is a chance the data may change due to inbound phone calls received by the Health Resource Center (HRC). In addition, we understand Phoenix VAMC staff continue to contact the Veterans we were unsuccessful in reaching. Please find below a summary of HRC's efforts.

Phoenix Outreach Campaign

Executive Overview – The Phoenix VAMC requested the HRC to contact Veterans identified by the Phoenix VAMC regarding scheduling appointments for health care. The Phoenix VAMC identified 3091 Veterans requiring contact 19 of which were duplicated. The list of unique records included 169 records with no phone number listed and 41 deceased Veterans leaving a total of 2862 total available records for the HRC to contact. In campaign 1 the HRC Contact Representatives (CRs) were able to locate an extra 19 Veteran's phone numbers out of the list of those that did not have a phone number listed on the original report increasing the total of available contacts to 2881. Out of the 2881 contacts 11 of the calls resulted in an urgent priority, 146 of the calls were high priority, 722 of the calls were medium priority, and 2002 of the calls were low priority. The first campaign began on 5/29/14 and the last campaign ended 6/10/14. The Health Resource Center was tasked to make three attempts for each identified Veteran. All outbound calls were documented according to our internal procedures (a service request created for each attempt and a documented disposition). The snapshot below is related to a fixed point in time. The reported numbers may change due to inbound calls associated with voicemails left by the HRC and inbound calls related to mailings by the Phoenix VAMC.

Revised 06/24/2014 12:30 PM CST

Campaign 1 – The Phoenix VAMC originally provided a list of 1704 Veterans to the HEC. The list included 19 entries that were determined to be duplicated leaving 1685 unique Veteran records. The list of unique records included 108 records with no phone number listed and 14 deceased Veterans leaving a total of 1563 total available records for the HRC to contact. Through the effort of the HRC CRs making the phone calls an extra 19 Veteran's phone numbers were located to be contacted raising the number of records to be attempted to 1582. Out of the 1582 contacts 9 of the calls resulted in an urgent priority, 112 of the calls were high priority, 529 of the calls were medium priority, and 932 of the calls were low priority.

Phoenix NEAR Outreach Campaign 1	
Veterans on original NEAR list	1704
Duplicate Entries Found	19
Total Records Received by HRC (excluding duplicates)	1685
Total No Phone Number or Deceased Records	122
No Phone Number	108
Deceased	14
Net Veterans requiring Contact	**1563**
Campaign 1 Metrics	
Veterans Contacted (PRM Referral Sent)*	1582
Urgent (Crisis Call or Emergency Services)	9
High (Request Appt. within 7 Days)	112
Medium (Request Appt. within 30 Days)	529
Low (Request Appt. within 90 Days, wrong/disconnected number, or unsuccessful 3rd attempt)	932
Requesting Appointment within 90 Days	8
Veteran already has appointment	218
Unsuccessful in 3 Attempts	508
Transferred to another VAMC	27
Requesting not to be contacted	164
Deceased (Discovered by HRC outbound call)	7

Current as of June 4, 2014 10:00 AM CST

Defined as: Veterans Verbally Contacted, 3 attempted calls with message left, or wrong/disconnected number

Revised 06/24/2014 12:30 PM CST

Campaign 2 – The Phoenix VAMC identified an additional 823 Veterans requiring contact. The list of unique records included 55 records with no phone number listed and 23 deceased Veterans leaving a total of 745 total available records for the HRC to contact. Out of the 745 contacts 1 of the calls resulted in an urgent priority, 9 of the calls were high priority, 127 of the calls were medium priority, and 608 of the calls were low priority.

Phoenix NEAR Outreach Campaign 2	
Veterans on original NEAR list	823
Duplicate Entries Found	0
Total Records Received by HRC (excluding duplicates)	823
Total No Phone Number or Deceased Records	78
No Phone Number	55
Deceased	23
Net Veterans requiring Contact	**745**
Campaign 2 Metrics	
Veterans Contacted (PRM Referral Sent)*	745
Urgent (Crisis Call or Emergency Services)	1
High (Request Appt. within 7 Days)	9
Medium (Request Appt. within 30 Days)	127
Low (Request Appt. within 90 Days, wrong/disconnected number, or unsuccessful 3rd attempt)	608
Requesting Appointment within 90 Days	13
Veteran already has appointment	16
Unsuccessful in 3 Attempts	347
Does not want an appointment	164
Requesting not to be contacted	57
Deceased (Discovered by HRC outbound call)	11

Current as of June 6, 2014 8:40 AM CST

* Defined as: Veterans Verbally Contacted, 3 attempted calls with message left, or wrong/disconnected number

Revised 06/24/2014 12:30 PM CST

Campaign 3 – The Phoenix VAMC identified an additional 564 Veterans requiring contact. The additional Veterans requiring contact were identified after a comparison review was completed between the Veteran contacts received in the previous two campaigns and the official Office of Inspector General (OIG) report. The list of unique records included 6 records with no phone number listed and 4 deceased Veterans leaving a total of 554 total available records for the HRC to contact. Out of the 554 contacts 1 of the calls resulted in an urgent priority, 25 of the calls were high priority, 66 of the calls were medium priority, and 462 of the calls were low priority.

Phoenix NEAR Outreach Campaign 3	
Veterans on original NEAR list	564
Duplicate	0
List Received by HRC (excluding duplicates)	564
Veterans (No Phone Number or Deceased)	10
No Phone Number	6
Deceased	4
Net Veterans requiring Contact	**554**
Campaign 3 Metrics	
Veterans Contacted (PRM Referral Sent)*	544
Urgent (Crisis Call or Emergency Services)	1
High (Request Appt. within 7 Days)	25
Medium (Request Appt. within 30 Days)	66
Low (Request Appt. within 90 Days, wrong/disconnected number, or unsuccessful 3rd attempt)	462
Requesting Appointment within 90 Days	11
Veteran already has appointment	170
Unsuccessful in 3 Attempts	153
Does not want/need an appointment	45
Requesting not to be contacted	5
Deceased (Discovered by HRC outbound call)	1
Wrong Phone #	51
Disconnected Phone	17
Transferred to another VAMC	9

Current as of June 11, 2014 11:00 AM CST

* Defined as: Veterans Verbally Contacted, 3 attempted calls with message left, or wrong/disconnected number

matthew.eitut
is@va.gov

Matthew Eitutis
Director, Health Resource Center; (785)350-3742

Revised 06/24/2014 12:30 PM CST

Cc: Linda Halliday, Assistant IG for Audits; VA Office of Inspector General

Appendix E   Chronology of OIG Oversight of Patient Wait Times

For almost a decade, OIG and GAO reviews identified that VHA managers needed to improve efforts for collecting, trending, and analyzing clinical data. The following provides selected highlights in a chronological summary of OIG oversight addressing wait times, scheduling practices, data integrity concerns, and the lack of physician and nurse staffing standards.

2005	OIG reported, in the *Audit of Veterans Health Administration's Outpatient Scheduling Procedures*, July 2005, that VHA did not follow established procedures when scheduling appointments, resulting in inaccurate wait times and lists. OIG found: • Nationwide electronic wait lists could be understated by as many as 10,000 veterans. • VHA lacks standardized training programs for scheduling. • VHA had insufficient oversight.
2006	OIG reported in the *Review of Access to Care in the Veterans Health Administration*, May 2006, that VA medical facilities did not have effective controls to ensure all newly enrolled veterans in need of care received it and within VHA's goal of 30 days of the desired date of care. Nor did it have effective controls to ensure veterans received clinically indicated specialty procedures within a reasonable time. OIG recommended VA: • Monitor the demand for non-institutional care. • Direct VHA facilities to implement tracking mechanisms to identify newly enrolled veterans. • Establish standardized tracking methods and appropriate performance metrics throughout all medical facilities.

2007	OIG performed a follow-up audit, *Audit of Veterans Health Administration's Outpatient Waiting Times,* September 2007, again concluding the data in the scheduling system remained inaccurate. We reviewed 300 consult referrals and found more than 180 veterans were not on a wait list, but should have been. In addition, only 75 percent of appointments met 30 days for consults. • VHA disagreed and said that patient preference caused the unexplained differences. • Although policy requires schedulers to document patient preferences, VHA felt this was an unreasonable expectation. • VHA concluded that the system lacked documentation to support its position. Contrary to OIG reports, VA reported high performance in the VA Performance and Accountability Reports, even after we had twice reported the scheduling system contained inaccurate, incomplete, and unreliable data. We testified in December 2007 that these issues go beyond reported wait times. Debating whose numbers are more correct only overshadows the primary point of both our prior audit reports, which is that the information in the VHA scheduling system is incomplete. As reported in the Major Management Challenges, OIG reviews have shown unacceptably high wait times, and delays remain in obtaining sub-specialty procedures and sub-specialty medical diagnoses. OIG continues to identify wait times and patient wait lists, a problem about which OIG has reported and sought corrective action since 2005. OIG will continue to review medical outcomes and quality of care issues.
2008	In VA's Major Management Challenges, OIG reported VA made only limited progress in addressing the longstanding and underlying causes of problems with outpatient scheduling, accuracy of reported wait times, and completeness of electronic wait lists. Of concern is VHA's delay in implementing appropriate quality procedures necessary to ensure the reliability of wait times and wait lists. The May 2008 OIG report on VISN 3 wait times determined scheduling procedures were not followed, which affected the reliability of reported wait times and caused inaccuracies in the electronic wait lists. OIG recommended VHA establish procedures to routinely test the accuracy of reported wait times and the completeness of electronic wait lists, as well as take corrective action when its testing shows questionable differences between the desired dates of care and those documented in the scheduling system.

2008 (cont'd)	OIG reported that the problems and the causes associated with scheduling, wait times, and wait lists are systemic throughout VHA. VHA disagreed with the report's conclusions and all nine recommendations. The Under Secretary stated that the issues OIG reported reflected the need for policy solutions that VHA was already addressing. Therefore, singling out VISN 3 and holding them accountable was counterproductive. OIG investigated an allegation that VA employees at PVAHCS altered patient wait times in an effort to improve their performance measures. OIG found that it was an accepted past practice at the medical center to alter appointments to avoid wait times greater than 30 days and that some employees still continued that practice.
2009	OIG reported longstanding problems with outpatient scheduling delays, accuracy of reported wait times, and incomplete electronic wait lists. OIG recommended VHA implement an effective method to accurately measure and report outpatient appointments. VA's response, to address variations in the quality of care, was to establish new directives outlining VHA's leadership and accountability at all levels of the organization, and to improve communication throughout VA. OIG listed outpatient scheduling, wait times, and EWL data integrity issues as OIG's first "hot issues" paper in Administration transition briefing materials.
2010	OIG reported VHA lacked the management controls needed to ensure CBOCs provided with veterans consistent, quality care. OIG noted that CBOC primary care data were inaccurate. VA responded with new directives providing more detailed instruction for schedules on correct entry of the desired date and other essentials to improve the scheduling of veterans' appointments.
2012	OIG testified before the House and Senate Committees on Veterans' Affairs that VHA's mental health performance data are not accurate or reliable, and its measures do not adequately reflect critical dimensions of mental health care access. The inaccuracies in some of VHA's data sources presently hinder the usability of information by VHA decision makers to fully assess their: • Current capacity • Optimal resource distribution • Productivity across the system • Establishment of mental health staffing and productivity standards

2012 (cont'd)	In VA's 2011 *Performance Accountability Report*, VHA reported 95 percent of first-time patients received a full mental health evaluation within 14 days. Our analysis of the same information calculated only 49 percent of the first-time patient's initial contact in Mental Health and their full mental health evaluation occurred within their goal of 14 days. OIG also reported that controls over pre-authorizing of fee care services needed improvement. In FY 2011, OIG substantiated an allegation that PVAHCS experienced an $11.4 million budget shortfall—20 percent of the non-VA fee care programs funded for that year. Health care system management did not have sufficient procedural and monitoring controls to establish that: • The official designated to pre-authorize fee care thoroughly reviewed requests • Clinical staff conducted necessary utilization and concurrent reviews • Fee staff obligated sufficient funds for fee care As a result, PVAHCS had to obtain additional funds from the National Fee Program and VISN 18, and it had to cancel equipment purchases to cover the $11.4 million shortfall. OIG concluded that authorization procedures and the procedures to obligate sufficient funds to insure it could pay its commitments were so weak that PVAHCS processed about $56 million of fee claims during FY 2010 without adequate review. OIG's *Audit of VHA's Physician Staffing Levels for Specialty Care Services* identified the need for VHA to improve its staffing methodology by implementing productivity standards. OIG determined VHA had not established productivity standards for 31 of 33 specialty care services reviewed, and had not developed staffing plans that addressed the facilities' mission, structure, workforce, recruitment, and retention issues to meet current or projected patient outcomes, clinical effectiveness, and efficiency. VA agreed to put staffing standards for specialty care in place by FY 2015.
2014	OIG, in the *Review of Patient Wait Times, Scheduling Practices, and Alleged Patient Deaths at the Phoenix Health Care System - Interim Report*, May 2014, substantiated serious conditions at PVAHCS. We identified about 1,400 veterans who did not have a Primary Care appointment but were appropriately included on PVAHCS's EWLs. However, we identified an additional 1,700 veterans who were waiting for a Primary Care appointment but were not on the EWL. Until that happens, the reported wait time for these veterans has not started. Most importantly, these veterans were and continue to be at risk of being forgotten or lost in PVAHCS's convoluted scheduling process. Our reviews at additional VA medical facilities provided insight into the current extent of these inappropriate scheduling issues throughout the VA health care system and have confirmed that inappropriate scheduling practices are systemic. OIG testified on VA Data Manipulation and Access to VA health care before the HVAC, Subcommittee on Oversight and Investigations.

Appendix F   OIG Oversight Reports on VA Patient Wait Times

A list of the published OIG reports follows.

1. *Audit of the Veterans Health Administration's Outpatient Scheduling Procedures (7/8/2005)*

2. *Review of Access to Care in the Veterans Health Administration (5/17/2006)*

3. *Audit of the Veterans Health Administration's Outpatient Waiting Times (9/10/2007)*

4. *Audit of Alleged Manipulation of Waiting Times in Veterans Integrated Service Network 3 (5/19/2008)*

5. *Audit of Veterans Health Administration's Efforts to Reduce Unused Outpatient Appointments (12/4/2008)*

6. *Healthcare Inspection – Mammography, Cardiology, and Colonoscopy Management Jack C. Montgomery VA Medical Center Muskogee, Oklahoma (2/2/2009)*

7. *Audit of Veterans Health Administration's Non-VA Outpatient Fee Care Program (8/3/2009)*

8. *Veterans Health Administration Review of Alleged Use of Unauthorized Wait Lists at the Portland VA Medical Center (8/17/2010)*

9. *Healthcare Inspection – Delays in Cancer Care West Palm Beach VA Medical Center West Palm Beach, Florida (6/29/2011)*

10. *Healthcare Inspection – Electronic Waiting List Management for Mental Health Clinics Atlanta VA Medical Center Atlanta, Georgia (7/12/2011)*

11. *Review of Alleged Mismanagement of Non-VA Fee Care Funds at the Phoenix VA Health Care System (11/8/2011)*

12. *Healthcare Inspection – Select Patient Care Delays and Reusable Medical Equipment Review Central Texas Veterans Health Care System Temple, Texas (1/6/2012)*

13. *Review of Veterans' Access to Mental Health Care (4/23/2012)*

14. *Healthcare Inspection – Access and Coordination of Care at Harlingen
     Community Based Outpatient Clinic VA Texas Valley Coastal Bend
     Health Care System Harlingen, Texas* (8/22/2012)

15. *Healthcare Inspection – Consultation Mismanagement and Care
     Delays Spokane VA Medical Center, Spokane, Washington* (9/25/2012)

16. *Healthcare Inspection – Delays for Outpatient Specialty Procedures
     VA North Texas Health Care System Dallas, Texas* (10/23/2012)

17. *Audit of VHA's Physician Staffing Levels for Specialty Care Services*
     (12/27/2012)

18. *Healthcare Inspection – Patient Care Issues and Contract Mental
     Health Program Mismanagement Atlanta VA Medical Center Decatur,
     Georgia* (4/17/2013)

19. *Healthcare Inspection – Gastroenterology Consult Delays William
     Jennings Bryan Dorn VA Medical Center Columbia, South Carolina*
     (9/6/2013)

20. *Review of Patient Wait Times, Scheduling Practices, and Alleged
     Patient Deaths at the Phoenix Health Care System - Interim Report*
     (5/28/2014)

Appendix G   VHA Directive 2010-027: VHA Outpatient Scheduling Processes and Procedures, June 9, 2010

DEPARTMENT OF VETERANS AFFAIRS   VHA DIRECTIVE 2010-027
VETERANS HEALTH ADMINISTRATION
WASHINGTON, DC 20420   JUNE 9, 2010

VHA OUTPATIENT SCHEDULING PROCESSES AND PROCEDURES

1. PURPOSE: This Veterans Health Administration (VHA) Directive provides policy for implementing processes and procedures for the scheduling of outpatient clinic appointments and for ensuring the competency of staff directly or indirectly involved in any, or all, components of the scheduling process.

2. BACKGROUND

a. It is VHA's commitment to provide clinically appropriate quality care for eligible Veterans when they want and need it. This requires the ability to create appointments that meet the patient's needs with no undue waits or delays. Wait times for patients to be seen through scheduled appointments in primary care and specialty care clinics are monitored. In addition, patients (both new and established) are surveyed to determine if they received an appointment when they wanted one.

b. VHA is mandated to provide priority care for non-emergent outpatient medical services for any condition of a service-connected (SC) Veteran rated 50 percent or greater or for a Veteran's SC disability. Priority scheduling of any SC Veteran must not impact the medical care of any other previously scheduled Veteran. Veterans with SC disabilities are not to be prioritized over other Veterans with more acute health care needs. Emergent or urgent care is provided on an expedient basis. Emergent and urgent care needs take precedence over a priority of service connection.

c. The assurance of timely access to care requires consistent and efficient use of Veterans Health Information Systems and Technology Architecture (VistA) in the scheduling of outpatient clinic appointments.

d. Tracking and assessing the utilization and resource needs for specialty care also require use of the Computerized Patient Record System (CPRS) electronic consult request package.

e. **Definitions**

(1) **Desired Date**. The desired appointment date is the date on which the patient or provider wants the patient to be seen. Schedulers are responsible for recording the desired date correctly.

(2) **Emergent and Urgent Care**

(a) Urgent Care is care for an acute medical or psychiatric illness or for minor injuries for which there is a pressing need for treatment to manage pain or to prevent deterioration of a condition where delay might impair recovery. For example, urgent care includes the follow-up appointment for a patient discharged from a Department of Veterans Affairs (VA) medical facility if the discharging physician directs the patient to return on a specified day for the appointment.

THIS VHA DIRECTIVE EXPIRES JUNE 30, 2015

VHA DIRECTIVE 2010-027
June 9, 2010

(b)   Emergency care is the resuscitative or stabilizing treatment needed for any acute medical or psychiatric illness or condition that poses a threat of serious jeopardy to life, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part.

(3)   **Provider.** A provider is an individual licensed to deliver health care and services to patients.

(4)   **Service-Connected (SC).** Service connection or "service-connected" means that VA has determined that a condition or disability was incurred in, or has been aggravated by, military service.

(5)   **Non-Service Connected (NSC).** NSC refers to a condition or disability VA has not determined was incurred in, or has been aggravated by, military service.

(6)   **New Enrollee.** A new enrollee is a previously non-enrolled Veteran who applies for VA health care benefits and enrollment by submitting VA Form 10-10EZ, Application for Health Benefits, is determined to be eligible, and is enrolled.

(7)   **New Enrollee Appointment Request (NEAR) Call List.** The NEAR Call List is a tool to be used by enrollment staff to communicate to Primary Care Management Module (PCMM) Coordinators or schedulers, at the Veteran's designated preferred location, that a newly enrolled Veteran has requested an appointment during the enrollment process.

(8)   **Appointment Type.** Using VistA, an outpatient appointment requires the selection of at least one appointment type, which combined with the "Purpose of Visit" code creates one of 40 unique appointment types. Appointment types can be critical when scheduling different types of appointments. Examples of appointment types include: regular, employee, collateral of Veteran, sharing agreement, etc. For a complete list of appointment types, see the Patient Appointment Information Transmission (PAIT) Release Notes and Installation Guide Patch SD*5.3*333 at http://www.va.gov/vdl/documents/Clinical/Patient_Appointment_Info_Transmission/sd_53_p33 3_rn.doc.

(9)   **Newly registered Patient to the Facility.** A newly registered patient to the facility is a Veteran who is enrolled with VHA, but who has not been registered at a specific facility.

(10) **New Patient as Defined for VHA Wait Time Measurement Purposes.** For VHA Wait Time Measurement purposes, a "new patient" is any patient not seen by a qualifying provider type within a defined stop code or stop code group at that facility, within the past 24 months.

NOTE: See data definitions at http://vssc.med.va.gov/WaitTime/New_Patient_Monitor.asp# . This is an internal VA Web site not available to the public. In order to access this site, VA staff may need to go first to http://vssc.med.va.gov and accept the VHA Support Service Center Data Use Agreement.

2

(11) **Electronic Wait List (EWL).** The EWL is the official VHA wait list. The EWL is used to list patients waiting to be scheduled, or waiting for a panel assignment. In general, the EWL is used to keep track of patients with whom the clinic does not have an established relationship (e.g., the patient has not been seen before in the clinic).

(12) **Service Agreement.** A service agreement is a written agreement defining the work flow rules between any two or more services that send work to one another. Ideally, this document is developed based on discussion and consensus between the two or more involved services. The document is signed by service chiefs from involved services. If the agreement is between services at separate facilities, as with inter-facility consult service agreements, it needs to be signed by the Chiefs of Staff of each involved facility.

(13) **Encounter.** An encounter is a professional contact between a patient and a provider vested with responsibility for diagnosing, evaluating, and treating the patient's condition.

(a) Contact can include face-to-face interactions or those accomplished using telecommunications technology.

(b) Encounters are neither occasions of service nor activities incidental to an encounter for a provider visit. For example, the following activities are considered part of the encounter itself and do not constitute encounters on their own: taking vital signs, documenting chief complaint, giving injections, pulse oximetry, etc.

(c) Use of e-mail is limited and does not constitute an encounter. E-mail communications are not secure and e-mails must not contain patient specific information. ***NOTE:*** *Secure messaging communication is available through the My HealtheVet (MHV) personal health record (PHR). These communications may meet the definition of an encounter, based on type of message and content.*

(d) A telephone contact between a practitioner and a patient is only considered an encounter if the telephone contact is documented and that documentation includes the appropriate elements of a face to face encounter, namely, history and clinical decision-making. Telephone encounters must be associated with a clinic that is assigned one of the Decision Support System (DSS) Identifier telephone codes and are designated as count clinics.

(14) **Occasion of Service.** Formerly known as ancillary service, an "occasion of service" is a specified identifiable instance of an act of technical and administrative service involved in the care of a patient or consumer, which is not an encounter and does not require independent clinical judgment in the overall diagnosing, evaluating, and treating the patient's condition(s).

(a) Occasions of service are the result of an encounter. Clinical laboratory tests, radiological studies, physical medicine interventions, medication administration, and vital sign monitoring are all examples of occasions of service.

(b) Some occasions of service, such as clinical laboratory and radiology studies and tests, are automatically loaded to the Patient Care Encounter (PCE) database from other VistA packages.

3

VHA DIRECTIVE 2010-027
June 9, 2010

(15) **Count.** The term "count" refers to workload that meets the definition of an encounter or occasion of service.

(16) **Count versus Non-Count Clinics.** In the creation of Clinic Profiles, clinics are designated as either Count Clinics or Non-Count Clinics. Count Clinics are transmitted to PCE as encounters. Non-Count Clinics are not transmitted to PCE. There are generally two reasons why a clinic might be designated as non-count: if the clinic is administrative in nature and therefore not providing patient care; and if the workload associated with the clinic is transmitted to PCE automatically through another means (a VistA package other than Scheduling) then the clinic is setup as non-count to avoid sending duplicate workload to PCE (for example, occasions of service.)

(17) **DSS Identifiers.** DSS Identifiers are used to measure workload for all outpatient encounters. They are the single designation by which VHA defines clinical work units for costing purposes. In some, but not all cases, DSS Identifiers are defined to be used only for specific Non-Count Clinics assigned to a clinic profile. In these cases, DSS rules must be followed. As a specific example: when a clinic's Primary Stop Code is 674, that clinic is explicitly defined to be a Non-Count Clinic and that is the only way it should be used.

(a) Primary Stop Code. The first three numbers of the DSS Identifier represent the primary stop code. The primary stop code designates the main clinical group responsible for the care. Three numbers must always be in the first three characters of a DSS Identifier for it to be valid.

(b) Secondary Stop Code. The last three numbers of the DSS Identifier contain the secondary or credit stop code, which the VA medical center may use as a modifier to further define the primary work group. For example, a flu vaccination given in Primary Care is designated by 323710. The secondary stop code modifier may also represent the type of provider or team. For example, a Mental Health Clinic run by a social worker can be designated 502125.

(c) Credit Pair. A DSS Identifier Credit Pair is the common term used when two DSS Identifiers, a primary code and a secondary code, are utilized when establishing a clinic in the VistA software. Some specific credit pairs are listed in the DSS Identifier References.

3. POLICY. It is VHA policy that all outpatient clinic appointments, meeting the definition of an encounter, are made in Count Clinics using the VistA Scheduling software in a fashion that best suits patients' clinical needs and preferences; this includes, but is not limited to: appointments made for clinic visits; VA provided home care; consultations; and medical, surgical, dental, rehabilitation, dietetic, nursing, social work, and mental health services and procedures.

NOTE: The Count Clinic requirement does not include: non-VA care paid through VistA Fee; procedures performed in the operating room and recorded in the VistA Surgery Software; instances where encounters are generated based on unscheduled telecommunication; and occasions of service, such as clinical laboratory, radiology studies, and tests that are automatically loaded to the PCE database. An exception from the requirement of using VistA

4

Scheduling software is also extended to providers and programs such as Care Coordination Home Telehealth when encounters are generated based on unscheduled communication.

4. ACTION

a. **Director of Systems Redesign.** The Director, VHA Systems Redesign, within the Office of the Deputy Under Secretary for Health for Operations and Management (10N), is responsible for oversight of implementation of requirements of this Directive, to include measurement and monitoring of ongoing performance.

b. **Veterans Integrated Service Network (VISN) Director.** The VISN Director, or designee, is responsible for the oversight of enrollment, scheduling, processing, consult management, and wait lists for eligible Veterans.

c. **Facility Director.** The facility Director, or designee, is responsible for:

(1) Ensuring that when outpatients are seen for what constitutes an encounter on a "walk-in" basis without an already scheduled appointment, an appointment is recorded in a Count Clinic with the "Purpose of Visit" entered in the VistA Scheduling Software as "unscheduled." *NOTE: Since unscheduled visits include no entry of "desired date" for wait time measurement, desired date is equated to appointment creation date. In addition, applicable profiles need to be designed to ensure sufficient capacity to accommodate unscheduled "walk-in" patients. Unscheduled encounters that occur via telephone will not be used in the VistA Scheduling Software.*

(2) Ensuring outpatient appointments for diagnostic laboratory and imaging services are <u>not</u> made using count clinics. Non-Count clinics may be used to schedule laboratory and imaging appointments. Requests for laboratory and imaging services must be made by provider orders (not consult requests). Orders transmit directly to the laboratory or radiology software applications. Work performed in response to such orders triggers transmission of encounter data via the VHA PCE software application. *NOTE: The use of Count Clinics for diagnostic services is inappropriate in part because it would generate duplicate workload reports.*

(3) Defining "standard work" for the clinic teams to most efficiently operate the clinic. This work includes:

(a) Ensuring clinic flow occurs in a standardized manner including patient check-in with scheduling staff, nurse interview, provider visit, and check-out.

(b) Ensuring providers document orders in CPRS and explain rationale and timeframes for medications, diagnostic tests, laboratory studies, return appointments, consultations, and procedures before the patient leaves the examination room.

(c) Ensuring a check out process occurs following each clinic visit. The check-out process may consist of: nurse-administered patient education; clinical pharmacist education and review of prescription orders; collection of patient feedback; scheduling of diagnostic studies; consultations; and follow-up visits. The check-out process must also include verifying that the

5

VHA DIRECTIVE 2010-027
June 9, 2010

disposition of the appointment in the VistA Appointment Management system has been completed.

(d)   Ensuring standardized systems are in place to balance supply and demand for outpatient services including continuous forecasting and contingency planning.

(e)   Ensuring each clinic follows these additional business rules for standardizing work.

1.   Schedules must be open and available for the patient to make appointments at least three to four months into the future. Permissions may be given to schedulers to make appointments beyond these limits when doing so is appropriate and consistent with patient or provider requests. Blocking the scheduling of future appointments by limiting the maximum days into the future an appointment can be scheduled is inappropriate and is disallowed.

2.   Synchronize internal provider leave notification practices with clinic slot availability to minimize patient appointment cancellations.

3.   Strive to make follow-up appointments "on the spot" for patients returning within the 3 to 4 month window.

4.   Use the Recall/Reminder Software application to manage appointments scheduled beyond the 3 to 4 month scheduling window.

NOTE: *Backlog must be eliminated and demand and supply balanced for the above suggestions to be successful.*

(f)   Using the preferred strategy for initiating scheduling which involves:

1.   Having the referring providers' team schedule clinical consultation appointments as soon as possible on the day the consult is ordered, before the patient leaves the referring provider team area.

2.   Having the treating provider's team either schedule an appointment or, if the timeframe specified by the provider is several months into the future, record in the Recall/Reminder Software application the need for the patient to return to clinic, before the patient leaves the treating provider team area.

a.   When a patient needs a follow-up appointment but cannot be immediately scheduled, this need is to be recorded in the Recall/Reminder Software application.

b.   The patient must be advised to expect to receive a reminder to contact the clinic to actually schedule an appointment a few weeks prior to the return to clinic timeframe that the provider has specified.

c.   The patient needs to be provided information for contacting the clinic at the appropriate time to make the appointment.

6

3. Having registration or enrollment staff obtain contact information and initiate scheduling action while in direct contact with a newly enrolled or newly registered patient.

(4) Ensuring correct entry of "desired date" for an appointment. The goal is to schedule an appointment on, or as close to the desired date as possible.

(a) For New Patients

1. The scheduler needs to ask the patient: "What is the first day you would like to be seen?" The date the patient provides is the desired date.

2. 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.

3. The third step is to offer and schedule an appointment on or as close to the desired date as possible.

(b) For Established Patients' Return Appointments: A specific or a general timeframe is communicated by the provider and the actual desired date is established by the patient.

1. In order for the provider and scheduler to have a clear understanding of the intent for a return appointment, the provider must document the return date in CPRS, preferably through an order. The provider must specify if the return appointment request is for a specific day, or a general timeframe.

2. In order to establish the actual desired date correctly, the scheduler needs to tell the patient that the provider wants to see them again, giving the patient either the provider's specified date or general timeframe, and asking when the patient would like to be seen. The date the patient provides is the desired date.

3. The desired date needs to be 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.

4. The scheduler is to offer and schedule an appointment on or as close to the desired date as possible.   If there is a discrepancy between the patient and provider desired date, the scheduler must contact the provider for a decision on the return appointment timeframe.

(c) For Patients Scheduled in Response to Intra and Inter Facility Consults

1. The provider specified timeframe for the appointment needs to be the date of the provider request, unless otherwise specified by the provider.

7

VHA DIRECTIVE 2010-027
June 9, 2010

2. In order to establish the actual desired date correctly, the scheduler informs the patient of the provider's specified date or general timeframe and asks the patient "What day would you like to be seen?" The date the patient provides is the desired date.

3. The desired date needs to be 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.

4. The scheduler offers and schedules an appointment on or as close to the desired date as possible. If the provider has specified a desired date (or "soonest appropriate date") and there is a discrepancy between the patient and provider specified desired date, the scheduler must contact the provider for a decision on the appointment timeframe.

5. In creating an appointment in response to a CPRS consult request, the scheduler must use VistA menu options to link the CPRS consult request to the scheduled appointment.

(5) Ensuring that when an appointment is cancelled and rescheduled by the clinic, the scheduler enters as the desired date for the new appointment the desired date for the original appointment.

(6) Ensuring that if the patient must be contacted to create an appointment, policies are in place that outline actions to be taken to make contact, the number of attempts necessary, and documentation required.

(7) Monitoring telephone access and taking action, as needed, to minimize patient problems in accessing providers, teams, and schedulers by phone.

(8) Implementing standardized processes for enrollment, and the scheduling, processing, and management of appointments, consults, and wait lists for eligible Veterans.

(9) The creation and maintenance of a Master List of all staff members that have any of the VistA Scheduling options that may be used for scheduling patients: PCMM menu options for primary care team or for provider assignments, menu options for entries onto the EWL, and the direct supervisors of all such individuals.

(10) Ensuring successful completion of VHA Scheduler Training by all individuals on the Master List. Menu options for creating outpatient appointments are not to be provided to new schedulers without proof of their successful completion of this training. To retain these menu options, all individuals must complete newly released training for schedulers within 120 days of it being announced. *NOTE: Details regarding the availability of this training will be posted on the Mandatory Training Web page located at: http://vaww.ees.lrn.va.gov/mandatorytraining . This is an internal Web site and is not available to the public.*

(11) Ensuring all individuals on the Master List have their position description or functional statement include specific responsibilities relative to scheduling, PCMM assignments, and entries into EWL.

8

VHA DIRECTIVE 2010-027
June 9, 2010

(12) Ensuring all individuals on the Master List have, on file with their supervisor, an annual competency assessment that includes their responsibilities relative to scheduling, PCMM assignments, and entries into EWL.

(13) Ensuring completion, using VISN-approved processes and procedures, of a standardized yearly scheduler audit of the timeliness and appropriateness of scheduling actions, and of the accuracy of desired dates.

(14) Ensuring that identified deficiencies in competency or performance, identified by the annual scheduler audit, are effectively addressed.

(15) Ensuring that all clinic profiles are current at all times and subject to an annual review. This review must include compliance in requirements for use of Count versus Non-Count clinics.

(16) Ensuring full compliance by all involved services with Service Agreements. Service agreements must be reviewed and, if necessary, re-negotiated regularly (at least annually).

(17) Measuring and tracking all unused outpatient appointments in count clinics including those from no shows, patient cancellations, and unscheduled appointment slots.

(18) Ensuring that when appointments become available and the facility has at least 3 days to give patients notice, scheduling personnel offer appointments to patients who are either on the EWL waiting for appointments, or currently have appointments more than 30 days past the desired dates of care. *NOTE: This applies to management of scheduling in Count Clinics.*

(19) Ensuring that the following Business Rules for Scheduling Outpatient Clinic Appointments are followed.

(a) Patients with emergent or urgent medical needs must be provided care, or be scheduled to receive care, as soon as practicable, independent of SC status and whether care is purchased or provided directly by VA.

(b) Generally, patients with whom the provider does not yet have an established relationship and cannot be scheduled in target timeframes must be put on electronic waiting lists (EWL). VHA's EWL software is used to manage these requests, which usually consist of newly registered, newly enrolled, or new consult requests for patients waiting for their first scheduled appointment. No other wait list formats (paper, electronic spreadsheets) are to be used for tracking requests for outpatient appointments. When patients are removed from the EWL, except for medical emergencies or urgent medical needs, Veterans who are SC 50 percent or greater, or Veterans less than 50 percent SC requiring care for a SC disability must be given priority over other Veterans.

(c) Facilities are required to provide initial triage evaluations within 24 hours for all Veterans either self-requesting or being referred for mental health or substance abuse treatment. Additionally, when follow-up is needed, it must include a full diagnostic and treatment

9

VHA DIRECTIVE 2010-027
June 9, 2010

evaluation within 14 days. *NOTE: VHA leadership may mandate specific timeframes for special categories of appointments.*

(d) PCMM Coordinators or Scheduling Coordinators must check the Primary Care EWL daily and act on requests received. Schedulers in all clinics at all locations (substations) must review the EWL daily to determine if newly enrolled or newly registered patients are requesting care in their clinic at their location.

(e) A wait list for hospice or palliative care will not be maintained as VHA must offer to provide or purchase needed hospice or palliative care services without delay.

(f) A patient currently or formerly in treatment for a mental health condition, who requests to be seen outside of the clinician desired date range, needs to be seen or contacted within 1 working day by the treatment team for evaluation of the patient's concern.

(g) The VHA Class I Recall/Reminder Software application is used for patients with whom the service has an established relationship. This software application is typically used when the requested follow-up appointment date is more than 3 to 4 months into the future. These patients include those that have either been seen initially in a given VA clinic and need to return in the future; or those who have been seen initially through purchased non-VA care with a plan to be seen in follow-up at the VA clinic. *NOTE: Even though a patient seen initially through purchased non-VA care may be new to a facility clinic, the organization has committed to this relationship, so Recall/Reminder scheduling may be appropriate.*

(h) Non-VA care may be utilized in accordance with regulatory authority when service is not available in a timely manner within VHA due to capability, capacity, or accessibility. Availability of non-VA care and access to VA care must be taken into account before non-VA care is authorized. An analysis of costs of care needs to be undertaken at appropriate intervals to determine if services could be more efficiently provided within VA facilities. Use of purchased care may only be considered when the patient can be treated sooner than at a VA facility and the service is clinically appropriate and of high quality. Purchased care must only be considered when the request for care can be resolved efficiently, including having results available to the referring facility in a timely manner.

(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.

(j) Clinic cancellations, particularly when done on short notice, are to be avoided whenever possible. If a clinic must be canceled or a patient fails to appear for a scheduled appointment, the medical records need to be reviewed to ensure that urgent medical problems are addressed in a timely fashion. Provisions need to be made for necessary medication renewals and patients need to be rescheduled as soon as possible, if clinically appropriate.

(k) When a patient does not report ("no-show") for a scheduled appointment, the responsible provider, surrogate, or designated team representative needs to review the patient's

10

VHA DIRECTIVE 2010-027
June 9, 2010

medical record, including any consult or procedure request received or associated with the appointment and then determine and initiate appropriate follow-up action. *NOTE: It may be useful for the facility to assign a case manager to the patient with multiple "no-shows" to determine the best method to manage the patient's pattern of repetitive "no-shows."*

(l)   Facility leadership must be vigilant in the identification and avoidance of inappropriate scheduling activities. *NOTE: For further guidance, please see the Systems Redesign Consultation Team Guidebook available on the Systems Redesign Web site at Systems Redesign Consultation Team Guide 2008 (https://srd.vssc.med.va.gov/Pages/default.aspx). This is an internal VA Web site not available to the public.*

(20) Providing annual certification through the VISN Director to the Director, Systems Redesign, in the Office of the Deputy Under Secretary for Health for Operations and Management, of full compliance with the content of this Directive. Initial certifications are due 6 months following issuance of this Directive and then annually thereafter.

5. **REFERENCES**

   a.   Public Law 104-262.

   b.   Title 38 United States Code (U.S.C.) Sections 1710, and 1703, 1705.

   c. Code of Federal Regulations, § 17.52, 17.100, 17.36, 17.37, 17.38, and 17.49.

6. **FOLLOW-UP RESPONSIBILITY:** The Deputy Under Secretary for Health for Operations and Management (10N) is responsible for the contents of this Directive. Questions may be directed to the Director, Systems Redesign Program at 605-720-7174.

7. **RESCISSIONS:**   VHA Directive 2009-070 is rescinded.   This VHA Directive expires June 30, 2015.

Robert A. Petzel, M.D.
Under Secretary for Health

DISTRIBUTION: E-mailed to the VHA Publications Distribution List 6/9/2010

11

Appendix H Memorandum From the Deputy Under Secretary for Health for Operations and Management, April 26, 2010, Titled: Inappropriate Scheduling Practices

**Department of
Veterans Affairs**

Memorandum

Date: April 26, 2010

From: Deputy Under Secretary for Health for Operations and Management (10N)

Subj: Inappropriate Scheduling Practices

To: Network Director (10N1-23)

1.   The purpose of the memorandum is to call for immediate action within every VISN to review current scheduling practices to identify and eliminate all inappropriate practices including but not limited to the practice specified below.

2.   It has come to my attention that in order to improve scores on assorted access measures, certain facilities have adopted use of inappropriate scheduling practices sometimes referred to as "gaming strategies." Example: as a way to combat Missed Opportunity rates some medical centers cancel appointments for patients not checked-in 10 or 15 minutes prior to their scheduled appointment time. Patients are informed that it is medical center policy that they must check in early and if they fail to do so, it is in the medical center's right to cancel that appointment. This is not patient centered care.

3.   For your assistance, attached is a listing of the inappropriate scheduling practices identified by a multi-VISN workgroup charted by the Systems Redesign Office. Please be cautioned that since 2008, additional new or modified gaming strategies may have emerged, so do not consider this list a full description of all current possibilities of inappropriate scheduling practices that need to be addressed. These practices will not be tolerated.

4.   For questions, please contact Michael Davies, MD, Director, VHA Systems Redesign (Michael.Davies@va.gov) or Karen Morris, MSW, Associate Director (Karen.Morris@va.gov).

William Schoenhard, FACHE

Attachment

ATTACHMENT

Scheduling Practices to Avoid: Strategies leading to poor customer service and misrepresentation of Performance Measures/Monitors

Introduction

The purpose of this chapter is to provide assistance in ensuring scheduling accuracy during consultative site visits. It will provide an outline for consultants to better assess scheduling practices and recommend improvements.

As we strive to improve access to our veterans we must ensure in fact that improvement does not focus or rely on workarounds. Workarounds have the potential to compromise the reliability of the data as well as the integrity and honesty of our work.

Workarounds may mask the symptoms of poor access and, although they may aid in meeting performance measures, they do not serve our veterans. They may prevent the real work of improving our processes and design of systems.

We need to speak in a unified voice when interacting with staff at all levels. Our expectations are that there will be no workarounds, and that access will continue to improve with integrity and honesty in all the work that we do.

Systems Redesign principles provide us with the opportunity to improve not only access, but also quality, because without access there can be no quality; satisfaction, because waiting is a huge source of dissatisfaction; and cost of care because, delay creates waste and waste costs money. Please review the practices below to better equip you and your team during your upcoming site visits.

Scheduling Practices to Avoid

- Limiting/Blocking appointment scheduling to 30-day booking. Clinic profiles are created to allow for no more than 30-day scheduling. When patients require appointments beyond the 30 days,
  - they are told to call back another month to make their request, or
  - staff holds the appointments without scheduling until capacity opens within 30 days.
  - Evaluation Method: Ask the scheduler to make an appointment past 30 days. Review the use of recall system and EWL.
- Use of a log book or other manual system. Using this method, appointments are scheduled in VistA at a later date instead of placing patients on the EWL. This has been observed in mental health and in other clinics. The use of log books are now prohibited.

  - Evaluation Method: Interview clinical staff and scheduling staff, especially in mental health. Ask specifically about whether log books are used and ask whether patients schedule directly with the scheduler or if they must schedule with the clinician. Check Display Clinic Availability listing to assure the patients are being scheduled in VISTA.
- Creation and cancellation of New patient visits: A New patient visit is created for a date within 30 days. This visit is cancelled by the clinic; however, it is entered in Appointment Management as "cancelled by patient" instead of "cancelled by clinic" and rescheduled for another date within 30 days of the cancellation. The performance measure would show a wait time under 30 days, though it should have been calculated at >30 days if entered correctly as "cancelled by clinic." There are several ways this has been observed:

- o Scheduling the New patient visit at a time the patient would prefer not to come in and then re-scheduling.
- o Creating a New patient appointment without notifying the patient. This creates a very high likelihood that the patient will no-show which allows for another rebooking with a restarted wait time.
- o Sites may also appropriately enter "cancelled by clinic" in Appointment Management, but inappropriately reschedule the appointment 1+ days later, which restarts the wait time clock.
- o Evaluation Method: Conduct random audits of patient appointments, sampling a variety of clinics. Critically assess the scheduling process using both CPRS and Appointment Management. Check performance measure clinics with unusually low no show rates and wait times.

- Auto-Rebooking: This scheduling option removes critical scheduling data (including Desired Date) from the Appointment Management scheduling package, which prevents us from verifying that the patient was scheduled within 30 days. Recommend against using this option.
  - o Evaluation Method: Conduct random audits of patient appointments. Enter "Expanded Profile" in Appointment Management on the "*** Clinic Wait Time Information ***" screen and make sure that the "Request Type" does not state "AUTO REBOOK" (see screenshot below):
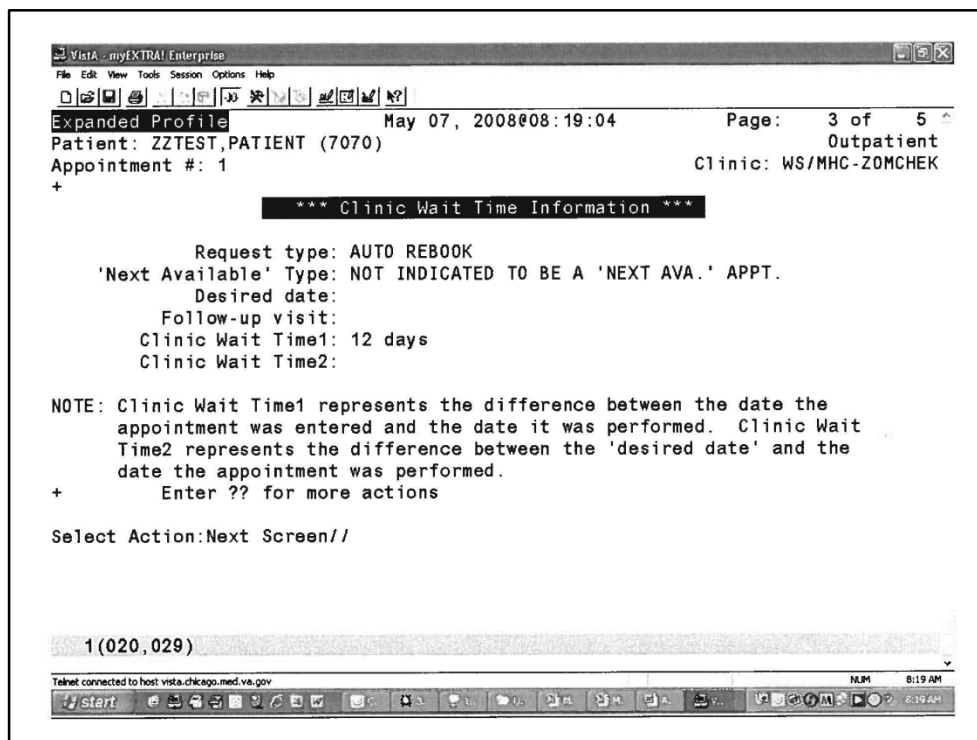
- Use of the recall system to "hold" patients until slots within 30 days open up.
  - o Evaluation Method: Conduct random audits of patient appointments entered in the recall system. If recall is being used properly, there should be evidence in the CPRS Progress Notes supporting the appointment date in the recall system.
- Use of slot for Test Patient so that this slot cannot be used but then cancelling the Test Patient and

scheduling a patient in the appointment slot. Some providers also use the Test Patient to book up their clinics if they are going on vacation so they do not have to cancel their clinic.

- o Evaluation Method: Interview schedulers and randomly look at the future clinic grids (e.g., t + 90 days) to see if test patients are scheduled.

- Block scheduling: Numerous patients are scheduled at one block of time (e.g., 8:00-12:00 pm) and have to wait a long time to be seen. Each patient should have his/her own appointment slot.
  - o Evaluation Method: Randomly look at the future clinic grids to see if several patients are scheduled at one time. If so, ask the respective schedulers whether block scheduling is being used. Note: Clinics often legitimately schedule 2+ patients in each appointment slot because they are staffed with enough clinicians to manage patients 1:1.

- Cancelling patients before the appointment time has passed if:
  - o the patient does not confirm the appointment in response to a reminder call/letter, or if
  - o the patient does not show up 15 minutes before the appointment time.

This strategy inappropriately eliminates the patient from the Missed Opportunity measure and is misleading to patients who will show up for their appointments.

  - o Evaluation Method: Interview schedulers to determine if this practice occurs. Clinics with unusually low Missed Opportunity rates should be investigated more closely.

- For established patients, entering a Desired Date that is later than what the provider/patient agreed upon in order to fit the patient in within 30 days.
  - o Evaluation Method: Cross-reference the provider's desired date from CPRS (i.e., progress note) with the Desired Date entered in Appointment Management. Also interview schedulers to determine if this practice occurs. Verify that the dates on routing slips (if used) match the Desired Date entered in Appointment Management.

- Allowing providers to request RTC dates in windows (e.g., 4-6 months). This practice allows the scheduler to enter a Desired Date based on clinic availability instead of when the patient needs to be seen.
  - o Evaluation Method: Cross-reference the provider's Desired Date from CPRS (i.e., progress note) with the Desired Date entered in Appointment Management. Also interview schedulers and providers to determine if this practice occurs. Some facilities may have a policy allowing schedulers to make appointments within 2 weeks before and after the provider's date. Interview staff and request the policy if this is occurring. If this occurs, there needs to be an entry in the "Comments" section of Appointment Management describing the provider's/patient's preference.

- For Established patients, allowing the Desired Date not to be documented prevents sites from knowing whether the patient was given an appointment within 30 days:
  - o For call-ins and walk-ins, schedulers should enter patient requests into the "Comments" field in VistA's Appointment Management system.
  - o For normal RTC appointments, providers should document the Desired Date using electronic orders in CPRS. These orders must include the provider's name, the clinic name, and the requested RTC date. It is recommended that routing slips not be used, as they are shredded daily and the information is lost. Instead, some sites require providers to complete their treatment plan progress note before patients leave, which documents the RTC date in a CPRS progress note.
  - o Evaluation Method: Interview schedulers in various clinical areas to determine whether routing slips are being used for RTC appointments. Also, randomly sample appointments to

determine whether adequate documentation exists for call-ins, walk-ins, and standard RTC appointments.

- Basing the Desired Date on clinic availability: When a provider writes RTC in 3 weeks, the clerk enters +3W to find the availability of future appointments. Once a date/time is found, the clerk exits the system and then starts over using the identified date/time as the Desired Date.
  - o Evaluation Method: Cross-reference the provider's Desired Date from CPRS (i.e., progress note) with the Desired Date entered in Appointment Management to ensure they match. Also, witness schedulers making appointments, watching for this practice.
- When clinics are cancelled and the patients need to be rescheduled, patients will be called and offered the next available appointment for that clinic. If they accept it, the scheduler will enter that date as the Desired Date as per patients' request, instead of next available.
  - o Evaluation Method: Try to observe the way appointments are rescheduled following a clinic cancellation. Interview schedulers to determine whether this is happening. One option is to call a sampling of scheduled patients and ask how their future appointment was offered to them.
- Patients (New and Established) are offered appointments beyond 30 days, but they are documented as being >30 days per patient request.
  - o New patient appointments will still fail the performance measure because the clock starts on the Creation Date. Nevertheless, this strategy misrepresents the patient's Desired Date. Patients should be asked when they would like an appointment and that date should be entered as the Desired Date for Established patients and entered in the Comments field for New patients.
  - o Evaluation Method: The team can interview front-line schedulers, asking for the wording used to schedule an appointment with patients. The best method for evaluating, however, would be to directly observe schedulers/patients while appointments are being scheduled. One option is to call a sampling of scheduled patients and ask how their future appointment was offered to them.
- Access data and Performance Measures meet the standard but when you view the clinic schedules, they are full for the next 30+ days. This suggests the site may be gaming the system.
  - o Evaluation Method: Examine random clinic grids 30 days into the future to determine whether there are any open slots. If not, ask the respective schedulers and/or service chiefs how they are able to meet the 30-day standard when the grids are booked 30+ days.
  - o It is possible that they are legitimately meeting the measure if they are feeing out all New patients who cannot get an appointment within 30 days, or if they open clinics for extended hours on an as needed basis to increase supply.
- Not including the patient in scheduling the appointment. This occurs most often in specialty clinics when scheduling New patients off consults. It creates poor customer service, a high Missed Opportunity rate, and considerable rework to reschedule these missed appointments.
  - o Evaluation Method: For specialty services, interview schedulers and other staff to determine how consults are processed and scheduled. Is there clinical review of the consults? If a clinician reviews the consult, does he/she reschedule the appointment him/herself? Does a nurse review the consult and schedule the appointment him/herself? Ask staff if they include patients in scheduling initial appointments and, if possible, observe their practices.

- Consult management:
  - When clinics are full within 30 days, consults are Cancelled or Discontinued with comments for the requesting provider to re-submit at a later date. This practice makes wait times appear shorter than they are and compromises patient care.
    - Evaluation Method: Interview Consult Manager to determine how consults are managed when no appointments within 30 days are available. Also, run the consult tracking report (Service Consults By Status [GMRC RPT CONSULTS BY STATUS]) to assess whether an unusually high percentage of consults are being Cancelled or Discontinued. If yes, investigate closer. This strategy may be occurring. The service may also have a Service Agreement in place that isn't working.
  - Holding a consult without scheduling the visit but marking the consult as completed. This method does not give the patient timely care, yet it allows the service to pass the 7-day monitor to act upon a consult.
    - Evaluation Method: Use the Completion Time Statistics ([GMRC COMPLETION STATISTICS]) report. This will display how many consults are completed without results or without a note attached.
  - Completing the consult when the appointment is scheduled rather than when the patient is seen.
    - Evaluation Method: Look in the Comments of the consult request. You will see that the appointment was made for a future date and the consult status is completed.
  - Discontinuing/Cancelling consults for simple reasons, forcing the consult to go back and forth between the requester and specialist until the clinic has availability within 30 days.
    - Evaluation Method: Run the consult tracking report to assess whether an unusually high percentage of consults are being discontinued or cancelled. Services with poor access are more likely to use this method to decrease their demand. Also, randomly select discontinued/ cancelled consults from the consult tracking report and examine them in CPRS to determine if they appear legitimate.
  - Not linking the consult to a scheduled appointment. If the patient no-shows or cancels, it would have to be manually recorded on the consult to make it active again. If it were attached, the consult would automatically return to an "active status for no-shows or cancellations and show as incomplete. Thus, not linking the consult properly will falsely improve your compliance with the timeliness of acting on a consult.
    - Evaluation Method: Use the Completion Time Statistics ([GMRC COMPLETION STATISTICS]) report. This will show how many appointments are not linked to a consult.
  - Cancelling and re-establishing consults on the day of the appointment. This practice effectively makes it appear that there are no outstanding consults and no wait times for consults to be "acted on."
    - Evaluation Method: Run the consult tracking report and randomly select consults to review. Verify in CPRS that consults weren't being cancelled and re-established, as above. Auditors can also verify that the requesting physician of the consult did not belong to the service receiving the consult.
  - Consults are not "acted on" within 7 days, which delays the start of the wait time measure. Sites should develop a process to monitor this.
    - Evaluation Method: Run the VSSC New and Established Wait Time report. This will tell you the number of days between the consult request date and the appointment creation date.
    - Below is a Fileman Template for Action on a Consult, developed in VISN 12, that can help sites monitor this:

```
SORT TEMPLATE:
OUTPUT FROM WHAT FILE: REQUEST/CONSULTATION//
SORT BY: FILE ENTRY DATE// @'DATE OF REQUEST
START WITH DATE OF REQUEST: FIRST// T-7          (MAR 25, 2008)
GO TO DATE OF REQUEST: LAST// T      (APR 01, 2008)
WITHIN DATE OF REQUEST, SORT BY: (CPRS STATUS["ACTIVE")!(CPRS STATUS["PENDING")
WITHIN (CPRS STATUS ["ACTIVE")!(CPRS STATUS["PENDNING"), SORT BY: TO SERVICE:
REQUEST SERVICES FIELD: ASSOCIATED STOP CODE       (multiple)
ASSOCIATED STOP CODE SUB-FIELD: ASSOCIATED STOP CODE:
CLINIC STOP FIELD: @AMIS REPORTING STOP CODE
START WITH AMIS REPORTING STOP CODE: FIRST// 303
GO TO AMIS REPORTING STOP CODE: LAST// 303
WITHIN AMIS REPORTING STOP CODE, SORT BY:
STORE IN 'SORT' TEMPLATE:   DE CONSULTS NOT ACTED ON
                           (Apr 01, 2008@07:47) User #673 File #123    SORT OUTPUT
FROM WHAT FILE:
SHOULD TEMPLATE USER BE ASKED 'FROM'-'TO' RANGE FOR 'DATE OF REQUEST'? NO//YES

SHOULD TEMPLATE USER BE ASKED 'FROM'-'TO' RANGE FOR 'AMIS REPORTING STOP CODE'?
NO//YES

PRINT TEMPLATE:
FIRST PRINT FIELD: PATIENT NAME;L25
THEN PRINT FIELD: TO SERVICE;L20
THEN PRINT FIELD: DATE OF REQUEST;L20
THEN PRINT FIELD: CPRS STATUS
THEN PRINT FIELD: TO SERVICE://
THEN PRINT REQUEST SERVICES FIELD: ASSOCIATED STOP CODE


OUTPUT:

PATIENT NAME          TO SERVICE          DATE OF REQUEST          CPRS STATUS
ASSOCIATED STOP CODE
-------------------------------------------------------------------------------

TEST    TEST        ECHOCARDIOGRAM — IRO  MAR 17,2008  12:12    PENDING CARDIOLOGY
TEST    TEST        ECHOCARDIOGRAM — IRO  MAR 17,2008  14:34    PENDING CARDIOLOGY
```

- o Not scheduling consults for Established patients within 30 days. Sites may schedule only New patients within 30 days, even if the Established patient is presenting with a new problem. This practice provides untimely care to Established patients simply because they have been seen within the past 2 years.
  - ▪ Evaluation Method:
    - - Search consults for Established patient and lookup the appointment information in Appointment Management. Verify that the Desired Date was not entered for a date into the future. If so, the service is not providing timely care to these Established patients with new problems.
    - - The VSSC new and Established Wait Time Report will give you a list of established patients that have a consult linked to the appointment. You will need real SSN access to drill down to patient names.

Appendix I   OIG Testimony on VA Patient Wait Times

The following testimony provides a broad overview of OIG's oversight and reporting to Congress on patient wait times.

Congressional Testimony **- 6/9/2014 -** Statement of Richard J. Griffin, Acting Inspector General, Office of Inspector General, Department of Veterans Affairs, Before the Committee on Veterans' Affairs, United States House of Representatives, Hearing on "Data Manipulation and Access to VA Healthcare"

Congressional Testimony **- 5/15/2014 -** Statement of Richard J. Griffin, Acting Inspector General, Office of Inspector General, Department of Veterans Affairs, Before the Committee on Veterans' Affairs, United States Senate, Hearing on "The State of VA Health Care"

Congressional Testimony **- 4/9/2014 -** Statement of John D. Daigh, Jr., M.D., Assistant Inspector General for Healthcare Inspections, Office of Inspector General, Department of Veterans Affairs, Before the Committee on Veterans' Affairs, United States House of Representatives, Hearing on "A Continued Assessment of Delays in VA Medical Care and Preventable Veteran Deaths"

Congressional Testimony **- 8/7/2013 -** Statement of Michael L. Shepherd, M.D., Senior Physician, Office of Healthcare Inspections, Office of Inspector General, Department of Veterans Affairs, Before the Committee on Veterans' Affairs, United States Senate, Field Hearing: "Ensuring Veterans Receive the Care They Deserve: Addressing VA Mental Health Program Management"

Congressional Testimony **- 3/13/2013 -** Statement of Linda A. Halliday, Assistant Inspector General for Audits and Evaluations, Office of Inspector General, Department of Veterans Affairs, Before the Subcommittee on Health, Committee on Veterans' Affairs, United States House of Representatives, Hearing on "Meeting Patient Care Needs: Measuring the Value of VA Physician Staffing Standards"

Congressional Testimony **- 2/13/2013 -** Statement of Office of Inspector General, Department of Veterans Affairs, to the Committee on Veterans' Affairs, United States House of Representatives, Hearing on "Honoring The Commitment: Overcoming Barriers to Quality Mental Health Care for Veterans"

Congressional Testimony **- 9/14/2012 -** Statement of Office of Inspector General, Department of Veterans Affairs, to Subcommittee on Health

Committee on Veterans' Affairs, United States House of Representatives, Hearing on "VA Fee Basis: Examining Solutions to a Flawed System"

Congressional Testimony **- 5/8/2012 -** Statement of Office of Inspector General, Department of Veterans Affairs, Before the Committee on Veterans' Affairs, United States House of Representatives, Hearing on "VA Mental Health Care Staffing: Ensuring Quality and Quantity"

Congressional Testimony **- 4/25/2012 -** Statement of Office of Inspector General, Department of Veterans Affairs, Before the Committee on Veterans' Affairs, United States Senate, Hearing on "VA Mental Health Care: Evaluating Access and Assessing Care"

Congressional Testimony **- 11/15/2011 -** Statement of Belinda J. Finn, Assistant Inspector General for Audits and Evaluations, Office of Inspector General, Department of Veterans Affairs, Before the Committee on Veterans' Affairs, United States House of Representatives, Hearing on "Potential Budgetary Savings Within VA: Recommendations From Veterans Service Organizations"

Congressional Testimony **- 3/9/2011 -** Statement of Richard J. Griffin, Deputy Inspector General, Office of Inspector General, Department of Veterans Affairs, Before the Subcommittee on Military Construction, Veterans Affairs, and Related Agencies; Committee on Appropriations, United States House of Representatives, Hearing on "The State of the Department of Veterans Affairs"

Congressional Testimony **- 9/10/2009 -** Statement of Maureen T. Regan, Counselor to the Inspector General, Office of Inspector General, Department of Veterans Affairs, Before the Subcommittee on Economic Opportunity, Committee on Veterans' Affairs, United States House of Representatives, Hearing on "The Review of SPAWAR and VA's Interagency Agreement"

Congressional Testimony **- 5/6/2008 -** Statement of Michael Shepherd, M.D., Senior Physician, Office of Healthcare Inspections, Office of Inspector General, Department of Veterans Affairs, Before the Committee on Veterans' Affairs, United States House of Representatives, Hearing on "Veterans' Suicides"

Congressional Testimony **- 2/27/2008 -** Statement of the Office of Inspector General, Department of Veterans Affairs, Before Subcommittee on Military Construction, Veterans Affairs, and Related Agencies; Committee on Appropriations, United States House of Representatives, Hearing on "The Fiscal Year 2009 Budget for the Office of the Inspector General, Department of Veterans Affairs"

Congressional Testimony **- 2/13/2008 -** Statement of Jon A. Wooditch, Deputy Inspector General, Department of Veterans Affairs, Before the Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, United States House of Representatives, Hearing on "The FY 2009 Budget for the Office of Inspector General"

Congressional Testimony **- 12/12/2007 -** Statement of Belinda J. Finn, Assistant Inspector General for Auditing, Office of Inspector General, Department of Veterans Affairs, Before the Subcommittee on Oversight and Investigations and the Subcommittee on Health, Committee on Veterans' Affairs, United States House of Representatives, Hearing on "Veterans Health Administration's Outpatient Waiting Times"

Congressional Testimony **- 10/3/2007 -** Statement of Larry Reinkemeyer, Director, Kansas City Audit Operations Division, Office of Inspector General, Department of Veterans Affairs, Before the Special Committee on Aging, United States Senate, Hearing on "Audit of the Veterans Health Administration's Outpatient Waiting Times"

Appendix J   Congressional Requests

House Committee on Veterans' Affairs
Hon. Jeff Miller, Chairman
Hon. Mike Michaud, Ranking Member

Subcommittee on Oversight and Investigations, House Committee on Veterans' Affairs
Hon. Mike Coffman, Chairman
Hon. Ann Kirkpatrick, Ranking Member

House Committee on Appropriations
Hon. Harold Rogers, Chairman
Hon. Nita Lowey, Ranking Member

Subcommittee on Military Construction, Veterans Affairs, and Related Agencies, House Committee on Appropriations
Hon. John Culberson, Chairman
Hon. Sanford D. Bishop, Jr., Ranking Member

Senate Committee on Appropriations
Hon. Barbara Mikulski, Chairwoman
Hon. Richard Shelby, Ranking Member

Subcommittee on Military Construction, Veterans Affairs, and Related Agencies, Senate Committee on Appropriations
Hon. Tim Johnson, Chairman
Hon. Mark Kirk, Ranking Member

US Senate

Hon. Kelly Ayotte	Hon. Amy Klobuchar
Hon. Michael Bennet	Hon. John McCain
Hon. Richard Blumenthal	Hon. Lisa Murkowski
Hon. Dianne Feinstein	Hon. Brian Schatz
Hon. Jeff Flake	Hon. Jeanne Shaheen
Hon. Charles Grassley	Hon. Tom Udall
Hon. Dean Heller	Hon. Mark Udall
Hon. Mazie Hirono	Hon. David Vitter
Hon. Mark Kirk	

US House of Representatives

Hon. Joe Barton
Hon. Jaime Herrera Beutler
Hon. Kevin Brady
Hon. Michael Burgess
Hon. John Carter
Hon. Mike Conaway
Hon. John Culberson
Hon. Mike Doyle
Hon. Tammy Duckworth
Hon. Blake Farenthold
Hon. Bill Flores
Hon. Pete Gallego
Hon. Louie Gohmert
Hon. Paul Gosar
Hon. Kay Granger
Hon. Al Green
Hon. Ralph Hall
Hon. Jeb Hensarling

Hon. Sam Johnson
Hon. Jack Kingston
Hon. Ann Kirkpatrick
Hon. Kenny Marchant
Hon. Michael McCaul
Hon. Tim Murphy
Hon. Randy Neugebauer
Hon. Pete Olson
Hon. Ted Poe
Hon. Pete Sessions
Hon. Kyrsten Sinema
Hon. Lamar Smith
Hon. Mac Thornberry
Hon. Dina Titus
Hon. Randy Weber
Hon. Ed Whitfield
Hon. Roger Williams

Appendix K   VA Secretary Comments

Department of Veterans Affairs

Memorandum

Date: August 18, 2014

From: Secretary of Veterans Affairs (00)

Subj: OIG Draft Report,   Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System

To: Acting Inspector General (50)

1. VA is in the midst of a very serious crisis. As we now tackle nationwide challenges to timely Veteran access to health care while also fixing our scheduling system, our priorities are clear: 1) to get Veterans off wait lists and into clinics; 2) to address VA's cultural issues, which includes holding people accountable for willful misconduct or management negligence, and creating an environment of openness and transparency; and 3) to use our resources to consistently deliver timely, high-quality health care to our Nation's Veterans.

2. We sincerely apologize to all Veterans and we will continue to listen to Veterans, their families, Veterans Service Organizations and our VA employees to improve access to the care and benefits Veterans earned and deserve.

3. We concur with all the recommendations in the draft final report and will use them to hone the focus of VA's actions moving forward.

4. We appreciate OIG's in-depth investigation into a whistleblower's allegation that 40 Veterans died waiting for an appointment. OIG pursued this allegation, but the whistleblower was unable to provide OIG with a list of 40 patient names. It is important to note that while OIG's case reviews in the report document substantial delays in care, and quality of care concerns, OIG was unable to conclusively assert that the absence of timely quality care caused the death of these Veterans.

5. VA took immediate and ongoing actions to address the deficiencies identified in the Interim Report. Attached are our specific responses to address the 24 recommendations contained in the OIG report. If you have any concerns regarding this memorandum, please email Karen Rasmussen, M.D., Director, Management Review Service (10AR) at VHA10ARMRS2@va.gov.

Carolyn Clancy, M.D.   Robert A. McDonald
Interim Under Secretary for Health   Secretary of Veterans Affairs

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)
Action Plan

OIG Draft Report, Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System

Date of Draft Report: July 28, 2014

Recommendations/ Actions	Status	Completion Date

Recommendation 1. **We recommended the VA Secretary direct the Veterans Health Administration to review the cases identified in this report to determine the appropriate response to possible patient injury and allegations of poor quality of care. For patients who suffered adverse outcomes, Phoenix VA Health Care System should confer with Regional Counsel regarding the appropriateness of disclosures to patients and families.**

VHA Comments: Concur.

The Phoenix VA Health Care System (PVAHCS) has reviewed all cases identified in the OIG Report. Final determinations regarding the appropriate responses, including disclosures to patients and families, is underway. Over 70 clinical staff have been formally trained to conduct disclosure discussions, which consistently involve clinical leadership, such as the Chief of Staff or Nurse Executive. These discussions and this process are used to develop opportunities for improvement for the facility. Regional Counsel will be included in these discussions. In response to identified issues, the PVAHCS reviewed the records of over 1,200 patients who were determined to be waiting for an appointment. When issues were identified relating to quality of care, those individual cases were referred for additional review and action, when appropriate. PVAHCS completed five protected peer reviews and one institutional disclosure prior to the release of this report. If additional Disclosures are warranted, they will be completed as quickly as possible taking into account the needs and preferences of Veterans and their family members.

<table>
<tr><td>Status:
In progress</td><td>Target Completion Date:
November 30, 2014</td></tr>
</table>

Recommendation 2. **We recommended the VA Secretary require the Phoenix VA Health Care System to ensure continuity of mental health care, improve delays in assignments to a dedicated provider, and expand access to psychotherapy services.**

VHA Comments: Concur.

The (PVAHCS) has taken action to address this recommendation as outlined below and in the draft OIG report.

PVAHCS leadership began making significant changes in Mental Health services in the past year. In October 2013, there were 13 Psychiatry vacancies and limited Mental Health services in the Emergency Department. A new Chief of Psychiatry was hired and all but 3 of the Psychiatry vacancies are filled. Four additional Social Workers were hired to support the Emergency Department and six of the seven vacant Psychology positions have now been selected.

Prior to the release of the Interim OIG Report, PVAHCS Mental Health leadership began to convert the urgent walk-in Mental Health clinic (CSTAT) into a multi-disciplinary, team –based clinic (Behavioral Health Interdisciplinary Program team model) that significantly improved provider assignments for

Veterans as well as continuity and coordination of care. Not only are these changes already showing a considerable improvement in patient access, but they have improved the process by which Veterans are assigned a Mental Health Treatment Coordinator (MHTC). Since the release of the Interim OIG Report, Mental Health leadership has reached out to over 2,000 mental health patients who did not have MHTCs assigned to ensure that they were reassigned a MHTC and given an appointment in Mental Health if they desired. Patients who could not be seen within 30 days in Mental Health were offered the option of obtaining Mental Health care in the community via purchased care. PVAHCS will conduct audits to evaluate the new Behavioral Health Interdisciplinary Program model to ensure continuity of care occurs as intended. Results from these audits will be reported to Medical Center leadership on a quarterly basis for one year.

PVAHCS conducted a Community Summit with 25 community partners and 18 PVAHCS staff. Mental Health Summits help build and sustain collaborative efforts to enhance mental health well-being for Veterans and their families.

PVAHCS is working to obtain an emergency bridge lease to provide an additional 30,000 square feet of clinical space to support mental health and primary care operations, until a new Health Care Clinic is built. The major lease for the Health Care Clinic is pending Congressional approval.

In addition, we will hire additional staff to enhance access to psychotherapy, including services for Military Sexual Trauma, recovery model programming, addiction services and marriage and family therapy services. Additional VHA Human Resources support has been dedicated to support and streamline the hiring process.

Status:	Target Completion Date:
In progress	August 15, 2015

Recommendation 3. We recommended the VA Secretary require the Phoenix VA Health Care System to reevaluate and make the appropriate changes to its method of providing veterans primary care to ensure they provide veterans timely and quality access to care.

VHA Comments: Concur.

PVAHCS has already initiated action to address this recommendation as outlined below:

PVAHCS leadership received approval to increase Primary Care staffing by 53 additional full-time equivalent employees. All services – Physicians, Nursing and Clerks – have increased staffing in primary care clinics and Community Based Outpatient Clinics. Aggressive recruitment and hiring processes have been implemented to speed this process.   Local contracts are being secured to utilize Primary Care physicians through locum tenens agencies.

Mobile medical units were deployed from three other VA facilities to provide additional space. PVAHCS leadership requested permission to delay a minor construction project to remodel the Community Living Center, which was approved. This delay provided additional swing space in the facility to create an additional 27 examination rooms to temporarily accommodate new staff. This space has provided relief until an emergency bridge lease can be secured. PVAHCS is expediting procurement of two new Community Based Outpatient Clinics as well as obtain an emergency bridge lease to provide an additional 30,000 square feet of clinical space to support mental health and primary care operations. This additional space will allow expanded clinical operations until a new Health Care Clinic is built.

Other modalities of care, such as tele-health and extended clinic hours are being utilized to help expand capacity. These will be further expanded once the new additional Primary Care staff has been hired.

Ongoing training and education is provided to scheduling staff regarding proper scheduling processes and compliance with the VHA scheduling directive.

PVAHCS leadership has been working with the Arizona Congressional delegation and Veterans Service Organizations to increase outreach efforts in the community. Since May 1, 2014, PVAHCS has participated in three community outreach events focused on Veteran's access to care.

Status:	Target Completion Date:
In progress	August 15, 2015

Recommendation 4. We recommended the VA Secretary direct the Veterans Health Administration to establish a process that requires facility directors to notify, through their chain of command, the Under Secretary of Health when their facility cannot meet access or quality of care standards.

VHA Comments: Concur.

Issues related to access no longer solely depend on local leadership raising the concern up through a chain of command. VHA is transparent by making these data available and easily accessible to the public and the entire organization. Transparency of data facilitates timely, honest, and open discussion throughout the organization, among leadership peers, among employees, and among Veterans.

Twice monthly, VHA publishes data on access to care on a public website (http://www.va.gov/health/access-audit.asp). Leadership at all levels use the same data to determine trends, foretell access shortfalls, and address underlying issues that impede Veterans' access. This data includes: the number of appointments scheduled at each facility; the number of requested appointments that are on each facility's Electronic Wait List; the number of newly enrolled patients who have not yet been scheduled by facility; and average wait times for mental health, primary care, and specialty care at each facility, for both new and established patients.

Additionally, VHA publishes a scorecard model for internal quality of care benchmarking. Strategic Analytics for Improvement and Learning (SAIL) Value Model assesses 25 quality measures in areas such as mortality, complications, and customer satisfaction, as well as overall efficiency. SAIL benchmark tables can be found at http://www.hospitalcompare.va.gov/docs/SAILData.pdf

Status:	Target Completion Date:
Completed	Implemented

Recommendation 5. We recommended the VA Secretary review all existing wait lists at the Phoenix VA Health Care System to identify veterans who may be at risk because of a delay in the delivery of health care and provide the appropriate medical care. We provided this recommendation to the former VA Secretary in the Interim Report.

VHA Comments: Concur.

PVAHCS – with support from VHA's Health Resource Center (HRC) – has reached out to all Veterans identified as being on unofficial lists or the facility Electronic Waiting List (EWL). Those Veterans, in addition to the new daily Veteran enrollments, have resulted in over 7,300 new patients being addressed by PVAHCS. Over 3,200 appointments have been made in Primary Care for new patients since this initiative began. As of August 5, 2014, there were 87 Veterans on the EWL at PVAHCS, of which 60 had received three telephone calls and a certified letter, leaving only 27 Veterans remaining on the EWL.

PVAHCS is now scheduling the vast majority of patients directly into a Primary Care appointment when enrollment/registration occurs.

This has been accomplished by leveraging VISN 18 and VHA resources to support PVAHCS. An Incident Command Center was established and lead by the facility Chief of Staff. The Disaster Emergency Medical Personnel System was activated to mobilize VHA staff nationally to Phoenix. In addition, the VHA Interim Staff Program was utilized to mobilize additional nurses and providers to Phoenix. To date, over 70 staff have arrived on station to assist and many more (Human Resources, Patient Advocates, etc.) have helped through virtual means.

Status: Target Completion Date:
Implemented   Completed

Recommendation 6. We recommended the VA Secretary take immediate action to ensure the Phoenix VA Health Care System reviews and provides appropriate health care to all veterans identified as being on unofficial wait lists. We provided this recommendation to the former VA Secretary in the Interim Report.

VHA Comments: Concur.

PVAHCS took immediate actions to contact all Veterans identified by OIG as being on unofficial waitlists; they were all contacted by June 4, 2014. This was accomplished by leveraging resources provided by the VHA Health Resources Center (HRC) located in Topeka, KS, in conjunction with PVAHCS scheduling staff. The campaign was later expanded to include all Veterans remaining on the PVAHCS New Enrollees Appointment Request (NEAR) list, and resulted in 1,057 scheduled appointments. Of the Veterans not scheduled, all had been contacted and either indicated they did not want an appointment or did not respond to at least three telephone calls and a certified letter offering the opportunity to schedule an appointment. This aggressive campaign concluded on June 10, 2014. PVAHCS now monitors all new Veterans to ensure timely access to care.

Status: Target Completion Date:
Implemented   Completed

Recommendation 7. We recommended the VA Secretary ensure all new enrollees seeking care at the Phoenix VA Health Care System receive an appointment within the time frames directed by VHA policy.

VHA Comments: Concur.

Nationally, VHA expeditiously mobilized staff and resources from around the country to help PVAHCS identify patients waiting for care, and cleared the way for them to get the care they needed. We have completed the immediate and urgent work and are publicly publishing data on our progress.

Locally, PVAHCS implemented process changes to ensure all new enrollees seeking care receive an appointment when desired. In May of 2014, the New Enrollee Appointment Request (NEAR) list reached levels of over 1,900 Veterans potentially waiting for care. As of July 2014, fewer than 10 Veterans were in a pending status on the NEAR list. To ensure continued success, the Electronic Wait List (EWL) and NEAR List are reviewed daily and reported to facility and VISN leadership.

Status: Target Completion Date:
In progress   December 2014

Recommendation 8. We recommended the VA Secretary ensure the Phoenix VA Health Care System timely process enrollment applications.

VHA Comments: Concur.

Nationally, VHA is developing an automated system for monitoring enrollment processing at every VA facility.

Locally, PVAHCS is hiring dedicated staff to complete on-line enrollment processing and are implementing an ongoing review of the NEAR list with daily reports of Veteran status to medical center leadership. Tele-health enrollment was implemented at all Community Based Outpatient Clinics to provide patients with an enrollment option close to their home. At the VISN-level, the Network Director is evaluating trends at PVAHCS on a monthly basis.

	Status:	Target Completion Date:
	In progress	August 2015

Recommendation 9. We recommended the VA Secretary ensure the Phoenix VA Health Care System follows VA consultation guidance and appropriately reviews consultations prior to closing them to ensure veterans receive necessary medical care.

VHA Comments: Concur.

PVAHCS established a consult management committee to ensure appropriate processes follow VA consultation policy. The initial focus of their work was to address aging consults to ensure Veterans received care in a timely manner. This initiative lead to the PVAHCS having less than 1 percent of all submitted consults being open greater than 90 days as of May 1, 2014. The facility continues to report weekly consult status reports to Medical Center Leadership.

Since the Accelerating Care Initiative (ACI) began, resources have been provided to continue to work down the number of open consults even further. Since the beginning of the ACI, over $16.9 million has been used to obtain care for over 3,100 unique Veterans in the community via purchased care.

Consults are reviewed prior to closing to ensure Veterans receive necessary medical care. The facility is following nationally established standards, making telephone contacts and sending letters when telephone contacts are not successful.   However, additional education for providers is needed to come into full compliance. The Chief of Staff will provide leadership oversight of this educational effort in the next 90 days.

Over the past year, PVAHCS lost several Urology providers. An action team was established to address this crisis which ultimately determined that no additional new consults could be seen by Urology Service. A decision was made to discontinue all of the active or pending status Urology consults (approximately 280 Veterans). These consults were sent back to their Primary Care providers for review and referral to Non-VA Care if Urology care was still warranted. Instructions were provided to the Primary Care providers by the Chief of Staff as well as the Chief of Primary Care prior to these consults being discontinued. PVAHCS has hired two new Urologists, a Nurse Practitioner and two Physician Assistants to support future Urology needs for patients. An offer has been extended to another Urologist.

	Status:	Target Completion Date:
	In process	December 31, 2014

**Recommendation 10. We recommended the VA Secretary ensure the Phoenix VA Health Care
System staff timely verify and record veteran deaths in Veterans Health Information Systems and
Technology Architecture.**

VHA Comments: Concur.

To address timeliness of acting on notifications of death by the Decedent Affairs Office, PVAHCS trained
two additional staff members to serve as Decedent Affairs Clerks to provide cross-coverage to the
Decedent Affairs Office, as needed. This additional resource has proven sufficient to provide timely
processing of death notifications. In addition, VA will address the technical issues that have caused
delays in sharing information about Veteran deaths across different information systems.

Status:	Target Completion Date:
In progress	October 30, 2014

**Recommendation 11. We recommended the VA Secretary ensure the Phoenix VA Health Care
System establish an internal mechanism to perform routine quality assurance reviews of
scheduling accuracy.**

VHA Comments: Concur.

Locally, the PVAHCS Acting Medical Center Director visited all facility and CBOCs in July, 2014. During
these visits, the facility Director emphasized to scheduling staff that everyone needs to follow scheduling
policies and procedures to ensure we are delivering timely care to Veterans. All front line supervisors
received training on auditing schedulers' work. The monthly audit process includes a mechanism to
randomly identify appointments for review. Over 10 items per appointment are reviewed. Results are
used in regular feedback for schedulers and in performance reviews.

Nationally, VHA is developing a "Scheduling accuracy" database to compliment front line audits. The
national database consists of 4 measures that audit elements of appointments available in centralized
data sets. The national audits will provide insight into scheduling accuracy and process reliability.

Status:	Target Completion Date:
In progress	August 2015

**Recommendation 12. We recommended the VA Secretary ensure all Phoenix VA Health Care
System staff with scheduling privileges satisfactorily complete the mandatory Veterans Health
Administration scheduler training.**

VHA Comments: Concur.

Nationally, between May 27, 2014 and June 6, 2014, the Access and Clinic Administration Program
Office and the Employee Education System held individual training sessions for all 21 VISNs. Each
session trained on a number of elements related to patient access including: new patient definitions,
EWL, recall reminder, and the NEAR list. To date, 8,248 employees across the VHA System have been
trained including 764 at Phoenix.

PVAHCS now requires review by the Health Administration Service (HAS) to ensure all staff requesting
scheduling privileges have taken the mandatory scheduling training. All staff members that have any of
the VistA scheduling options are also now identified on a Master List required by the VHA Scheduling
Directive. In addition to the monitoring of the mandatory training and adherence to maintaining a Master
List, PVAHCS offered face-to-face refresher training that was attended by more than 450 staff members

in July 2014. Finally, to ensure staff members are fully trained and compliant with scheduling policies and procedures moving forward, the PVAHCS began an intensive, week-long scheduling training for all new dedicated schedulers, as well as those individuals requesting remedial training. This training includes hands-on experience for staff members and results in a local certification of scheduling competency.

Status:	Target Completion Date:
In progress	August 2015

Recommendation 13. We recommended that upon the completion of the investigation the VA Secretary confer with appropriate VA staff and determine whether administrative action should be taken against management officials at the Phoenix VA Health Care System and ensure that action is taken where appropriate.

VHA Comments: Concur.

Following completion of all external reviews, VA will charge an internal group to convene an Administrative Investigation Board (AIB) responsible for conducting a focused review of Phoenix VA Health Care System managers' culpability for the deficiencies identified in the OIG report. Additionally, the internal group will coordinate the issuance of appropriate proposals or actions should the AIB report determine that management accountability actions are warranted.

Status:	Target Completion Date:
In progress	To be determined after completion of all external reviews

Recommendation 14. We recommended the VA Secretary ensure Phoenix VA Health Care System include an employee satisfaction measure and a veteran satisfaction measure in Phoenix VA Health Care System management's performance plans and facility goals.

VHA Comments: Concur.

VHA Senior Executive performance plans communicate the priorities of VA and VHA. The Executive plans are used to inform the performance expectations for subordinate leaders and workforce.

The lessons of Phoenix have provided a major impetus for VHA to reexamine its entire process of setting performance expectations for its leaders and managers. We are taking vigorous action to ensure that a "data driven" approach does not have the unintended impact of diverting attention from our primary goal of providing Veterans with personalized, proactive, patient-driven health care.   To ensure that operational indicators of access promote the correct behaviors, we are committed to having all performance plans emphasize an ethical organizational culture that promotes constructive and engaged relationships between Veterans and their health care teams. The performance plans will align the entire staff of our health care system to support that goal.

Accordingly, beginning in fiscal year (FY) 2015, the performance plans and goals for management at Phoenix, and across VHA, will emphasize the importance for all leaders to engage deeply with Veterans and staff. VHA currently has an ongoing Survey of Health Experiences of Patients (SHEP) and an annual All Employee Survey (AES) that elicit the perspectives of Veterans and staff, respectively, about the factors that promote or hinder a healing environment and a healthy organization. No later than the 2nd quarter of FY 2015, VHA leadership will be expected to share the results of both surveys with all employees during town halls, staff meetings, and other venues.   AES results will be made available at the workgroup level so that individual workgroups and departments can prioritize what changes are

needed, develop an action plan based on those priorities, and follow through with actions designed to improve the workplace. SHEP results, including an analysis of the key drivers of Veteran experience of Access, will similarly be provided at the level of facility, division, and CBOC as a reliable Veteran-generated indicator of progress towards meeting Veteran needs.

The VHA 2015 Senior Executive Performance Plan is currently in development. Upon approval of the Senior Executive Performance Plan by VHA senior leadership, management performance plans and facility goals at Phoenix will include an expectation that senior executives demonstrate action to address the results identified by local AES and SHEP survey data. Facility, network, and national results will be published internally to document progress as well as ensure that appropriate technical support and resources are provided. Additionally, the agency will provide an annual summary report of progress for our stakeholders and the public upon completion of the performance period.

	Status:	Target Completion Date:
	In progress	March 2015

Recommendation 15. We recommended the VA Secretary initiate a nationwide review of veterans on wait lists to ensure that veterans are seen in an appropriate time, given their clinical condition. We provided this recommendation to the former VA Secretary in the Interim Report.

VHA Comments: Concur.

VHA has taken aggressive steps at the national and local levels to address recent reports of unacceptable delays in access to care. The Accelerating Care Initiative (ACI), a coordinated, system-wide initiative designed to increase timely access to care for Veteran patients; decrease the number of Veteran patients on the EWL longer than 30 days for their care; and standardize the process and tools for ongoing monitoring and access management at VA facilities was implemented in June 2014. The ACI is a process where network and health care facility leadership teams reviewed where Veterans were either waiting too long for care or where Veterans did not yet have appointments. ACI identified requirements for over $400 million to support care delivery requirements. These funds have been used to support overtime for clinical and administrative support and for acquiring health care services for Veterans in the community through non-VA care. As of August 6, 2014, VA has obligated $128 M in funding and authorized non-VA care for 83,000 Veterans. The success of ACI ensures it will be among the remediation options made available to medical center directors through this process.

	Status:	Target Completion Date:
	Completed	Implemented

Recommendation 16. We recommended the VA Secretary direct the Health Eligibility Center to run a nationwide New Enrollee Appointment Request report by facility of all newly enrolled veterans and direct facility leadership to ensure all veterans have received appropriate care or are shown on the facility's electronic wait list. We provided this recommendation to the former VA Secretary in the Interim Report.

VHA Comments: Concur.

The Health Eligibility Center, in connection with the Veterans Health Administration Support Services Center, developed a report to identify those individuals currently waiting on the NEAR list.

As of May 15, 2014, approximately 64,000 Veterans were currently pending on the NEAR list.

As of July 15, 2014, approximately 2,100 individuals remained on the NEAR list.

A preliminary analysis of the 61,900 Veterans removed from the NEAR list show:

- 20 percent cancelled their request for an appointment

- 11 percent scheduled an appointment

- 2 percent were placed on the Electronic Wait List

- 7 percent requested and were referred to other VA services

- 7 percent were in the early stages of eligibility and verification

- VA has made several attempts to contact the remaining Veterans (52%) by phone. After verifying mailing addresses, VA sent certified letters to every Veteran who could not be reached by phone.

Status:	Target Completion Date:
Completed	Implemented

Recommendation 17. We recommended the VA Secretary establish veteran-centric goals and eliminate current goals that divert focus away from providing timely quality care to all eligible veterans.

VHA Comments: Concur.

VHA will establish Veteran-centric goals for the agency as a whole as well as its operating executives. VHA will review and modify all current performance plans to remove measures related to waiting time goals. VA will work with the Office of Management and Budget to remove wait time goals from the FY15 Agency Performance Plan.

Status:	Target Completion Date:
In progress	September 30, 2014

VHA will develop additional Veteran-centric measures for access to care and responsiveness and have in place validated indicators and goals.

Status:	Target Completion Date:
In progress	September 30, 2015

Recommendation 18. We recommended the VA Secretary take measures to ensure use of "desired date" is appropriately applied.

VHA Comments: Concur.

VA will take measures to ensure use of "desired date" is appropriately applied. VA has suspended the use of Desired Date performance metrics for the Agency Performance Accountability Report as well as in all individual performance plans. To date, over 8,200 employees have undergone additional scheduler training. Additionally, VISN and VA Medical Center Directors have conducted over 2,000 in-person site visits to review understanding of scheduling practices. As part of ongoing efforts to reinforce proper use of the "desired date," the Acting Deputy Under Secretary for Health for Operations and Management issued a memorandum on August 15, 2014, to all VISN directors titled, "Clarification of Certain Scheduling Definitions."

Status:	Target Completion Date:
In progress	August 2015

Recommendation 19. We recommended the VA Secretary provide veterans needed care in a timely manner that minimizes the use of the electronic wait list.

VHA Comments: Concur

VHA's policy is that patients requesting new appointments in a clinic where they have not been seen in the last 24 months are placed on the EWL if an appointment cannot be made within 90 days. In some cases, appointments are made beyond 90 days rather than placed on an EWL (for example, patients without a phone). The value of the EWL is that it allows staff to see the volume of appointment request backlog, secure appointment supply or make a decision to use Non-VA care, and then make the appointment with the patient once (rather than cancel and reschedule). Since VA tracks waiting times for each appointment whether a patient is on the EWL or in a scheduled appointment, VA can track appointment backlog and wait times in either case.

VHA seeks to provide care within 30 days. EWL volume in general signals clinics with waiting times of over 90 days for new appointments. To minimize wait times, VHA has created the Accelerating Care Initiative, which requires facilities to reach out to patients waiting more than 90 days and offer them more timely care within VA, or Non-VA care. As of August 6, 2014, VHA had contacted over 150,000 patients. In addition, VHA is expanding the number of providers in facilities and the use of Non-VA care to meet demand. VHA will report on effectiveness of the ACI in providing timely care to Veterans and appropriate minimal usage of the EWL.

Status:	Target Completion Date:
In progress	August 2015

Recommendation 20. We recommended the VA Secretary require facilities to perform internal routine quality assurance reviews of scheduling accuracy of randomly selected appointments and schedulers.

VHA Comments: Concur.

VHA has developed and deployed a leadership scheduling audit process. VA medical center directors and VISN directors are completing face-to-face audits of their facilities' scheduling practices. Additionally, VHA will seek independent external reviews by The Joint Commission at all facilities. These external reviews will assess VHA processes and accreditation standards directly related to timely access to care; identify processes that may potentially indicate delays in care and diagnosis; review continuity of care and patient flow; and review the environment of care and those standards that assess organizational leadership and culture.

Status:	Target Completion Date:
In progress	August 2015

Recommendation 21. We recommended the VA Secretary initiate a process to selectively monitor calls from veterans to schedulers and then incorporate lessons learned into training or performance plans.

VHA Comments: Concur

VHA Telephone infrastructure is diverse. Some lines of the business are served by professional call centers that have up-to-date equipment, well trained staff, and the capability to selectively monitor calls and incorporate lessons learned into training and performance plans. Some facilities have established call centers at a facility or network level on a pilot basis. However, the majority of facilities have either

small or non-existent call centers and decentralized staff that answer calls in addition to their other duties. Many facilities have outdated telephone equipment and simply do not have the infrastructure to automatically distribute or monitor calls. In any case, VHA Scheduling Audit Training Materials currently include selective call monitoring as an option for scheduler performance review. Practically, compliance with the recommendation is most likely in selected facilities and services with the most up-to-date infrastructure.

VHA will convene a workgroup to fully understand the complexities of the widely variable telephone systems used in each of the facilities and CBOCs across the country. This workgroup will also assess applicable regulation, statute, and labor management agreements regarding call monitoring. The workgroup will be charged with providing recommendations to the Under Secretary for Health regarding feasible options for auditing telephone systems for answered calls, dropped calls, and unanswered calls.

Status:	Target Completion Date:
In progress	August 2015

Recommendation 22. We recommended the VA Secretary conduct a review of the Veterans Health Administration's Ethics Program to ensure the Program's operational effectiveness, integrity, and accountability.

VHA Comments: Concur.

VA strongly believes that the agency's core values of integrity, commitment, advocacy, respect and excellence are critical elements in VA's overall pledge to serve all Veteran's and must be embodied by all employees and incorporated into all operational processes. Many factors promote effectiveness, integrity, and accountability for ethical behavior, and leadership commitment, human resource processes, staff engagement, and performance expectations must work in synergy to promote an ethical culture. To ensure the presence and alignment of the proper elements needed for an ethical culture, VHA will establish a work group, to include external experts and facilitation, to conduct a holistic review, including the proper role and functions of the National Center for Ethics in Health Care. VHA will expect the review to provide recommendations on essential structural elements necessary for reinforcing a strong ethical culture: such as how to select and hire ethical leadership and staff; how to communicate expectations around ethical behavior, and the proper organizational structures and processes for eliciting and responding to ethical concerns.

Status:	Target Completion Date:
In progress	January 15, 2015

Recommendation 23. We recommended the VA Secretary initiate actions to update the Veterans Health Administration's current electronic scheduling system and ensure milestones and costs are monitored.

VHA Comments: Concur.

VA Office of Information and Technology and VHA will implement incremental changes to the VISTA Scheduling Package via the VistA Scheduling Enhancement Project. These Milestones are identified below:

Planning	7/21/2014 – 9/15/2014
Development & Testing	9/15/2014 – 1/16/2015
Initial Operating Capability	1/20/2015 – 5/19/2015
Integration/Deployment	5/20/2015 – 8/18/2015

Status:	Target Completion Date:
In progress	August 2015

**Recommendation 24. We recommended the VA Secretary ensure that the Veterans Health
Administration establishes a mechanism to ensure data representing VA's national performance
are validated by an internal group that has direct access to the Under Secretary for Health.**

VHA Comments: Concur.

VA has created SAIL, the Strategic Analytics for Improvement and Learning Value Model, to distill salient
information from a large number of individual metrics. SAIL is a web-based, balanced scorecard model
that the Department of Veterans Affairs (VA) is developing and continuously improving to measure,
evaluate and benchmark quality and efficiency at medical centers. SAIL is designed to offer high-level
views of health care quality and efficiency, enabling executives and managers to examine a wide breadth
of existing VA measures. The underlying data on which SAIL is based are identical to those available
through other Veterans Health Administration (VHA) sources such as: Linking Knowledge and Systems
(LinKS), ASPIRE, VA Inpatient Evaluation Centers (IPEC), Performance Management, and Office of
Productivity, Efficiency, and Staffing (OPES).

SAIL assesses 25 Quality measures in areas such as mortality, complications, and customer satisfaction,
which are organized within eight domains (See Appendix A for full list). In addition, SAIL includes
another measure to assess overall efficiency (the Efficiency domain). SAIL draws data from existing
measures prepared by VHA Program Offices and VA national databases for inpatient and outpatient
encounters and facility characteristics. SAIL is VA-specific and intended to suggest areas of focus. While
many of the measures are consistent with those reported in the private sector, others are unique to VA
and have not been as thoroughly validated. SAIL allows individual VAMCs to assess their performance
for each measure by comparing their results with those achieved by similar facilities by percentile ratings.
The benchmark is the performance achieved by the top 10 percent of similar facilities.

As part of the largest integrated health care system in the United States, each VAMC is organized slightly
differently to best serve Veterans' health care needs, and SAIL is designed accordingly. SAIL's quality
and efficiency measurements take into account the complexity level of each medical center (e.g., patient
volume, number of residents, complex clinical programs, and research dollars) when assessing
performance. Unlike most other health industry report cards which are updated annually, SAIL is
updated quarterly to allow medical centers to more closely monitor the quality and efficiency of the care
delivered to our Veterans. SAIL is produced by a unit of VHA that is independent of VHA operations
(VISNs/Medical Centers) whose leader has direct access to the Under Secretary for Health and the
Deputy Secretary of the Veterans Affairs.

Status:	Target Completion Date:
Completed	Implemented

Appendix L   Office of Inspector General Contact

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

Appendix M   Report Distribution

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