VA Office of Inspector General

Veterans Health Administration

- Interim Report -

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

May 28, 2014
14-02603-178

ACRONYMS AND ABBREVIATIONS

CBOC	Community Based Outpatient Clinic
EWL	Electronic Wait List
FY	Fiscal Year
GAO	Government Accountability Office
HAS	Health Administration Service
HCS	Health Care System
HVAC	House Veterans' Affairs Committee
NEAR	New Enrollee Appointment Request
OIG	Office of Inspector General
PCMM	Primary Care Management Module
PDF	Portable Document Format
VA	Veterans Affairs
VHA	Veterans Health Administration
VistA	Veterans Health Information Systems and Technology Architecture

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EXECUTIVE SUMMARY

This interim report provides an overview of our ongoing review at the Phoenix Health Care System (HCS), identifies the allegations we have substantiated to date, and provides recommendations that VA should implement immediately. Allegations at the Phoenix HCS include gross mismanagement of VA resources and criminal misconduct by VA senior hospital leadership, creating systemic patient safety issues and possible wrongful deaths. While our work is not complete, we have substantiated that significant delays in access to care negatively impacted the quality of care at this medical facility.

The issues identified in current allegations are not new. Since 2005, the VA Office of Inspector General (OIG) has issued 18 reports that identified, at both the national and local levels, deficiencies in scheduling resulting in lengthy waiting times and the negative impact on patient care. As required by the Inspector General Act of 1978, each of the reports listed was issued to the VA Secretary and the Congress and is publicly available on the VA OIG website. These reports are identified in Appendix D.

We initiated this review in response to allegations first reported to the OIG Hotline and expanded it at the request of the VA Secretary and the Chairman of the House Veterans' Affairs Committee (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: HVAC Ranking Member; HVAC Subcommittee on Oversight and Investigations; House Appropriations Committee; House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies; Senate Veterans' Affairs Committee; Senate Appropriations Committee; and Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies. In addition, we received requests from Senators John McCain, Jeff Flake, Dianne Feinstein, Charles Grassley, Tom Udall, and Michael Bennet; and Representatives Kyrsten Sinema and Jack Kingston. We also have requests from a number of Texas House members specific to facilities in Texas.

Due to the multitude and broad range of issues, we are conducting a comprehensive review requiring an in-depth examination of many sources of information necessitating access to records and personnel, both within and external to VA. We are using our combined expertise in audit, healthcare inspections, and criminal investigations, along with our institutional knowledge of VA programs and operations and legal authority to conduct a review of this nature and scope.

A detailed assessment of the information obtained from Phoenix HCS' medical records and its business practices requires a full understanding of VA's current and historical policies and procedures as well as the current practices, facts, and circumstances relating to these serious allegations. We have and will continue to conduct comprehensive interviews of numerous individuals to evaluate the many allegations, determine their validity, and if appropriate, assign individual accountability. Despite the number of allegations, each individual allegation is

nothing more than an allegation. We are charged with reviewing the merits of these allegations and determining whether sufficient, credible factual evidence exists to meet the standards required by applicable laws and regulations to hold VA, or specific individuals accountable on the basis of criminal, civil, or administrative law and regulations.

In late April, the OIG assembled a multidisciplinary team comprised of board-certified physicians, special agents, auditors, and healthcare inspectors from across the country to address numerous allegations at this and other VA medical facilities. Since the Phoenix HCS story broke in the national media, we have received allegations of similar issues regarding manipulated waiting times at other Veteran Health Administration (VHA) medical facilities through the OIG Hotline, from members of Congress, VA employees, veterans and their families, and the media.

In response, we have opened reviews at other VHA medical facilities to determine whether scheduling practices are and/or were in use that did not comply with VHA's scheduling policies and procedures. Clearly, there are national implications associated with inappropriate and non-compliant scheduling practices, including the impact on patient care and a lack of data integrity. Veterans who utilize the VA health care system deserve quality care in a timely manner. Therefore, it is necessary that information relied upon to make mission-critical management decisions regarding the demand for vital health care services must be based on reliable and complete data throughout VA's health care networks. It is important to note that the information in this interim report is dynamic and changes may occur as our review progresses. I have directed our teams to focus on two fundamental questions:

(1) Did the facility's electronic wait list (EWL) purposely omit the names of veterans waiting for care and, if so, at whose direction?

(2) Were the deaths of any of these veterans related to delays in care?

To address the allegations received thus far and remain prepared to address new allegations at medical facilities throughout VA, we are deploying Rapid Response Teams. We are not providing VA medical facilities advance notice of our visits to reduce the risk of destruction of evidence, manipulation of data, and coaching staff on how to respond to our interview questions. To date, we have ongoing or scheduled work at 42 VA medical facilities and have identified instances of manipulation of VA data that distort the legitimacy of reported waiting times. When sufficient credible evidence is identified supporting a potential violation of criminal and/or civil law, we have contacted and are coordinating our efforts with the Department of Justice.

Our review at the Phoenix HCS includes the following actions:

- Interviewing staff with direct knowledge of patient scheduling practices and policies, including scheduling clerks, supervisors, patient care providers, management staff, and whistleblowers who have stepped forward to report allegations of wrongdoing.
- Collecting and analyzing voluminous reports and documents from VHA information technology systems related to patient scheduling and enrollment.
- Obtaining and reviewing VA and non-VA medical records of patients whose death occurred while on a waiting list, or is alleged to be related to a delay in care.

- Reviewing performance standards, ratings, and awards of senior facility staff.
- Reviewing past and new 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.
- Reviewing other documents and reports relevant to these allegations, including administrative boards of investigations or reports of reviews conducted by VHA's Office of the Medical Inspector.
- Reviewing over 550,000 email messages and documents, extracted from over 50 gigabytes of collected email. In addition, imaging and reviewing 10 encrypted computers and/or devices, and over 140,000 network files.

Our reviews at a growing number of VA medical facilities have thus far 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 throughout VHA. One challenge in these reviews is to determine whether these practices exist currently or were used in the past and subsequently corrected by VA managers.

To date, our work has substantiated serious conditions at the Phoenix HCS. We identified about 1,400 veterans who did not have a primary care appointment but were appropriately included on the Phoenix HCS' 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 Phoenix HCS's convoluted scheduling process. As a result, these veterans may never obtain a requested or required clinical appointment. A direct consequence of not appropriately placing veterans on EWLs is that the Phoenix HCS leadership significantly understated the time new patients waited for their primary care appointment in their FY 2013 performance appraisal accomplishments, which is one of the factors considered for awards and salary increases.

To review the new patient wait times for primary care in FY 2013, we reviewed a statistical sample of 226 Phoenix HCS appointments. VA national data, which was reported by Phoenix HCS, showed these 226 veterans waited on average 24 days for their first primary care appointment and only 43 percent waited more than 14 days. However, our review showed these 226 veterans waited on average 115 days for their first primary care appointment with approximately 84 percent waiting more than 14 days. At this time, we believe that most of the waiting time discrepancies occurred because of delays between the veteran's requested appointment date and the date the appointment was created. However, we found that in at least 25 percent of the 226 appointments reviewed, evidence, in veterans' medical records, indicates that these veterans received some level of care in the Phoenix HCS, such as treatment in the emergency room, walk in clinics, or mental health clinics.

Our reviews have identified multiple types of scheduling practices that are not in compliance with VHA policy. Since the multiple lists we found were something other than the official EWL, these additional lists may be the basis for allegations of creating "secret" wait lists. We are not reporting the results of our clinical reviews in this interim report on whether any delay in scheduling a primary care appointment resulted in a delay in diagnosis or treatment, particularly

for those veterans who died while on a waiting list. The assessments needed to draw any conclusions require analysis of VA and non-VA medical records, death certificates, and autopsy results. We have made requests to appropriate state agencies and have issued subpoenas to obtain non-VA medical records. All of these records will require a detailed review by our clinical teams.

Lastly, while conducting our work at the Phoenix HCS our on-site OIG staff and OIG Hotline received numerous allegations daily of mismanagement, inappropriate hiring decisions, sexual harassment, and bullying behavior by mid- and senior-level managers at this facility. We are assessing the validity of these complaints and if true, the impact to the facility's senior leadership's ability to make effective improvements to patients' access to care.

We will make recommendations in our final report and ask the VA Secretary to submit target dates and implementation plans. However, to ensure all veterans receive appropriate care, we submit to the VA Secretary the following recommendations for his immediate implementation. We will address the sufficiency of the VA Secretary's action to implement the following recommendations in our final report.

1. We recommend the VA Secretary take immediate action to review and provide appropriate health care to the 1,700 veterans we identified as not being on any existing wait list.
2. We recommend the VA Secretary review all existing wait lists at the Phoenix Health Care System to identify veterans who may be at greatest risk because of a delay in the delivery of health care (for example, those veterans who would be new patients to a specialty clinic) and provide the appropriate medical care.
3. We recommend 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.
4. We recommend 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 waiting list.

We will provide VA with the list of the 1,700 veterans we identified as not being on any wait list so that VA can mitigate any further access delays to health care services, and deliver higher quality of health care.

RICHARD J. GRIFFIN
Acting Inspector General

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RESULTS AND RECOMMENDATIONS

Issue 1 Did the Phoenix Health Care System Electronic Wait List (EWL) Purposely Omit the Names of Veterans Waiting for Care and, If So, At Whose Direction?

We substantiated serious conditions at the Phoenix Health Care System (HCS) negatively impacted access to health care services. As of April 22, 2014, we identified about 1,400 veterans waiting to receive a scheduled primary care appointment and who were appropriately included on the Phoenix HCS electronic waiting list (EWL). At the same time, we identified an additional 1,700 veterans who were waiting for a primary care appointment but were not on the EWL. We identified these 1,700 veterans from three sources:

- New Enrollee Appointment Request (NEAR) tracking report at Phoenix HCS listed about 1,100 newly enrolled veterans who indicated they wanted a primary care appointment but as of April 28, 2014, had not received one and were not on the EWL.
- Screenshot Paper Printouts represented about 400 newly enrolled veterans who called the Phoenix HCS Helpline and requested a primary care appointment. As of April 2014, the facility had yet to schedule these veterans their primary care appointment or add them to the EWL.
- "Schedule an Appointment Consult" represented about 200 veterans referred to primary care, but the consult was still pending. These 200 veterans were seen in a non-primary care clinic, such as mental health or the emergency department, but were then referred to primary care. As of April 2014, the facility had yet to schedule these veterans their primary care appointment or add them to the EWL.

The length of time these 1,700 veterans wait for appointments prior to being scheduled or added to the EWL will never be captured in any VA wait time data because Phoenix HCS staff had not yet scheduled their appointment or added them to 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 lost or forgotten in Phoenix HCS' convoluted scheduling practices. As a result, these veterans may never obtain their requested or required primary care appointment.

NEAR Report

The NEAR report is a tool used by enrollment staff to notify Primary Care Management Module (PCMM) coordinators or schedulers that a newly enrolled veteran has requested an appointment during the enrollment process. As of April 28, 2014, the NEAR report listed 1,138 veterans who were waiting for an appointment an average of 200 days. However, only 53 of the

1,138 veterans were on the EWL. The remaining 1,085 patients were not on the EWL. Consequently, their wait time prior to being scheduled or added to the EWL would potentially never be captured in any VA wait time data.

Screenshot Paper Printouts

According to Health Administration Service (HAS) personnel, when veterans enrolled for care at the Phoenix HCS, eligibility staff provided the veteran the Phoenix HCS Helpline phone number to call and get their primary care appointment. When the veteran called the Helpline, staff from the Helpline collected patient demographics of the veteran, took a screenshot, and then printed the information. From about February 2013 through March 2014, the Helpline information printed directly to HAS printers in Data Management services. HAS personnel from Outpatient services were responsible for collecting the screenshot paper printouts from Data Management and adding the veterans from the printouts to the EWL. HAS personnel told us there were often delays and backlogs in adding the veterans from the printouts to the EWL. In addition, HAS personnel said they held the printouts for a 1-2 month period during the beginning of this process before adding them to the EWL. HAS personnel also told us they destroyed these screenshot paper printouts after they either scheduled the veteran an appointment, placed the veteran on the EWL, or determined the veteran was not a new patient. Because of this, we could not identify these veterans or confirm that they were ever provided an appointment.

In March 2014, instead of printing the screenshot paper printouts to Data Management services, another HAS employee received the printouts and created a Portable Document Format (PDF) of the compiled screenshots each day and electronically forwarded the PDF to the responsible Outpatient services personnel. We obtained PDF screen prints from March 24 through April 25, 2014, and identified about 400 veterans who were waiting for an appointment and were not on the EWL. According to a HAS employee, these veterans were subsequently added to the EWL during our on-site review. For example, a veteran emailed the OIG Hotline on May 14, 2014, and said he enrolled at Phoenix HCS on April 3, 2014. At that time, he was told by Phoenix HCS 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, and suggested it would be another 3-4 months before he would be seen. This veteran was one of the 400 names we found in the PDF screenshot paper printouts. This veteran's wait time was unaccounted for during this 1-month period from April to May 2014.

Schedule an Appointment Consult

Emergency department physicians, inpatient services, and mental health providers at the Phoenix HCS use a "Schedule an Appointment Consult" to request primary care appointments for their patients. As of April 2014, there were 200 veterans with a pending "Schedule an Appointment Consult." The wait time for patients with a pending consult starts when schedulers create the appointment or place them on the EWL. This means the wait time for these

200 patients prior to being scheduled or added to the EWL will never be captured in any VA wait time data.

Issue 2 Are VHA Personnel Following Established Scheduling Procedures To Ensure Waiting Times Are Calculated Accurately?

New Patient Waiting Times

The Phoenix HCS leadership understated the time new patients waited for their primary care appointment listed in their FY 2013 performance appraisal accomplishments, which is one of the factors considered for awards and salary increases. To review the accuracy of new patient wait times for primary care in FY 2013, we reviewed a statistical sample of 226 new patient primary care appointments completed at Phoenix HCS. VA national wait time data, which was reported by Phoenix HCS, showed these 226 veterans waited on average 24 days for their primary appointment and only 43 percent waited more than 14 days. However, our review found these 226 veterans waited on average 115 days for their primary care appointment, and an estimated 84 percent waited more than 14 days. Most of the wait time discrepancies occurred because of delays between the veteran's requested appointment date and the date the appointment was created. We noted in at least 25 percent of the 226 appointments reviewed, patients received some health care in the Phoenix HCS, such as the emergency department, walk-in clinics, or mental health clinics.

Established Patient Waiting Times

We are continuing to analyze interviews of over 65 schedulers at the Phoenix HCS. However, at this time, it appears that a significant number of schedulers are manipulating the waiting times of established patients by using the wrong desired date of care. Instead of schedulers using a date based on when the provider wants to see the veteran or when the veteran wants an appointment, the scheduler deviates from VHA's scheduling policy by going into the system to determine when the next available appointment is and using that as a purported desired date. This results in a false 0-day wait time. We evaluated FY 2013 established patient appointments in primary care and determined that for 66 percent of appointments, Phoenix HCS recorded veterans had no wait time. We will conduct interviews with facility scheduling supervisors and senior management and initiate additional document reviews to identify management's involvement in manipulating wait times.

Inappropriate Scheduling Practices Corroborated at a Number of Other Facilities

Our review broadened to address allegations of the manipulation of patient wait times and inappropriate scheduling practices at other VA medical facilities. We are finding that inappropriate scheduling practices are a systemic problem nationwide. We have identified multiple types of scheduling practices not in compliance with VHA policy. Our preliminary work has revealed a number of types of scheduling schemes are in use

throughout VHA. Many of these schemes are detailed in the then Deputy Under Secretary for Health for Operations and Management April 2010 Memorandum on Inappropriate Scheduling Practices. The purpose of the memorandum was to call for immediate action to identify and eliminate VHA's use of inappropriate scheduling practices to improve scores on clinical access performance measures. The memorandum discussed many of the same schemes we identified at Phoenix HCS and other medical facilities throughout VHA. The following schemes are examples we have identified and should not be considered a complete listing of inappropriate scheduling practices. The memorandum is Appendix E.

Scheduling Scheme #1

Schedulers go into the scheduling program, find an open appointment, ask the veteran if that appointment would be acceptable, 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 of an established patient 0 days.

Scheduling Scheme #2

Schedulers at several locations described a process using the Clinic Appointment Availability Report (or similar report) to identify individual schedulers whose appointments exceeded the 14-day goal. Scheduling supervisors told schedulers to review these reports and "fix" any appointments greater than 14 days. Schedulers say they were instructed to reschedule the appointments for less 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 at two VA medical facilities deleted consults without full consideration of impact to patients. The first facility deleted pending consults in excess of 90 days without adequate reviews by clinical staff. Schedulers working at the second facility cancelled provider consults without review by clinical staff.

Scheduling Scheme #4

Multiple schedulers described to us a process they use that essentially "overwrites" appointments to reduce the reported waiting times. Schedulers make a new appointment on top of an existing appointment of the same date and time. This cancels the existing appointment but does not record a cancelled appointment. This action allows the scheduler to overwrite the prior Desired Date and appointment Create Date with a new Desired Date. This adjusts 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.

VistA Audit Trail

During our review at Phoenix HCS we determined that certain audit controls within Veterans Health Information Systems and Technology Architecture (VistA) were not enabled. This limited VHA and the OIG's ability to determine whether any malicious manipulation of the VistA data occurred. To ensure our future oversight ability is not compromised, we requested VA

to immediately enable this audit trail capability at all VA medical facilities. VA completed this action.

We are also reviewing and assessing differences between EWLs for the Phoenix HCS. VA's national data showed an EWL of less than 300 veterans; however the Phoenix EWL included approximately 1,400 veterans.

Recommendations

We will make recommendations in our final report and will ask the VA Secretary to establish target dates and implementation plans. However, to ensure all veterans receive timely appropriate care, we submit to the VA Secretary the following recommendations for his immediate implementation. We will provide VA with the list of the 1,700 veterans we identified as not being on any wait list so that VA can address Recommendation 1. We will address the sufficiency of the VA Secretary's action to implement the following recommendations in our final report.

1. We recommend the VA Secretary take immediate action to review and provide appropriate health care to the 1,700 veterans we identified as not being on any existing wait list.

2. We recommend the VA Secretary review all existing wait lists at the Phoenix Health Care System to identify veterans who may be at risk because of a delay in the delivery of health care (for example, those veterans who would be new patients to a specialty clinic) and provide the appropriate medical care.

3. We recommend 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.

4. We recommend 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 waiting list.

Appendix A Background

Phoenix VA Health Care System

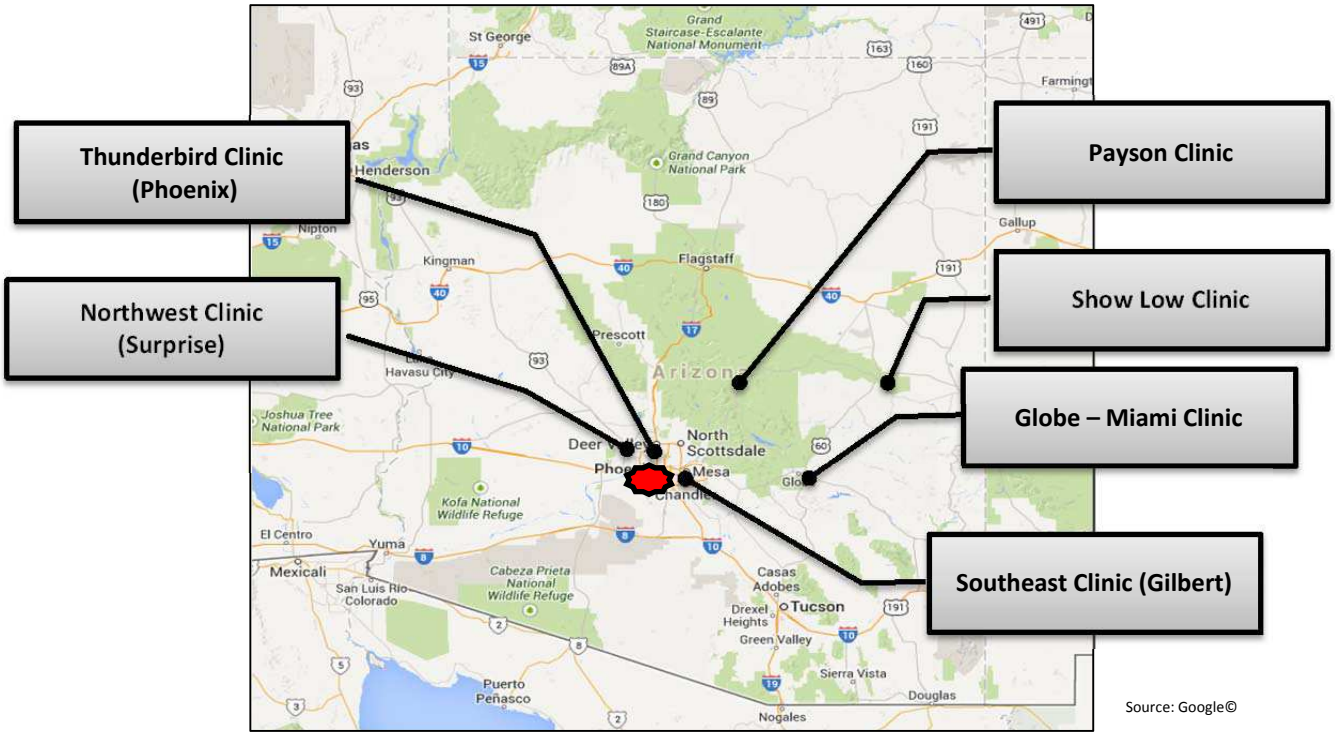
The Phoenix HCS serves veterans in central Arizona through its main medical facility, the Carl T. Hayden VA Medical Center. Veterans can be seen at one of the medical center's three full primary care clinics or its half-clinic.

The Phoenix HCS 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 Veterans Affairs 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 Veterans Affairs Health Care Clinic is a contract clinic offered to veterans through a partnership with Health Net Federal Services. The clinic serves veterans in the greater Payson area, approximately 90 miles north of Phoenix and is staffed by one physician.
- 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 clinic is approximately 180 miles northeast of Phoenix and has staffing allocations for a physician and nurse practitioner. As of May 2014, the nurse practitioner position was vacant.
- The Globe-Miami VA Health Care Clinic in Globe is 87 miles east of Phoenix and is staffed by a nurse practitioner.

On the following page is a map of the locations of the Phoenix area clinics.

PHOENIX AREA COMMUNITY CLINICS



Tracking Wait Time Data

In February 2002, the then Deputy Under Secretary for Health sent a memorandum to the VHA Deputy Chief Information Officer for Health requesting the development of an EWL to effectively track the demand for services at VA medical facilities. The memorandum indicated that existing wait time measures at the time reflected the experience of veterans already in the system but did not capture the waiting time experience of new veteran enrollees or patients without a scheduled appointment. At the time "*ad hoc*" written waiting lists of new veteran enrollees 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 to the primary care management module 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 primary care provider assignments. The EWL was intended to assist VA medical facilities in managing veteran access to outpatient health care, assist clinics in identifying

patients in need of appointments, primary care teams, and primary care providers.

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 the PCMM of VistA. When a patient cannot be assigned to a primary care team or position, the PCMM software asks if the patient should be placed on the EWL. PCMM 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. Patient eligibility information and service connected status is also recorded and updated. The EWL runs background programs to determine changes in the veteran's service-connected percentage, and service-connected priority, as well as changes to appointment, clinics, and personnel that affect EWL patients. EWL also sends messages to assigned mail groups to notify them of such changes. The EWL can also produce reports on demand regarding EWL related activities.

Appendix B Scope and Methodology

We initiated this review in response to allegations first reported to the OIG Hotline and expanded at the request of the VA Secretary and the Chairman of the House Veterans' Affairs Committee (HVAC) following an HVAC hearing on April 9, 2014, on delays in VA medical care and preventable veteran deaths. We began a review at the Phoenix HCS in December 2013 and expanded our work in April 2014. We reviewed patient care delays, scheduling practices, and wait times at Phoenix HCS from FY 2013 to present. In addition, we are reviewing patient care delays of veterans specifically named in allegations or media publications. To address our review objective, we reviewed applicable laws, regulations, policies, procedures, guidelines, and studies.

Our review at the Phoenix HCS includes the following actions:

- Interviewing staff with direct knowledge of patient scheduling practices and policies, including scheduling clerks, supervisors, patient care providers, management staff, and whistleblowers who reported allegations of wrongdoing.
- Collecting and analyzing voluminous reports and documents from VHA information technology systems related to patient scheduling and enrollment.
- Reviewing VA and non-VA medical records of patients whose deaths may be related to delays in care.
- Reviewing performance standards, ratings, and awards of senior facility staff.
- Reviewing past and newly reported 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.
- Reviewing other prior reports relevant to these allegations, including administrative boards of investigations or reports from the VHA's Office of the Medical Inspector.
- Reviewing over 550,000 email messages and documents, extracted from over 50 gigabytes of collected email. In addition, imaging and reviewing 10 encrypted computers and/or devices, and over 140,000 network files for review.

Additionally, we focused on measures contained in the FY 2013 Director's Performance Measures, to include the accuracy of new patient wait times for primary care in FY 2013. To review this, we analyzed a statistical sample of appointments to evaluate whether patients received a new primary care

appointment within 14 days. We obtained the data in which Phoenix HCS officials identified as the source data used to support the Director's FY 2013 performance appraisal. We then obtained a statistically random sample of 226 appointments to test the data.

We interviewed over 120 staff, including schedulers, data analysts, providers, and supervisors. During the review, we visited the Phoenix HCS main campus and three large primary care clinics located at the community based outpatient sites. The review teams are using these interviews to determine if Phoenix HCS personnel followed established scheduling procedures. Additional interviews are planned.

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 are completing this ongoing independent joint review in accordance with The Council of the Inspectors General on Integrity and Efficiency's Quality Standards for Inspection and Evaluation.

Appendix C Chronology of OIG and Government Accountability Office Oversight of Patient Wait Times

For almost a decade, OIG and Government Accountability Office (GAO) reviews identified that VHA managers needed to improve efforts for collecting, trending, and analyzing clinical data. Because of continued weaknesses in quality management data, particularly the implementation and evaluation of corrective actions, facility senior managers needed to clearly state their expectations to all managers and program coordinators. Further, VA's corrective actions must be evaluated until resolution is achieved. VHA needs to have a stronger system for corrective action implementation and evaluation to provide reasonable assurance that its facilities are thoroughly addressing quality of care and patient safety issues.

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 reports, in the *Audit of VHA's Outpatient Scheduling Procedures*, July 2005, that VHA did not follow established procedures when scheduling appointments, resulting in inaccurate wait times and lists. • Nationwide electronic wait lists could be understated by as many as 10,000 veterans • VHA lacks standardized training programs for scheduling • Insufficient oversight
2006	In the 2006 Performance and Accountability Report, we identified 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 or 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 VHA's Outpatient Wait Times,* Sept 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 waiting list, but should have been. • 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 their 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 waiting 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 waiting times, and delays remain in obtaining sub-specialty procedures and sub-specialty medical diagnoses. OIG continues to identify waiting times and patient waiting lists, a problem on which OIG 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 long-standing and underlying causes of problems with outpatient scheduling, accuracy of reported waiting times, and completeness of electronic waiting lists. Of concern is VHA's delay in implementing appropriate quality procedures necessary to ensure the reliability of waiting times and waiting lists. The May 2008 OIG report on Veterans Integrated Service Network (VISN) 3 waiting times determined scheduling procedures were not followed, which affected the reliability of reported wait times and caused inaccuracies in the electronic waiting lists. OIG recommended VHA establish procedures to routinely test the accuracy of reported waiting times and the completeness of electronic waiting lists, as well as take corrective action when their testing shows questionable differences between the desired dates of care and those documented in the scheduling system. OIG reported that the problems and the causes associated with scheduling, wait times, and wait lists, are systemic throughout VHA.

	VHA disagreed with the OIG assessment that appropriate implementation of quality assurance procedures to ensure reliability of wait time and wait lists, had been delayed. While VHA improved the trends in access to care, which is independent of the issues for measuring wait times, it did implement several initiatives to address some quality assurance measures for wait times and waiting lists: • VHA established a formal scheduler national training program • Required audits of scheduler performance • Implemented a "no veteran left behind" initiative • Hired an outside consultant to provide recommendations for wait time measurement • Implemented national reporting software linking consult-creation -date information to: – Appointment creation date – Appointment completion date – Desired appointment date • Though comprehensive in its capabilities, the inconsistencies and inaccuracies of data input affected the reliability of reported waiting times
2009	OIG reported long-standing problems with outpatient scheduling delays, accuracy of reported waiting times, and incomplete electronic waiting 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, waiting times, and EWL data integrity issues as OIG's first "hot issues" paper in Administration transition briefing materials.
2010	OIG reported VHA lacks the management controls needed to ensure Community Based Outpatient Clinics (CBOCs) provided veterans consistent, quality care. OIG noted that CBOC primary care data is inaccurate. VA responded with new directives providing more detailed instruction for schedules on correct entry of desired date and other essential to improve the scheduling of veterans/ appointments.
2012	OIG testified before the House and Senate Veterans' Affairs Committees that VHA's mental health performance data is 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 • Establish mental staffing and productivity standards 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 the Phoenix HCS 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, the Phoenix HCS had to obtain additional funds from the National Fee Program and VISN 18 and 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 the Phoenix HCS processed about $56 million of fee claims during FY 2010 without adequate review. OIG's A*udit o*f *VHA's Physician Staffing Levels for Specialty Care Services,* identified the need for VHA to improve their 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.
2013	GAO testified on wait times, before the HVAC, Subcommittee on Oversight and Investigations, that VA needed improvements in the reliability of VHA's reported medical appointment wait times, scheduling oversight and VHA initiatives to improve access to timely medical appointments.

Appendix D 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. *Audit of the Veterans Health Administration's Outpatient Waiting Times (9/10/2007)*
3. *Audit of Alleged Manipulation of Waiting Times in Veterans Integrated Service Network 3 (5/19/2008)*
4. *Audit of Veterans Health Administration's Efforts to Reduce Unused Outpatient Appointments (12/4/2008)*
5. *Healthcare Inspection – Mammography, Cardiology, and Colonoscopy Management Jack C. Montgomery VA Medical Center Muskogee, Oklahoma (2/2/2009)*
6. *Audit of Veterans Health Administration's Non-VA Outpatient Fee Care Program (8/3/2009)*
7. *Veterans Health Administration Review of Alleged Use of Unauthorized Wait Lists at the Portland VA Medical Center (8/17/2010)*
8. *Healthcare Inspection – Delays in Cancer Care West Palm Beach VA Medical Center West Palm Beach, Florida (6/29/2011)*
9. *Healthcare Inspection – Electronic Waiting List Management for Mental Health Clinics Atlanta VA Medical Center Atlanta, Georgia (7/12/2011)*
10. *Review of Alleged Mismanagement of Non-VA Fee Care Funds at the Phoenix VA Health Care System (11/8/2011)*
11. *Healthcare Inspection – Select Patient Care Delays and Reusable Medical Equipment Review Central Texas Veterans Health Care System Temple, Texas (1/6/2012)*
12. *Review of Veterans' Access to Mental Health Care (4/23/2012)*
13. *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)*

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

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

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

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

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

Appendix E Memorandum from the Deputy Under Secretary for Health for Operations and Management, Dated 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

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.

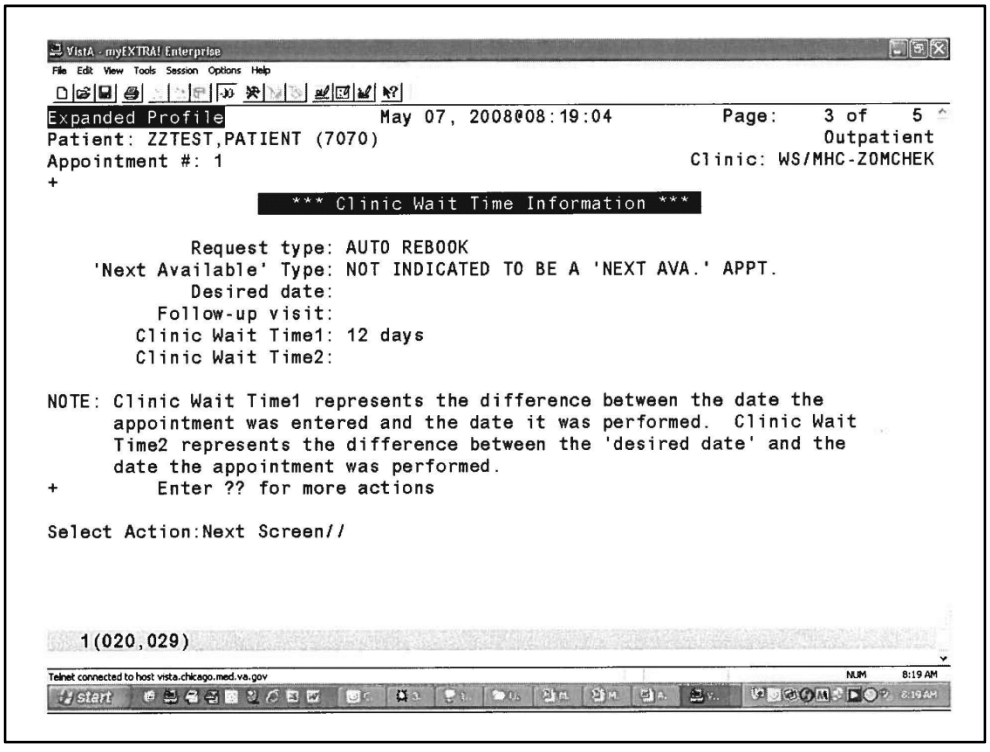
Scheduling Practices to Avoid

- 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:

- Scheduling the New patient visit at a time the patient would prefer not to come in and then re-scheduling.
- 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.
- 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.
- 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.
  - 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.
  - 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.
    - 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.
    - 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:
    - the patient does not confirm the appointment in response to a reminder call/letter, or if
    - 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.
    - 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.
    - 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.
    - 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:
    - For call-ins and walk-ins, schedulers should enter patient requests into the "Comments" field in VistA's Appointment Management system.
    - 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.
    - 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.
    - 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.
    - 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.
    - 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.
    - 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.
    - 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.
    - 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.
    - 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 waiting 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
```

- 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 F OIG Testimony on VA Patient Wait Times

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

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., 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, U.S. 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, U.S. 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, 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 G Office of Inspector General Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.

Appendix H Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Veterans Benefits Administration
National Cemetery Administration
Assistant Secretaries
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Non-VA Distribution

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