



DEPARTMENT OF VETERANS AFFAIRS  
WASHINGTON DC 20420

December 8, 2014

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

RE: OSC File No. DI-14-2953

Dear Ms. Lerner:

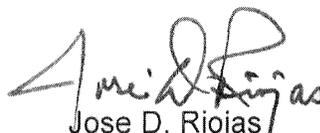
I am responding to your letter regarding allegations made by a whistleblower at the VA Puget Sound Healthcare System, American Lake division, in Tacoma, Washington (hereafter, American Lake). The whistleblower alleged that scheduling staff within the Mental Health Service at American Lake were improperly directed to "zero out" patient wait times, in violation of agency policy, and that American Lake managers failed to adhere to agency scheduling policies thereby endangering public health and safety. The Secretary has delegated to me the authority to sign the enclosed report and take any actions deemed necessary under 5 United States Code § 1213(d)(5).

The Secretary asked the Under Secretary for Health to review this matter and to take any actions deemed necessary under the above code. She, in turn, directed the Interdisciplinary Crisis Response Team (now the Office of Accountability Review [OAR]) to conduct an investigation. In its investigation, OAR could not substantiate that the Puget Sound American Lake campus engaged in the inappropriate scheduling practices alleged by the whistleblower. Specifically, OAR did not substantiate the allegation that schedulers were intentionally scheduling the patient's desired appointment dates for the purpose of falling within the 14-day performance metric. OAR similarly did not substantiate that VA endangered public health and safety by not taking required action in two separate cases of reported assault. OAR could not investigate the allegation that insufficient staffing at the facility created a risk of danger to patient health and safety because of the lack of specificity for this charge provided by the whistleblower.

Findings from the investigation are contained in the report, which I am submitting for your review. I have reviewed these findings and agree with the recommendations listed in the report. We will send your office a follow-up response describing actions that have been and will be taken in response to this report.

Thank you for the opportunity to respond.

Sincerely,

  
Jose D. Riojas  
Chief of Staff

Enclosure

**DEPARTMENT OF VETERANS AFFAIRS**

**Washington, DC**

**Report to the**

**Office of Special Counsel**

**OSC File Number DI-14-2953**

**Department of Veterans Affairs  
VA Puget Sound Healthcare System  
American Lake Campus  
Tacoma, Washington**



**Report Date: November 4, 2014**

Any information in this report that is the subject of the Privacy Act of 1974 and/or the Health Insurance Portability and Accountability Act of 1996 may only be disclosed as authorized by those statutes. Any unauthorized disclosure of confidential information is subject to the criminal penalty provisions of those statutes.

## Executive Summary

Pursuant to its authority in 5 United States Code (U.S.C.) § 1213(c), the Office of Special Counsel (OSC), by letter dated June 6, 2014, to the Secretary of Department of Veterans Affairs (VA), referred for investigation specific allegations made by VA employee, Mr. (b) (6) (hereafter, the whistleblower), about improper scheduling policies within the VA Puget Sound Healthcare System, American Lake division. The specific allegations are as follows:

- Scheduling staff were improperly directed to “zero out” patient wait times, in violation of agency policy; and
- Management failed to adhere to agency scheduling policies thereby endangering public health and safety.

The former Acting Secretary authorized the Interdisciplinary Crisis Response Team (now the Office of Accountability Review [OAR]) to investigate this complaint. OAR conducted a site visit and interviews at the Puget Sound American Lake campus on July 22 – 24, 2014.

During the investigation, the whistleblower testified that he had reported two additional allegations to OSC that were not included in the OSC referral letter. The first was that VA endangered public health and safety by not having enough patient care providers. The second additional allegation was that VA risked public health and safety by failing to take appropriate action in two reported situations: (1) when he reported to management that he had been assaulted by a former supervisor while on VA property; and (2) on a separate occasion when he reported to management that he had been assaulted by two patients while on VA property.

As stated, these two additional allegations were not included in OSC's referral letter. The first additional allegation (related to insufficient staffing) could not be investigated because the whistleblower failed to provide further specificity or examples to support his assertion. Given the Department's commitment to ensure a culture of safety exists within the Veterans Health Administration (VHA) including the appropriate reporting and addressing of patient safety incidents occurring on VA premises (see VHA directive 2012-026 (September 27, 2012); 38 Code of Federal Regulations (C.F.R) §§1.201-1.205), the assault-related allegations were; however, investigated. These two additional allegations are referred to as allegations #3 and #4, respectively, in the report.

The OAR team **substantiated** allegations when the facts and findings supported that the alleged events or actions took place. An allegation **was not substantiated** when the facts showed the allegation was unfounded. An allegation **could not be substantiated** when there was no conclusive evidence to either sustain or refute the allegations.

This constitutes the Department's response, as required by 5 U.S.C. § 1213(d).

## Summary of Conclusions

OAR conducted an investigation of the whistleblower's allegations. This investigation included a site visit to the VA American Lake campus, a telephone interview with the whistleblower, and interviews with key facility staff. A summary of the findings follows:

- **Allegation #1**, that the Puget Sound American Lake campus engaged in the scheduling practices alleged by the whistleblower, could not be substantiated. Statistical data provided by the facility reflected that appointments were routinely scheduled beyond the desired 14-day window. While these data suggest there was no "zero-out" policy, as alleged, inherent limitations of the data prevent a conclusion from being drawn in the absence of additional data. Further, based on interviews with staff, no evidence was discovered that the facility engaged in a regular practice of "zeroing out" patient wait times to meet the 14-day performance metric.

Based on the interviews, the allegation that schedulers were intentionally scheduling the patient's desired date for the purpose of falling within the 14-day performance metric was not substantiated. The whistleblower's assertion that his then supervisor, (b) (6), instructed him to "zero out" patient wait times (for the purpose of meeting the 14-day scheduling metric) was contradicted by the consistent testimony of multiple other witnesses. Despite the team's request, the whistleblower failed to offer any evidence to support his contention. By the whistleblower's own admission, he never reported to the facility's management that he was being instructed to "zero out" patient wait times.

- **Allegation #2**, that the alleged erroneous scheduling practices within the American Lake division campus endangered public health or safety, was not substantiated.
- **Allegation #3**, that insufficient staffing at the facility created a risk of danger to patient health and safety, could not be investigated because of the lack of specificity provided by the whistleblower.
- **Allegation #4**, that VA endangered public health and safety by not taking required action in two separate cases of reported assault (both of which were alleged to have occurred on VA property), was not substantiated.

## Summary of Recommendations

1. We recommend that the local facility comply with recommendations from the Office of Inspector General (OIG) report #VAOIG-14-02603- 267; "Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System" (originally published on August 26, 2014). Specifically, items #:
  - 15) 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.
  - 20) We recommend the VA Secretary require facilities to perform internal routine quality assurance reviews of scheduling accuracy of randomly selected appointments and schedulers.
2. We recommend that the local facility comply with recommendations from the Government Accountability Office (GAO) report #13-130; "VA HEALTH CARE: Reliability of Reported Outpatient Medical Appointment Wait Times and Scheduling Oversight Need Improvement" (originally published on January 18, 2013). Specifically, items #:
  - 1) To ensure reliable measurement of Veterans' wait times for medical appointments, the Secretary of VA should direct the Under Secretary for Health to take actions to improve the reliability of wait time measures either by clarifying the scheduling policy to better define the desired date, or by identifying clearer wait time measures that are not subject to interpretation and prone to scheduler error; and
  - 2) To better facilitate timely medical appointment scheduling and improve the efficiency and oversight of the scheduling process, the Secretary of Veterans Affairs should direct the Under Secretary for Health to take actions to ensure that VA Medical Centers consistently and accurately implement VHA's scheduling policy, including use of the electronic wait list, as well as ensuring that all staff with access to the VistA scheduling system complete the required training.

## Report to the Office of Special Counsel

### I. Introduction

The former Acting Secretary of Veterans Affairs authorized the Interdisciplinary Crisis Response Team (now the Office of Accountability Review [OAR]) to investigate a complaint lodged with OSC by a whistleblower employed by the VA Puget Sound Healthcare System, American Lake division. The whistleblower, Mr. (b) (6); alleged that scheduling staff within the mental health service at the American Lake division were improperly directed to “zero out” patient wait times, in violation of agency policy, and that management at American Lake endangered public health and safety by failing to adhere to agency scheduling policies.

### II. Facility Profile

VA Puget Sound serves Veterans from a five-state area in the Pacific Northwest. Puget Sound has two main divisions: American Lake and Seattle. In addition to the main medical centers Puget Sound offers services to patients in seven community-based outpatient clinics in Bellevue, Bremerton, Federal Way, Mount Vernon, North Seattle, South Sound and Port Angeles.

### III. Allegations

A June 6, 2014, letter from OSC (Exhibit 1) sent to the Acting Secretary of Veterans Affairs alleged:

- Since his employment in (b) (6), scheduling staff within the mental health service at the American Lake division were improperly directed to “zero out” patient wait times, in violation of agency policy; and
- Management’s failure to adhere to agency scheduling policies endangered public health and safety.

During the investigation, the whistleblower testified that he had reported two additional allegations to OSC that were not included in the OSC referral letter. The first was that VA endangered public health and safety by not having enough patient care providers. The second additional allegation was that VA risked public health and safety by failing to take appropriate action in two reported situations: (1) when he reported to management that he had been assaulted by a former supervisor while on VA property; and (2) on a separate occasion when he reported to management that he had been assaulted by two patients while on VA property.

As stated, these two additional allegations were not included in OSC’s referral letter. The first additional allegation (related to insufficient staffing) could not be investigated because the whistleblower failed to provide further specificity or examples to support his assertion. Given the Department’s commitment to ensure a culture of safety exists

within VHA including the appropriate reporting and addressing of patient safety incidents occurring on VA premises (see VHA Directive 2012-026 (September 27, 2012); 38 C.F.R. §§ 1.201-1.205), the assault-related allegations were; however, investigated. These two additional allegations are referred to as allegations #3 and #4, respectively, below.

The OAR team **substantiated** allegations when the facts and findings supported that the alleged events or actions took place. An allegation **was not substantiated** when the facts showed the allegation was unfounded. An allegation **could not be substantiated** when there was no conclusive evidence to either sustain or refute the allegations.

#### IV. Conduct of Investigation

An investigatory team, consisting of three employees from VA's OAR, conducted a site visit during the week of July 22, 2014. The team members were (b) (6), Human Resources (HR) Consultant, VHA Human Resources & Staffing Services; (b) (6), HR Consultant, VHA's Labor Relations and Senior Management Employee Relations Group; and (b) (6), Team Leader, Employee Relations & Performance Management, VA's Office of Human Resources Management Service (OHRM). The whistleblower was interviewed by phone on July 22, 2014. At the whistleblower's request, his spouse also participated in this telephone interview.

During the site visit, the OAR team interviewed the following individuals (under oath) in person or via conference calls:

(b) (6), whistleblower  
(b) (6), Supervisor, Health Plan Management  
(b) (6), Supervisor, Health Plan Management  
(b) (6), Clinic Manager  
(b) (6), Director of Health Information Management Systems  
(b) (6), Director, Health Plan Management  
(b) (6), Associate Director, Health Plan Management  
(b) (6), Lead Medical Clerk  
(b) (6), Program Support Assistant  
(b) (6), Lead Program Support Assistant  
(b) (6), Medical Support Assistant  
(b) (6), Medical Administrative Assistant  
(b) (6), Medical Support Assistant

Interviewees were also directed to submit emails and any other documents in their possession that related to this matter.

(b) (6), the whistleblower, stated that he worked as a clerk, scheduling patients, primarily in the Mental Health Service, under the direct supervision of (b) (6)

(b) (6) . Mr. (b) (6) testified that in November or December 2010 he received a couple of emails from his supervisor to clear appointments that were over the 14-day metric by going into the computer system and changing the patient's "desired date" to match the appointment date, thus showing a wait time in the computer system of zero days. He further testified that after he received these emails he told his supervisor he objected to doing "double work" by scheduling the appointment beyond the 14-day metric, and then at a later date amending the "desired date," so to save time he began inputting a "desired date" that was identical to the appointment date in all appointments he scheduled. The whistleblower does not currently possess any of the emails from (b) (6) instructing him to "zero out" patient wait times. The whistleblower acknowledged he never reported to anyone within his supervisory or managerial chain that he was being instructed to "zero out" patient wait times. He stated that he did mention his concerns to (b) (6), a former Director of the Puget Sound facility. The whistleblower says that he voiced his concerns about extended wait times for treatment to (b) (6) in a town hall style meeting. The whistleblower does not believe that any actions were taken as a result of his comments, other than to "put me in the doghouse," and later to take retaliatory actions against him such as accusing him of initiating a (b) (6). The whistleblower also said that he feared he would be reassigned if he reported he was being required to "zero out" wait times, so he never reported it and he was never reassigned. The whistleblower testified no patient appointments were ever changed by him to meet the 14-day metric, and therefore, the practice of "zeroing out" appointments would have been invisible to veterans.

The whistleblower testified that when he alleged to OSC that management had failed to adhere to agency policy and had endangered public health and safety, he was also referring to VA not having enough patient care providers and to an incident where he was assaulted by a former supervisor and another incident of assault by two patients while on VA property. He testified that he had been personally endangered by VA's failure to adhere to policy in that VA management, the Tacoma police department, or the VA police department failed to arrest the individuals who had assaulted him and that the United States Attorney for that jurisdiction failed to prosecute these individuals.

(b) (6) is the Supervisor of the clerks who function as patient schedulers in the Mental Health Service. She generally supervises approximately 13 patient schedulers. She was the whistleblower's supervisor in 2010. (b) (6) testified she has never instructed any of her subordinate staff to change a patient's "desired date" to manipulate patient wait time data. She only instructs her subordinate staff to change a patient's "desired date" when the patient schedule record appeared to be erroneous. For example, if the scheduler notes a "desired date" in the comments section of the appointment and then places a different date in the "desired date" field of the scheduling program, she refers the appointment back to the scheduler to address the discrepancy. The scheduler is instructed to try to remember the "desired date" the Veteran indicated, and if he or she cannot remember the correct date, the scheduler is instructed to contact the Veteran to correct the appointment record. If neither of these methods suffices to accurately correct the appointment record, the

scheduler is instructed to make no changes to the record. (b) (6) testified that if an appointment legitimately exceeds the 14-day metric because the patient has requested an appointment that cannot be accommodated by the facility within 14 days, she does not take any action, or instruct staff to take any action, to change the appointment record. She only takes action to correct facially erroneous records. Once (b) (6) refers an appointment back to a scheduler to correct an error, she does not follow up with schedulers to determine the basis for changing the erroneous record.

(b) (6) and (b) (6) were Supervisors of patient schedulers in the Health Plan Management Department. They testified that prior to 2010, when a memo from VA Central Office instructed medical centers to ensure proper scheduling procedures were followed, their subordinate patient schedulers were not consistent about asking patients for their "desired date" before scheduling their appointments. After the 2010 memo, they focused on training and reminding patient schedulers about this requirement. Some schedulers had difficulty complying with this instruction, probably because it took schedulers less time and keystrokes to default to "today" for the patient's "desired date." They testified that staff frequently exceeded the 14-day metric and attributed this to lack of clinical resources. Both witnesses testified they were never instructed to manipulate patient wait time data.

(b) (6), Associate Director, Health Plan Management, testified that schedulers were never instructed to manipulate patient wait time data and were only instructed to change patient schedule records when the records were erroneous on their face.

(b) (6), Director of Health Information Management, regularly reviews patient wait time data to observe whether patients are being scheduled outside the 14-day metric. He testified, "There [are] always patients over the 14-day threshold."

(b) (6) has never heard of any practice at the facility of canceling and rescheduling appointments or otherwise zeroing out wait times. He has never seen anything in his review of patient wait time data to suggest this has happened.

Scheduling clerks (b) (6), (b) (6), (b) (6), (b) (6) and (b) (6)<sup>1, 2</sup> testified they have never been instructed to cancel and reschedule appointments or otherwise alter patient schedule information to manipulate

<sup>1</sup> Local AFGE President (b) (6) was invited to provide contact information for any additional witnesses who may have been instructed to alter patient schedule data. To date he has not responded.

<sup>2</sup> (b) (6) testified she was instructed to change patient schedule data to meet the 14-day metric, but upon further examination she stated of management "(t)hey said they were doing an access to care review... (a)nd lots of the PSAs were putting in the wrong desired date, so, they wanted us to go in and remake the appointment... within 14 days of the appointment date." ((b) (6) 8:1) Her testimony is generally consistent with the credible testimony of record by all other scheduling clerks that they were instructed to amend only erroneous appointments.

patient wait time data; changes were permitted only to correct confirmed scheduling errors.

## **V. Background:**

### Law

VA regulation 38 C.F.R. § 17.49 provides (in part) that, in scheduling appointments for outpatient medical services priority is to be given to (1) Veterans with service-connected disabilities rated 50 percent or greater based on one or more disabilities or unemployment, and (2) Veterans needing care for a service-connected disability.

### Policy

VHA Directive 2010-027, VHA Outpatient Scheduling Processes and Procedures“ (June 9, 2010) (the “Directive”), establishes VA’s policy and procedures for scheduling outpatient clinic appointments and “ensuring the competency of staff directly or indirectly involved in any, or all, components of the scheduling process.” VA’s policy recognizes the regulatory mandate, but consistent with the standards of medical practice, makes clear that priority based on the regulation may not impact the medical care of any other previously scheduled Veteran. Nor can it take priority over other Veterans’ more acute health care needs. Emergent or urgent care is to be provided on an expedient basis and emergent and urgent care needs invariably take precedence over a scheduling priority based on the regulation.

VA policy requires all outpatient clinic appointments (meeting the definition of an encounter) to be made in the VistA Scheduling software in a fashion that best suits patients’ clinical needs and preferences. Directive at paragraph 3.e. It is the facility Director’s responsibility to ensure the “correct entry of ‘desired date’ for an appointment.” Directive at paragraph 4.(c)(4).

VHA’s scheduling policy requires the field to make a patient’s appointment on or as close to the patient’s desired date, which is defined as “the date on which the patient or provider wants the patient to be seen.” Directive at paragraph 2.e.(1). It also states in the same definition that schedulers are responsible for recording the desired date correctly.

As to actual scheduling procedures, if a patient walks into the facility with no scheduled appointment, the desired date to be entered is “equated to [be the] appointment creation date.” Directive at paragraph 4.c.(1). Note: The first step for new patients is for the scheduler to ask the patient for the desired date of appointment. Directive at paragraph 4.c.(4)(a)1. The desired date is strictly defined by the patient without regard to schedule capacity. Once this date is 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. Directive at paragraph 4.c.(4)(a)2. The next step is for the scheduler to offer and

schedule an appointment on or as close to the desired date as possible. Directive at paragraph 4.c.(4)(a)3.

For established patients, the Directive requires the provider to document the patient's return date for an appointment (by way of specific date or a general timeframe). The scheduler then tells the patient the specified date or general timeframe when the provider wants to see him or her. The patient is then asked when he or she would like to be seen and the date the patient provides is the desired date. The desired date is defined by the established patient without regard to schedule capacity, and once established it cannot be altered to reflect an appointment date the patient acquiesces to accept for lack of appointment availability on the desired date. If there is any discrepancy between the provider and the patient desired date, then the scheduler is required to contact the provider for a decision on the return appointment timeframe. Directive at 4.c.(4)(b)1-4.

As alluded to above, the field is required to use the VistA Scheduling Software program to schedule outpatient clinic appointments. In addition, they are to use VA's Computerized Patient Record System to request consults for specialty care. Directive at paragraph 4.c.(4)(c)5.

Under the policy, the facility Director is responsible, among other things, for ensuring: (1) completion, using the Veterans Integrated Service Network (VISN) approved processes and procedures, of a standardized annual scheduler audit that assesses the timeliness and appropriateness of scheduling actions and of the accuracy of desired dates; and (2) ensuring identified deficiencies in competency or performance, identified by the annual scheduler audit, are effectively addressed. Directive at paragraphs 4.c.(13), (14).

#### Non-Policy Guidance

The Deputy Under Secretary for Health for Operations and Management issued a memorandum titled "Inappropriate Scheduling Practices" (dated April 26, 2010 – exhibit #2). It advises the field on scheduling practice to avoid.

#### Performance Measures

In 1995, VHA established a 30-day goal for scheduling primary and specialty care medical appointments. In 2011, VHA shortened that goal to 14 days. VHA included these performance measures in the performance contracts for VISN and VA medical center Directors. VA also includes these measures in its budget submissions and performance reports to Congress. This metric is not; however, a legal or policy requirement.

For example, VA's 2013 VA Performance & Accountability Report stated the following: In 2012, VHA began measuring appointment performance measures using a

14-day standard:

1. Percent of new primary care appointments completed within 14 days of the create date for the appointment.
2. Percent of new specialty care appointments completed within 14 days of the create date for the appointment.
3. Percent of new mental health appointments completed within 14 days of the create date for the appointment.

## VI. Allegations

### Allegation #1

The whistleblower alleges that since he was hired in (b) (6), he and fellow employees were directed to change the patient's "desired date" for an appointment to the appointment date (to avoid a gap between the two dates), and that this was done in violation of VA's outpatient clinic scheduling policy and in order to meet the 14-day performance metric. As discussed above, the 14-day metric was not instituted until 2011, and so the whistleblower's allegation is unfounded insofar as it concerns scheduling practices before that time period. The review included scheduling practices occurring after the 14-day metric was established.

The whistleblower alleges that the erroneous scheduling practice served to effectively "zero out" any such difference, as the desired date would be the same as the actual appointment date, thus meeting the goals of the performance measure. This was alleged to be the case for outpatient clinical appointments for both new patients and established patients with return appointments. If the desired date was not available, schedulers allegedly exited the VistA scheduling software system and re-entered it to locate the first available appointment. They then allegedly used that date as both the desired date and appointment date. The whistleblower contends that VA's scheduling policy expressly prohibits the patient's desired date from being changed, even if that date is unavailable, to reflect the date of an appointment the patient accepts. He contends this violation of policy resulted in a specific and substantial harm to public health and safety.

### Findings:

The Directive states that once the patient's desired date has been established, it must not be altered (*emphasis in the original*) to reflect an appointment date that the patient acquiesces to accept for lack of appointment availability on the desired date. This prohibition in policy is understandable, as the waiting time measurement would be of no value were these two entries permitted to be one and the same.

The data revealed no indication of data manipulation, as alleged. The investigative team received mental health access data from the facility for fiscal years 2011 through 2014 (**exhibit #1**) on patient appointments that exceeded the 14-day metric. (Exhibit #3)

The data indicate the number of patients waiting over 14 days for an appointment ranged from a high of 36 (in the Mental Health Clinic in February 2011), to lows of zero (for the Substance Abuse area in March and July 2011). There are also no data demonstrating that schedulers were being instructed to “zero out” patient wait times, such as a marked decline in the over 14-day appointments on any particular date. The testimony of those interviewed, including scheduling clerks, did not indicate that schedulers were ordered to alter data in the VistA system. Scheduling clerks testified they have never been instructed to cancel and reschedule appointments or otherwise alter patient schedule information to manipulate patient wait time data, other than when they were instructed to correct facially erroneous records. In addition, the facility’s Director of Health Information Management testified that there were usually patients who had to wait over the 14-day threshold for future appointments. He has never seen anything in his review of patient wait time data to suggest that the canceling and rescheduling appointments or otherwise zeroing out wait times occurred or is occurring.

## **Conclusion**

The data reflect that appointments were routinely beyond the 14-day performance metric due to limited provider capacity within the various clinics. While the data are non-suspicious of the existence of a “zero out” policy, the data do not prove or disprove the allegation. At best, the data are suggestive that there was no routine or systemic manipulation of data to “zero out” differences between the patients’ desired dates and their scheduled appointment dates. Still, we cannot draw any firm conclusion because the data explains only when a patient was scheduled but not why. There are many valid and appropriate reasons why appointments may be scheduled within or outside the 14-day metric. For instance, the data do not identify cases where scheduling priority for outpatient clinic appointments was appropriately made within the 14-day metric as the result of a legal or policy requirement to ensure certain patients received priority in scheduling outpatient appointments (i.e., based on emergent or urgent medical need or priority in scheduling granted by section 17.49). By the same token; however, the occurrence of appointments regularly falling beyond the 14-day window does not alone rule out any possibility that some appointments could have been made within the 14-day window in violation of policy requirements. Because the data do not make necessary distinctions, a qualitative analysis is precluded. One would need to conduct an administrative and clinical chart review of appointments included in the data to identify if a particular appointment was legitimately within or outside the 14-day time frame. A suspicious finding would then need to be further investigated to rule out simple error. Such a review as part of this investigation was simply not feasible. In sum, given the inherent limitations of the reported outpatient clinic scheduling data, as described, the first allegation could not be substantiated.

Of note, the Directive does not address how erroneous entries of desired dates are to be resolved and documented; instead, it instructs the field to conduct (annual) audits using VISN approved processes and procedures. In this case, supervisors required changes to be made to desired date entries based on their audit or review findings of

facially erroneous entries, as described. While even a facially erroneous entry is by definition an inaccurate entry, it must be said that human error in making the necessary computer inputs cannot be avoided entirely. Also, not every change to a desired date appears to be prohibited by policy. The Directive prohibits only a change to the desired date in order to make it the same as the scheduled appointment date based on VA availability and to which the patient acquiesces. It is thus implicit that other circumstances, such as cases of facially erroneous errors, may warrant amendments to the scheduling record and to that data point in particular. What appears to be needed is identification of a permissible error rate (for schedulers) and active monitoring of performance to ensure that the desired dates for new and established patients are not being changed for the impermissible reason set forth in the Directive.

Based on the interviews, the allegation that schedulers were intentionally scheduling the patient's desired date for the purpose of falling within the 14-day performance metric was not substantiated. Schedulers appear to vary; however, in their approach to determining desired date and in resolving identified discrepancies. In addition, while not directly relevant to the investigation of the allegations, it is noted that a lead supervisor, after referring files back to schedulers for correction of facially erroneous errors, does not confirm and track the reason for the original error and also does not document the action taken to resolve the identified error. Thus the magnitude of entry errors being made by schedulers along with any patterns in erroneous practices is unknown. Nor does there appear to be an established permissible "error rate" by which to evaluate each individual scheduler's performance and to ensure their compliance with VHA's scheduling policy.

#### **Recommendations:**

1. We recommend that the local facility comply with recommendations from OIG report #VAOIG-14-02603- 267; "Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System" (originally published on August 26, 2014). Specifically, items #:
  - 15) 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.
  - 20) We recommend the VA Secretary require facilities to perform internal routine quality assurance reviews of scheduling accuracy of randomly selected appointments and schedulers.
2. We recommend that the local facility comply with recommendations from GAO report #13-130; "VA HEALTH CARE: Reliability of Reported Outpatient Medical Appointment Wait Times and Scheduling Oversight Need Improvement" (originally published on January 18, 2013). Specifically, items #:

- 1) To ensure reliable measurement of veterans' wait times for medical appointments, the Secretary of Veterans Affairs should direct the Under Secretary for Health to take actions to improve the reliability of wait time measures either by clarifying the scheduling policy to better define the desired date, or by identifying clearer wait time measures that are not subject to interpretation and prone to scheduler error; and
- 2) To better facilitate timely medical appointment scheduling and improve the efficiency and oversight of the scheduling process, the Secretary of Veterans Affairs should direct the Under Secretary for Health to take actions to ensure that VAMCs consistently and accurately implement VHA's scheduling policy, including use of the electronic wait list, as well as ensuring that all staff with access to the VistA scheduling system complete the required training.

## **Allegation #2**

The second allegation is that management's failure to adhere to agency scheduling policies, as described, endangered public health and safety.

## **Findings**

Despite requests, the whistleblower did not identify any specific cases of alleged harm resulting from the alleged improper scheduling practices.

## **Conclusion**

The allegation was not substantiated. As noted above, in response to Allegation 1, the allegation that the Puget Sound American Lake campus engaged in scheduling practices alleged by the whistleblower could not be substantiated. Even were there evidence, however, of a scheduler having changed a patient's desired date in violation of VHA policy to meet the 14-day performance metric, it would constitute only a breach of internal procedure (to be followed-up by the appropriate personnel to determine if additional training is warranted). Use of the 14-day performance metric does not establish a patient right to be seen within that time. Neither does it equate to or establish a de facto clinical standard defining the period within which a patient is to be seen. Nor does it establish the medical necessity for the appointment or speak to the clinical appropriateness of the desired date. It is strictly a performance goal that in no way supersedes the terms of the regulation and the Directive. A differential between the desired date and the appointment date is instrumental only inasmuch as it helps VA to determine a patient's wait time, which is itself but one metric by which to define and assess customer expectations and satisfaction.

Within VA, like the private sector, outpatient scheduling depends on many factors, of which first and foremost is the individual patient's compelling medical need to be seen. For this reason, it is appropriate that the Directive does not establish any waiting times

for any cohort of patients. The policy makes clear that a Veteran's emergent or urgent medical needs take priority over all cases. Priority in scheduling is then to be given to certain Veterans, essentially those with service-connected disabilities of 50 percent or greater or for those requiring care for service-connected disabilities; yet, even then, such priority may not impact the medical care of any other previously scheduled Veteran or take precedence over another Veteran's more acute health care needs. New patients are asked to give their desired date of appointment. Established patients who need to return for follow-up appointments with their provider are asked to give a desired date for the return appointment after learning of the specific timeframe or general time-frame for the appointment designated by their provider. In each case, the scheduler tries to make the appointment on or as near the patient's desired date. While VA seeks to accommodate the date preferences of new patients, the patient generally receives the first available appointment on or nearest the desired date but this necessarily depends on the facility's resources. In the case of a return visit, VA likewise seeks to schedule appointments in a manner convenient to our patients but scheduling is dictated by clinical practice standards and the clinical judgment of their provider. This is shown by the fact that any discrepancy between the provider's and the patient's desired date is to be resolved by the provider, not the patient.

So, even if a patient's desired date for an appointment is changed inadvertently or intentionally in the system, the patient cannot be said to experience harm as a result. As explained above, this type of scheduling policy violation, although serious, is not medical in nature. An inquiry into whether a patient whose desired date was changed (for any reason) resulted in patient harm or patient endangerment would need to look to the actual appointment date, not the desired date, to determine whether the patient was seen timely within the time-frame consistent with applicable clinical standards of care.

The whistleblower's allegation assumes in error that the patient's desired date for an appointment equates to the medical need for the appointment on that date and/or signifies the date by which the patient must be seen to ensure the patient comes to no harm or endangerment (from a health perspective). Rooted in a flawed assumption, as discussed, the allegation was not substantiated.

## **Recommendations**

None

## **Allegation #3**

In addition to the allegations referred by OSC, the whistleblower alleged during his interview that the facility endangered patients by having an insufficient number of patient care providers.

## **Findings**

Despite requests, the whistleblower gave no specifics or details, and so the allegation could not be investigated.

## **Conclusion**

None

## **Recommendations**

None

## **Allegation #4**

During his interview, the whistleblower also alleged that he was assaulted on two different occasions while on VA property (once by his former supervisor and once by two patients) and that VA failed to adhere to policy requiring the Tacoma police department or the VA police department to arrest the individuals who had assaulted him. He also insisted that the United States Attorney (AUSA) for that jurisdiction was required to prosecute the individuals. By failing to follow policy, he alleges patients are put at risk of harm. Although these matters were not included in OSC's referral, the allegation was nonetheless investigated to ensure that proper action was taken in response to the alleged reported crimes/safety incidents, both of which were alleged to have occurred on VA property.

## **Findings**

All persons on or entering in property that is under the charge and control of VA are subject to the rules of conduct set forth in 38 C.F.R. § 1.218, including the prohibition against creating disturbances. See 38 C.F.R. 1.218(a)(5). VA Police reports for these two incidents (**exhibit #2**) indicate that each of his complaints were investigated by the local VA police and referred to the responsible AUSA, who declined to prosecute or pursue either allegation of assault. VA Police records also indicate that the whistleblower was an active participant in each altercation which led to the assault allegations.

## **Conclusion**

Based on the reports, we conclude that VA staff met the enforcement requirements of section 1.218(a)(5), the general requirements of VA Security and Law Enforcement policy requirements (see Directive and Handbook (0730 series), and the mandatory reporting requirements of 38 CFR §§ 1.201-1.205. In addition, appropriate action was taken. Accordingly, the whistleblower's allegation was not substantiated.

Importantly, no continuing security issue or lapse (requiring follow-up action) was identified.

## **Recommendations**

None

## **VII. Listing of any Violation of Apparent Violation of Any Law, Rule, or Regulation**

VA procedures related to the scheduling of outpatient clinic appointments is a clinical and administrative matter governed by VA regulation and policy. VA regulation, codified at 38 C.F.R. § 17.49, establishes priority in scheduling appointments to certain Veterans, i.e., Veterans with service-connected disabilities rated 50 percent or greater based on one or more disabilities or unemployability; and Veterans needing care for a service-connected disability. The investigation did not examine the facility's compliance with this regulation per se, because it exceeded the scope of the referred allegations. VHA Directive 2010-027 (2010) sets forth the procedures for scheduling of outpatient clinic appointments. No violation of policy, as alleged, was identified.

Facility staff met both the mandatory reporting requirements of 38 C.F.R. §§ 1.201-1.205 and enforced the conduct rules, particularly 38 C.F.R. § 1.218(a)(5). Given that the AUSA declined to accept (for investigation) the reported cases of assault and no action was taken, it appears no actionable violation of criminal law occurred.

In sum, based on this investigation, no violation of law, rule, regulation, or relevant policy (and identified herein) was identified.

## **VIII. Description of Any Action Taken or Planned As a Result of the Investigation.**

It is recommended that VHA consider the feasibility and advisability of the specific recommendations contained herein (which are intended to improve the value of the outpatient scheduling data that is reported and collected by facilities and improve national policy by standardizing how audits of schedulers are conducted and documented). Based on this investigation, no changes in VA rules, regulations, or practices are recommended. Nor is any disciplinary action against any employee recommended.

### **Documents Reviewed**

1. VHA Directive 2009-070, VHA Outpatient Scheduling Processes and Procedures (12/2009)
2. VHA Directive 2010-027, VHA Outpatient Scheduling Processes and Procedures (6/2010)
3. Memo from Deputy Under Secretary for Health for Operations and Management titled "Inappropriate Scheduling Practices" (4/2010)
4. VHA Directive 2012-026, Sexual Assaults and other Safety Incidents in Veterans Health Administration (VHA Facilities, (9/2012)

## Exhibits

1 Patient Wait Time Data – FYs 2011 – 2014

2. VAMC Police Reports # (b) (6) & (b) (6)

**Total patients waiting more than 14 days fore care**

Service Line	Stop Code	FY 2010 VSSC Access List (14 day)	MAX	Total patients waiting more than 14 days fore care	
				10/1/10	10/15/10
MHS	502	Mental Health--Indiv	97	34	24
MHS	509	Psychiatry-Ind	0		
MHS	513	Substand Use Disorder - Individual	28	5	4
MHS	540	PTSD--Indiv	42	14	12

Stop Code 509: There are no data available in VSSC for stop code 509.

**Total patients waiting more than 14 days fore care**

Each clinic gets evaluated on the 1st and 15th of each month to count the number of patients waiting more than 14 days for care.

Service Line	Stop Code	FY 2010 VSSC Access List (14 day)		Total patients waiting more than 14 days fore care	
				10/1/11	10/15/11
MHS	502	Mental Health--Indiv		23	30
MHS	509	Psychiatry-Ind			
MHS	513	Substand Use Disorder - Individual		4	2
MHS	540	PTSD--Indiv		8	8

Service Line	Stop Code	FY 2010 VSSC Access List (14 day)		Total patients waiting more than 14 days fore care	
				10/1/2012	10/15/2012
MHS	502	Mental Health--Indiv		44	58
MHS	509	Psychiatry-Ind			
MHS	513	Substand Use Disorder - Individual		1	2
MHS	540	PTSD--Indiv		36	8

11/1/10	11/15/10	12/1/10	12/15/10	1/1/11	1/15/11	2/1/11	2/15/11	3/1/11	3/15/11	4/1/11	4/15/11
18	17	18	11	22	16	35	8	13	15	11	18
5	5	14	4	3	3	2	2	2	0	3	3
14	14	6	11	6	5	5	11	13	9	10	15

11/1/11	11/15/20101	12/1/11	12/15/11	1/1/12	1/15/2012	2/1/2012	2/15/2012	3/1/2012	3/15/2012	4/1/2012	4/15/2012
9	16	22	15	7	8	15	9	14	7	4	10
1	1	4	1	0	8	2	1	1	0	2	0
6	12	18	21	21	20	12	14	9	8	11	7

11/1/2012	11/15/2012	12/1/2012	12/15/2012	1/1/2013	1/15/2013	2/1/2013	2/15/2013	3/1/2013	3/15/2013	4/1/2013	4/15/2013
33	39	34	29	57	16	52	21	45	40	40	51
2	2	3	1	6	3	3	3	2	2	0	1
8	14	11	9	18	10	6	6	9	15	18	31

5/1/2011	5/15/11	6/1/11	6/15/11	7/1/11	7/15/2011	8/1/2011	8/15/2011	9/1/2011	9/15/2011	10/1/2011
28	13	36	32	14	23	15	21	15	8	23
2	5	2	8	0	1	2	1	5	5	4
19	14	13	8	9	16	13	16	6	12	8

5/1/2012	5/15/2012	6/1/2012	6/15/2012	7/1/2012	7/15/2012	8/1/2012	8/15/2012	9/1/2012	9/15/2012	10/1/2012
7	12	27	48	78	74	60	51	60	50	44
1	2	1	2	2	10	10	8	17	18	1
7	11	18	18	40	41	52	49	64	50	36

5/1/2013	5/15/2013	6/1/2013	6/15/2013	7/1/2013	7/15/2013	8/1/2013	8/15/2013	9/1/2013	9/15/2013	10/1/2013
115	112	107	90	99	123	136	133	129	161	106
0	1	0	0	2	1	1	1	0	1	1
45	48	60	59	67	65	88	73	76	81	40

Service Line	Stop Code	FY 2014 VSSG Access List (14 day)	MAX	10/1/2013	10/15/2013
MHS	502	Mental Health--Indiv	97	106	94
MHS	509	Psychiatry-Ind	0		
MHS	513	Substand Use Disorder - Individual	28	1	0
MHS	540	PTSD--Indiv	42	40	34

11/1/2013	11/15/2013	12/1/2013	12/15/2013	1/1/2014	1/15/2014	2/1/2014	2/15/2014	3/1/2014	3/15/2014	4/1/2014	15-Apr
110	116	139	58	45	26	26	3	7	5	33	27
									0	0	0
0	0	1	0	0	0	0	0	2	0	0	4
17	43	52	27	18	10	10	2	3	3	5	14

1-May	15-May	1-Jun	15-Jun	1-Jul	15-Jul	1-Aug	15-Aug	1-Sep	15-Sep	not yet available
14	5	14	12	27	44	50	53	51	53	
0	0	0	0	1	0	0	0	0	0	
0	0	0	0	0	2	0	1	2	6	
4	2	5	9	13	14	29	21	14	25	

