VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Veterans Health Administration

Review of Alleged Manipulation of Appointment Cancellations at VA Medical Center Houston, Texas

June 20, 2016
15-03073-275

ACRONYMS

CBOC	Community Based Outpatient Clinics
OIG	Office of Inspector General
VA	Department of Veterans Affairs
VAMC	Veterans Affairs Medical Center
VISN	Veterans Integrated Service Network
VHA	Veterans Health Administration

Highlights: Review of VHA's Alleged Manipulation of Appointment Cancellations at VAMC Houston, TX

Why We Did This Review

The Office of Inspector General received an anonymous allegation that leadership was instructing staff at the Michael E. DeBakey VA Medical Center (VAMC) and its associated Community Based Outpatient Clinics (CBOCs) to incorrectly record clinic cancellations as patient cancellations.

What We Found

We found no evidence the VAMC Director instructed supervisors or staff to incorrectly record appointment cancellations. We substantiated that two previous scheduling supervisors and a current director of two CBOCs instructed staff to incorrectly record cancellations as canceled by the patient.

We identified 223 appointments incorrectly recorded as patient cancellations during the July 2014 through June 2015 time frame. Of the 223 appointment cancellations, staff rescheduled 94 appointments (42 percent) beyond 30 days. For these 94 appointments, veterans encountered an average 81-day wait, which was 78 days longer than shown in the electronic scheduling system. We found that wait times were understated about 66 days for 50 appointments (22 percent) when they were initially scheduled.

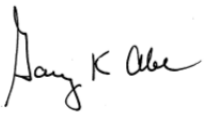
These issues have continued despite the Veterans Health Administration (VHA) having identified similar issues during a May and June 2014 system-wide review of access. These conditions persisted because of a lack of effective training and oversight. As a result, VHA's recorded wait times did not reflect the actual wait experienced by the veterans and the wait time remained unreliable and understated.

What We Recommended

We recommended the Veterans Integrated Service Network 16 Director confers with VA's Office of Accountability Review; provides scheduling staff training; improves scheduling audit procedures; and takes actions when the audits identify deficiencies.

Management Comments

The VISN Director concurred with all six recommendations. They conferred with and determined the Office of Accountability Review is responsible for advising on administrative actions toward Senior Executive Service employees and members of a hospital's leadership quadrad. Neither of the prior supervisors cited in this report was in a senior leadership position, and thus consideration of administrative actions does not fall within their purview. The VISN Director provided acceptable planned actions for Recommendations 3 through 6. Based on the actions taken, Recommendations 1 and 2 are closed and we will monitor the implementation of the remaining recommendations until completed.



GARY K. ABE
Acting Assistant Inspector General
for Audits and Evaluations

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INTRODUCTION

Allegation

The Office of Inspector General (OIG) received an anonymous allegation that leadership was instructing staff at the Michael E. DeBakey VA Medical Center (VAMC) and its associated Community Based Outpatient Clinics (CBOCs) to incorrectly record clinic cancellations as patient cancellations.

Michael E. DeBakey VA Medical Center

The Michael E. DeBakey VAMC is located in Houston, TX, as part of the Veterans Integrated Service Network (VISN) 16, South Central VA Health Care Network. In addition to primary care and mental health care services, the center provides specialized diagnostic care, radiation therapy, surgery, and medical treatment. This includes cardiovascular surgery, gastrointestinal endoscopy, nuclear medicine, ophthalmology, and treatment of spinal cord injury and diseases. The VAMC offers health care services to veterans in conjunction with nine CBOCs located in Beaumont, Conroe, Galveston, Katy, Lake Jackson, Lufkin, Richmond, Texas City and Tomball, TX.

Cancellation Procedures and Wait Time Calculation

The Veterans Health Administration (VHA) captures wait time data for new and established patients by measuring the elapsed days from the appointment's clinically indicated or preferred appointment date to the appointment date. For established patients, the clinician or licensed provider must record the appointment's clinically indicated date specifying when the patient needs to return to the clinic. For new appointment requests, or appointments for which providers did not document a clinical determination, the scheduler must use the appointment's preferred date, which is the date that the patient would like the appointment to occur. VHA calculates the wait time for the rescheduled appointments of clinic cancellations and patient cancellations differently.

- If the clinic cancels an appointment because they are unable to provide care to the patient at the original appointment time, staff must input the cancellation as a clinic cancellation. The veteran's wait time for this appointment would continue to use the original appointment's clinically indicated or preferred appointment date for the rescheduled appointment.
- If the patient cancels the appointment, the wait time will recalculate based on the patient's new preferred appointment date for the rescheduled appointment.

Other Information

- Appendix A provides scope and methodology.
- Appendix B provides management comments.

RESULTS AND RECOMMENDATIONS

ALLEGATION MICHAEL E. DEBAKEY VA MEDICAL CENTER LEADERSHIP INSTRUCTED STAFF TO MANIPULATE CANCELLATION DATA

Assessment

Although we found no evidence that the VAMC Director instructed supervisors or staff to enter appointment cancellations incorrectly, we substantiated that two previous scheduling supervisors and a current director of two CBOCs instructed staff, as recently as February 2016, to input clinic cancellations incorrectly as canceled by patient. We also found that staff did not consistently use the correct clinically indicated or preferred appointment date when scheduling appointments. This occurred despite VHA identifying inappropriate scheduling practices or supervisors instructing schedulers to modify scheduling dates at the VAMC during VHA's May and June 2014 system-wide review of access.

What We Did

We conducted a site visit at the Michael E. DeBakey VAMC to assess the merits of the allegation. We interviewed 17 VAMC managers responsible for providing guidance and oversight for appointment scheduling and cancellation procedures. We interviewed 31 staff who scheduled primary care, mental health, and specialty care appointments for the VAMC and 7 of the 9 CBOCs. We observed scheduling processes at four VAMC clinics, as well as Telecare whose staff scheduled appointments for clinics throughout the medical center and for CBOCs when schedulers from these clinics were not available. We reviewed 373 appointments that VAMC staff had recorded as canceled by patient to determine whether staff input the appropriate cancellation type. To determine if staff used the correct clinically indicated or preferred appointment dates, we evaluated the 223 appointments that staff incorrectly recorded as canceled by patient. We reviewed VHA's *System-Wide Review of Access* audit conducted from May 12 through June 3, 2014, and *Veterans Integrated Service Network 16 Access Audit and Wait Time Fact Sheet*, dated June 9, 2014.

Supervisors Instructed Staff To Incorrectly Enter Appointment Cancellations

We did not find evidence indicating that the VAMC Director instructed staff to input cancellation data incorrectly. However, we substantiated that two previous scheduling supervisors and a current director of two CBOCs instructed staff to input clinic cancellations incorrectly as canceled by patient. To determine this, we asked schedulers and supervisors if anyone had instructed them or anyone else to enter an appointment as canceled by patient when they should have entered the appointment as canceled by clinic. If the response was positive, we asked for additional details to corroborate that information, such as documentation of this instruction and information from other interviews. Based on the responses, we confirmed that two previous

supervisors had instructed staff to record canceled appointments as canceled by patient instead of canceled by clinic. One supervisor retired in [redacted] and the other no longer occupied the position as of [redacted].

We also confirmed that a current director of two CBOCs instructed staff, as recently as February 2016, to record an appointment as canceled by patient if clinic staff at one CBOC offered to reschedule a veteran's appointment at a different CBOC situated about 17 miles away and the veteran declined the appointment. The CBOC Director believed this was appropriate since the CBOC was still offering the patient an appointment. When interviewed regarding these cancellations, the CBOC Director acknowledged she instructed staff to cancel appointments by patient if the veteran declined an appointment in the alternate location. Entering the correct cancellation type is essential to ensuring data integrity and accuracy, and calculating a veteran's actual wait time.

We recommend that the VISN Director confers with VA's Office of Accountability Review to determine, what if any, administrative actions should be taken based on the factual circumstances developed in this report regarding appointments incorrectly recorded as cancelled by patient, or instructions to staff to incorrectly record appointments, as canceled by patient.

Appointments Incorrectly Entered as Canceled By Patient Understate Wait Times

We reviewed 373 appointments that staff recorded as canceled by patient. We found that staff incorrectly recorded 223 of the 373 appointments as canceled by patient. Staff rescheduled veterans' appointments for 219 of these 223 appointments, but did not reschedule the remaining 4 appointments. Staff documented their attempts to schedule one of the four appointments but the patient declined the appointment. We provided the details of the three other appointments to VAMC staff for review to ensure the veterans received the necessary care.

Of these 219 rescheduled appointments, 124 were correctly rescheduled within 30 days of the original clinically indicated or preferred appointment date and one chose to be rescheduled through non-VA care options. For the remaining 94 rescheduled appointments (42 percent), veterans waited an average of 81 days. This was an average of 78 days longer than shown in the electronic scheduling system. Example 1 highlights the differences in calculating the wait time for a patient versus a clinic cancellation.

Example 1

> *In 2014, a scheduler set up a primary care appointment for a veteran 40 days in the future (Appointment 1). However, the veteran's preferred appointment date was 20 days prior to the Appointment 1 date. According to the cancellation notes, the doctor was out sick and a scheduler canceled Appointment 1 and then rescheduled the veteran's appointment to 28 days after Appointment 1. However,*

instead of using the original preferred appointment date for the rescheduled appointment, the scheduler incorrectly used the Appointment 1 date. Therefore, VHA reported a 28-day wait, rather than the veteran's actual wait of 48 days for the appointment.

Schedulers used incorrect clinically indicated or preferred appointment dates when scheduling appointments. For the 223 appointments that were incorrectly recorded as canceled by patient, we reviewed the clinically indicated or preferred appointment dates for their initially scheduled appointments, and found that schedulers did not use the correct clinically indicated or preferred appointment date for 54 appointments (24 percent). Of these 54 appointments, 4 contained clinically indicated or preferred appointment dates that were earlier than the provider's clinically indicated appointment date, which resulted in overstating the veterans' wait time. The remaining 50 appointments (22 percent) incorrectly recorded clinically indicated or preferred appointment dates that understated the veterans' wait times.

Incorrect Clinically Indicated or Preferred Appointment Dates Could Understate Wait Times

During our review, we also determined that staff did not consistently enter clinically indicated or preferred appointment dates correctly. Recording the incorrect clinically indicated or preferred appointment date could understate the time that a veteran waits for the appointment. Of the 223 appointments we reviewed, staff incorrectly recorded the clinically indicated or preferred appointment dates for 50 appointments that understated the veterans' average wait time by about 66 days. Example 2 illustrates the effect of using an incorrect clinically indicated or preferred appointment date on wait time data.

Example 2

We observed a call from a patient to cancel and reschedule a primary care appointment in 2015 (Appointment 1). The veteran requested an appointment for 6 days later. The scheduler made an appointment (Appointment 2) for 47 days after Appointment 1, and correctly entered the patient's preferred appointment date. Since the appointment was beyond a 30-day wait, the scheduler transferred the veteran to a primary care scheduler to try to get an earlier appointment. We reviewed the scheduling system to determine if staff provided the veteran an earlier appointment. Instead, we found that a supervisor revised the data to show the veteran encountered a zero-day wait. Two weeks after the patient called to cancel and reschedule his primary care appointment, the supervisor canceled the Appointment 2 and rebooked it for a time slot 30 minutes later. However, the supervisor entered Appointment 2 as the preferred appointment date. Consequently, VHA reported the veteran had a zero-day wait instead of the 41 days the veteran actually waited.

We further reviewed 20 appointments created from August 13, 2015, to February 11, 2016, by the supervisor who changed the appointment's preferred date in the above example. The supervisor recorded correct dates

for 14 of the 20 appointments. The supervisor did not record the correct clinically indicated or preferred appointment date for 6 of the 20 appointments.

Inadequate Training and Insufficient Oversight

We found that these incorrectly entered appointment cancellations and appointment date entries occurred because of a lack of effective training and oversight. Although the VAMC had policies and procedures describing when to use the patient or clinic cancellation options and how to define the clinically indicated or preferred appointment date, leadership did not reinforce this information through effective training and scheduling audits.

The VAMC leadership we interviewed understood the policy and knew when staff should use the patient and clinic cancellation options. The assistant chief of staff of the CBOCs told us she has been tracking patient and clinic cancellation rates since July 2013, as CBOC administrative officers must report on canceled appointments weekly. She also provided examples of these reports, which monitored various scheduling metrics, including the percentage of appointments staff canceled by clinic and canceled by patient. However, incorrectly entered appointment cancellations still occurred.

Of the 31 scheduling staff we interviewed, 22 did not fully understand the difference between a VAMC-canceled appointment and a patient-canceled appointment. Since the use of clinically indicated or preferred appointment dates was not an issue identified in the allegation, we did not ask all interviewees about this question initially. However, for the 27 schedulers and 12 supervisors questioned about their use of these dates, 16 schedulers and 10 supervisors correctly indicated when to use the provider's clinically indicated appointment date for established patients or the veteran's preferred date. Of the remaining 11 schedulers and 2 supervisors:

- Six schedulers and one supervisor told us they based the clinically indicated or preferred appointment date on the provider's availability or next available appointment date regardless of whether the provider or veteran requested the next available appointment. This next available appointment may be days, weeks, or months in the future.
- Four schedulers and one supervisor told us that for consults, they would use the date determined by specialty providers as the clinically indicated appointment date instead of the initial consult request date, as required by VHA and VAMC policy. Staff told us some specialty providers prioritized the new patient consults to determine how quickly they needed to see the veteran.
- One scheduler partially understood the VHA policy. While the scheduler told us it was incorrect to record the available appointment date as the clinically indicated or preferred appointment date, the scheduler was unable to explain specifically how to identify the clinically indicated or preferred appointment date.

Although leadership had scheduling training for all schedulers in 2014, the training did not specifically address cancellation procedures or the clinically indicated date for established patients and new consults. We reviewed the training documents provided by VAMC staff and found that the documentation did not describe when to use the clinic versus patient cancellation options, nor did it show schedulers how to determine the clinically indicated date. We recommend that the VISN Director ensure the VAMC provides training on when to use clinic versus patient cancellation options and how to identify the clinically indicated appointment date.

VAMC leadership also told us they perform audits of scheduling data and provided us examples of the audits they perform. However, the audits focused on appointments in which the clinically indicated or preferred appointment date was the same as the appointment create date, or appointments that staff scheduled greater than 30 days from the clinically indicated or preferred appointment date. These audits did not review appointment cancellation procedures, nor did they provide a comprehensive review of the clinically indicated or preferred appointment dates schedulers use, to ensure staff correctly input appointments with a 0-day wait.

This finding was significant because for the 223 appointments reviewed, 38 of the 50 appointments that understated the veterans' wait times showed a 0-day wait. The scheduling audits would not identify scheduling errors for these appointments. As a result, by staff incorrectly entering appointments as canceled by patient and recording incorrect clinically indicated or preferred appointment dates, VHA's reported wait times did not reflect the actual wait experienced by veterans, and the wait time information remained unreliable and understated.

We recommend that the VISN Director ensure the VAMC monitors cancellation and appointment data to make sure that schedulers use the correct cancellation type and clinically indicated or preferred appointment date, and take corrective actions on identified deficiencies. To ensure the VAMC's corrective actions are effective, we recommend that the VISN Director conduct a scheduling audit at the VAMC within 3 months of the VAMC's implementing our recommendations for improved training and oversight.

Recurring Issues

VHA previously identified inappropriate scheduling practices, such as supervisors instructing schedulers to use incorrect clinically indicated or preferred appointment dates. In May and June 2014, VHA conducted a system-wide Access Audit to ensure a full understanding of VA's policy among scheduling staff; identify any inappropriate scheduling practices used by employees regarding veteran preferences for appointment dates; and review wait list management. On May 16, 2014, VHA conducted a site visit at the Michael E. DeBakey VAMC to review veteran access to care, and subsequently flagged the VAMC for further review due to concerns identified

during the visit. The VAMC was 1 of 112 facilities that VA flagged because of concerns that indicated inappropriate scheduling practices or interviewed staff indicated they had received instruction to modify scheduling dates. A VA Access Audit and Wait Times Fact Sheet for VISN 16, dated June 9, 2014, stated that VA was already taking corrective action to address issues resulting from the audit. However, the Fact Sheet provided no details of specific actions taken by the VAMC. Following VHA's Access Audit, an OIG investigation* found that schedulers at the VAMC "zeroed out" patient wait times between 2010 and 2014, having been trained to use the patients' appointment date as their desired date.

Conclusion

We did not find evidence indicating that the VAMC Director instructed staff to input cancellation data incorrectly. However, we substantiated that two previous scheduling supervisors and a current director of two CBOCs instructed staff to record clinic cancellations incorrectly as canceled by patient. Schedulers used this inappropriate practice and did not enter the correct cancellation type for canceled appointments. In addition, staff used incorrect clinically indicated or preferred appointment dates. This occurred even though VHA identified inappropriate scheduling practices, including supervisors instructing schedulers to use incorrect clinically indicated or preferred appointment dates at the VAMC during a system-wide review of access in May and June 2014, and the VAMC's efforts to correct scheduling deficiencies. Because of a lack of effective training and management oversight, the VAMC understated veterans' appointment wait times. As a result, VHA's recorded wait times understated the actual wait experienced by the veterans. Furthermore, we considered the errors identified significant, resulting in unreliable patient wait times.

RECOMMENDATIONS

1. We recommended the Veterans Integrated Service Network 16 Director confers with VA's Office of Accountability Review to determine what, if any, administrative action should be taken based on the factual circumstances developed in this report regarding appointments incorrectly recorded as canceled by patient.

2. We recommended the Veterans Integrated Service Network 16 Director confers with VA's Office of Accountability Review to determine what, if any, administrative action should be taken regarding instructions to staff to incorrectly record appointments as canceled by patient.

* *Administrative Summary of Investigation by the VA Office of Inspector General in Response to Allegations Regarding Patient Wait Times*, VA OIG Administrative Summary 14-02890-163, March 8, 2016.

3. We recommended the Veterans Integrated Service Network 16 Director ensure the Director of the Michael E. DeBakey VA Medical Center provides training on when to use clinic versus patient cancellation options and how to identify the clinically indicated appointment date.

4. We recommended the Veterans Integrated Service Network 16 Director ensure the Director of the Michael E. DeBakey VA Medical Center improves scheduling audit processes to ensure that managers conduct a complete review of appointment data to ensure scheduling staff are using the correct cancellation type and clinically indicated or preferred appointment date.

5. We recommended the Veterans Integrated Service Network 16 Director ensure the Director of the Michael E. DeBakey VA Medical Center makes sure managers take corrective action when audits identify deficiencies in scheduling staff's use of appointment cancellation type and clinically indicated or preferred appointment dates.

6. We recommended the Veterans Integrated Service Network 16 Director conduct a scheduling audit within 3 months after Recommendations 3 through 5 are implemented to ensure the corrective actions taken were effective.

Management Comments

The VISN Director provided general comments and explanations for the actions taken by the Michael E. DeBakey VA Medical Center employees. Those explanations included:

- Limited options are available in the scheduling software. The software is complex to navigate and limited to outdated technology. It can be correct for schedulers to select either "canceled by patient" or "canceled by clinic" depending on the circumstances. The CBOC Director and schedulers were using their best judgement to accurately reflect the scheduling transaction, and did not engage in malicious or ethically unjustifiable conduct or deliberately manipulate scheduling data.
- Medical Support Assistants (MSAs) who are required to use the scheduling software to schedule, reschedule, and cancel appointments comprise a large population of often inexperienced, entry-level employees. VHA experiences nearly a 25 percent turnover in MSA positions annually.
- The Michael E. DeBakey VA Medical Center has substantially changed its scheduling practices during the past 2 years. The facility's scheduling data demonstrates an expected and appropriate decline in appointments "canceled by patient" consistent with training and policy clarification. May 2015 was the peak of "cancellations by patient," which corrected to baseline by July 2015. Interestingly, the IG audit team selected 43 percent of its sample during this isolated peak period, which does not

reflect Houston's baseline data. This selection bias is not explained in the report, and should not be used to make broad conclusions about the reliability of VA's data on wait times.

The VISN Director concurred with all six recommendations. The VISN Director conferred with the VA Office of Accountability Review, and determined they were responsible for advising on possible administrative actions only toward Senior Executive Service employees and members of the hospital's leadership quadrad. Neither of the prior supervisors, nor the Director of the two CBOCs, was in a senior leadership position. [redacted] As the report accurately states, the other supervisor retired in [redacted], prior to the time of this investigation. The CBOC Director was using their best judgement to reflect the scheduling transaction, and did not engage in malicious or ethically unjustifiable conduct or deliberately manipulate scheduling data. Accordingly, no administrative action was taken. For recommendations 3 through 6 the VISN Director provided details of the action plans for implementing training and monitoring efforts to improve appointment scheduling.

OIG Response

This is not just a scheduling software issue. The canceled appointments in question were not at the request of the veteran. The CBOC Director incorrectly, and contrary to VHA guidance, instructed her subordinates to use the option canceled by patient instead of canceled by clinic. VHA Directive 2006-055 Attachment G Business Rules for Handling No-Shows, Patient Cancellations, and Clinic Cancellations stated that elective clinic cancellation are those canceled for the convenience of the provider of the local VA facility. Also, current Standard Operation Policy and Procedures and Interim Guidance (#7588555) for Outpatient Scheduling stated schedulers should use the option canceled by the patient when the patient initiates the appointment change request. In addition, Michael E. DeBakey's VA Medical Center's Policy Memorandum No. 00A-005, dated June 12, 2014, stated that in the event of an unplanned clinic cancellation, patients will be contacted and given the option of rescheduling the appointment, and if the patient declines, the existing appointment will be entered as canceled by clinic. Although the CBOC Director offered the patient an appointment at a different location, the patient should decide if the alternate location is a viable option. If not, the appointment cancellations should be entered as canceled by clinic.

The VISN Director stated the scheduling software complexity, scheduling staff inexperience, and turnover as reasons for continued scheduling errors, even with extensive training. VHA's current scheduling software is antiquated and cumbersome to use and as we have recently reported, it is time for VA to commit to make its replacement or modernization a priority. However, the scheduling software was not the sole reason for the

appointment cancellation and scheduling errors we identified. These errors were caused by inadequate training and monitoring efforts that were not sufficient. We found that training for schedulers did not adequately explain when to use a clinic or patient appointment cancellation. In addition, the scheduling audits did not review appointment cancellation procedures, nor did they provide a comprehensive review of the clinically indicated or preferred appointment dates schedulers use, to ensure staff correctly input appointments that resulted in a 0-day wait.

The VISN Director stated that our report did not explain a selection bias when OIG's review included an isolated peak period when appointments canceled by patient were at their highest during May 2015, and therefore should not be used to make broad conclusions about the reliability of VA's data on wait times. There was no selection bias in how the review was conducted. The allegations indicated the issues started in July 2014 and were still ongoing when we received the hotline referral February 26, 2015. While we reviewed data from the time frame for the alleged issues, we also reviewed more current data closer to the time we began our review in June 2015. This data from May and June 2015 comprised 43 percent of our sample selected for review and clearly showed that the issues were still occurring with how schedulers were canceling appointments. Further, our results also showed there were recurring issues with the reliability of the VA wait times.

The VISN Director concurred with all six recommendations. We obtained documentation indicating that the VISN Director conferred with the Office of Accountability Review. The Office of Accountability Review advised they are responsible for advising on possible administrative actions toward Senior Executive Service employees and members of a hospital's leadership quadrad. Neither of the prior supervisors cited in this report was in a senior leadership position, and thus consideration of administrative actions does not fall within their purview. We consider Recommendations 1 and 2 closed.

We consider the planned corrective actions for Recommendations 3 through 6 acceptable. We will monitor the facility and VISN's progress and follow up on the implementation of the open recommendations until all proposed actions are completed. Appendix B provides the full text of the VISN Director's comments.

Appendix A Scope and Methodology

Scope

We conducted our review from June 2015 through March 2016. We focused on individual outpatient appointments recorded as canceled by patient at the VAMC and its CBOCs during fiscal year 2014 and fiscal year 2015.

Methodology

We reviewed applicable national and local policies, procedures, and guidance related to scheduling processes. VHA Directive 2006-055, Attachment G, Business Rules for Handling No-Shows, Patient Cancellations, and Clinic Cancellations, and current Standard Operation Policy and Procedures and Interim Guidance (#7588555) for Outpatient Scheduling stated that schedulers should use the option canceled by the patient when the patient initiates the appointment change request. In addition, Michael E. DeBakey's VA Medical Center's Policy Memorandum No. 00A-005, dated June 12, 2014, stated that in the event of an unplanned clinic cancellation, patients will be contacted and given the option of rescheduling the appointment, and if the patient declines, the existing appointment will be entered as canceled by clinic.

We conducted interviews with key VAMC staff and leadership. We reviewed a non-statistical sample of 373 appointments staff recorded as canceled by patient to determine whether staff had recorded the cancellation type correctly. We selected the non-statistical sample from two populations:

- A total of 4,320 canceled appointments recorded by VAMC staff as canceled by patient during the July 1, 2014, through February 28, 2015, time frame that we considered questionable. These 4,320 appointments were from clinics that had 4 or more appointments canceled by patient and 3 or fewer completed appointments on the same day. From this, we selected 211 appointments within primary care, mental health, and specialty care clinics. We did not select appointments associated with group clinics for review. We determined that staff incorrectly recorded 163 of these 211 appointments as canceled by patient.
- A total of 173 appointments that VAMC staff recorded as canceled by patient during the May 1, 2015, through June 10, 2015, time frame. We identified the 173 appointments from analysis of cancellation notes and a list provided by a site representative indicating when providers had taken unplanned leave. From this, we reviewed 162 appointments associated with individual outpatient clinics and determined that staff incorrectly recorded 60 of 162 as canceled by patient. We did not review 11 appointments associated with 2 group clinics since these appointments did not identify clinically indicated or preferred appointment dates.

From these universes, we identified 223 appointments that staff incorrectly recorded as patient cancellations. To determine the reason staff canceled the appointment, we asked whether the clinic was open or the provider was

available and analyzed the scheduler notes. We considered appointments that contained notes such as "provider out," "clinic closed," or "doctor sick" to be indicators that staff incorrectly entered the appointments as canceled by patient. To determine if staff used the correct clinically indicated or preferred appointment date, we reviewed the scheduling and provider notes for 223 appointments that staff incorrectly recorded as canceled by patient. We also reviewed an additional 20 appointments created by a supervisor from August 13, 2015, to February 11, 2016.

Data Reliability

We used computer-processed data from the VHA Support Service Center's Cancellation Cube, Completed Appointment Cube, the VHA Supervisory Appointment Tool's Cancellations Consolidated Facility Detail Report and Appointment List Report. To assess the reliability of the Cancellation Cube data and the VHA Supervisory Appointment Tool's Cancellations Consolidated Facility Detail Report, we compared the details of the patient cancellations selected for review with the clinical data available for each patient in the Computerized Patient Record System.

We compared the appointment's date and time, appointment type, and clinic type to ensure that the appointments selected were valid and applicable for our review. To assess the reliability of the Completed Appointment Cube, we compared the details of completed appointments selected for review with the clinical data available for each patient in the Computerized Patient Record System. We compared the date, appointment type, and clinic type and looked to see whether the clinician had entered a note to support the appointment occurred. To test the reliability of the Appointment List report, we compared the details of the appointment selected for review with the clinical data available for each appointment in the Computerized Patient Record System. We found the information to be sufficiently reliable for our review purpose.

Government Standards

We conducted this review in accordance with the Council of the Inspectors General on Integrity and Efficiency's *Quality Standards for Inspection and Evaluation*.

Appendix B Management Comments

Department of Veterans Affairs

Memorandum

Date: April 25, 2016

From: Network Director (10N16)
South Central VA Health Care Network

Subj: Response to Draft Report, Review of Alleged Manipulation of Appointment Cancellations at the Houston, TX, VA Medical Center. Project Number 2015-03073-R5-0165

To: Acting Assistant Inspector General for Audits and Evaluations (52)

1. Thank you for the opportunity to review and comment upon the draft report. The Houston VAMC is faced with a unique staffing challenge at the two Community-Based Outpatient Clinics (CBOCs) discussed in the report. Occasionally, when a health care provider at one CBOC is on leave, a provider from the other CBOC relocates temporarily to cover for the absence. When this occurs, the covering provider maintains his/her original clinic schedule and sees his/her own patients at the other location. Scheduling clerks call these patients and offer them the opportunity to have their appointment with their provider at the alternative location. Some patients accept this arrangement and attend their previously scheduled appointment; others decline the offer and request rescheduling; while still others indicate that they couldn't make their appointment anyway and choose to cancel it.

2. A key point of contention is whether the CBOC Director acted improperly when instructing schedulers to select "canceled by patient" in cases when a Veteran declined the offer of an appointment with his or her health care provider at an alternative location. I find that this direction was reasonable given the limited options available in the scheduling software. The software is complex to navigate and limited to outdated technology. It can be correct for schedulers to select either "canceled by patient" or "canceled by clinic" depending on the circumstances. The CBOC Director and schedulers were using their best judgement to accurately reflect the scheduling transaction, and did not engage in malicious or ethically unjustifiable conduct or deliberately manipulate scheduling data.

3. The complex, antiquated nature of the scheduling software makes it exceedingly difficult for any employee to navigate proficiently 100 percent of the time. This problem is further magnified because the Medical Support Assistants (MSAs) who are required to use this system to schedule, reschedule, and cancel appointments comprise a large population of often inexperienced, entry-level employees. VHA experiences nearly 25 percent turnover in MSA positions annually, and, with respect to the Houston VAMC, each new scheduler must undergo 40 hours of training. From 2014 through April 2016, Houston trained 1,481 employees in one or more of the five scheduling courses, local scheduling training, or Houston's locally developed MSA Academy. Yet, even with extensive training, errors occur because of the complexity of the software program and the special needs of our patients.

4. Moreover, the Houston VAMC has substantially changed its scheduling practices during the past two years. The facility's scheduling data demonstrates an expected and appropriate decline in appointments "canceled by patient" consistent with training and policy clarification. In May 2015, the attached data shows a transient peak of "cancellations by patient," which corrected to baseline by July 2015. Interestingly, the IG audit team selected 43 percent of its sample during this isolated peak period, which does not reflect Houston's baseline data. This selection bias is not explained in the report, and should not be used to make broad conclusions about the reliability of VA's data on wait times. VISN 16 provided a chart showing these results below the signature.

5. VISN 16's responses to the recommendations are as follows:

   Recommendation 1: We recommended the Veterans Integrated Service Network 16 Director confers with VA's Office of Accountability Review to determine what, if any, administrative action should be taken based on the factual circumstances developed in this report regarding incorrectly recorded appointments as canceled by patient.

   VISN 16 Response: Concur. We consulted with the VA Office of Accountability Review (OAR) which is responsible for advising on possible administrative actions toward Senior Executive Service (SES) employees and members of a hospital's leadership quadrad. Neither of the prior supervisors cited in this report was in a senior leadership position, and thus consideration of administrative actions does not fall within the purview of OAR. [redacted] As the report accurately states, the other supervisor retired in [redacted] prior to the time of this investigation.

   Recommendation 2: We recommended the Veterans Integrated Service Network 16 Director confers with VA's Office of Accountability Review to determine, what, if any, administrative action should be taken regarding instructions to staff to incorrectly record appointments as canceled by patient.

   VISN 16 Response: Concur. We consulted with the VA Office of Accountability Review (OAR) which is responsible for advising on possible administrative actions toward Senior Executive Service (SES) employees and members of a hospital's leadership quadrad. The Director of the two CBOCs was not in a senior leadership position, and thus consideration of administrative actions does not fall within the purview of OAR. The CBOC Director was using their best judgement to accurately reflect the scheduling transaction, and did not engage in malicious or ethically unjustifiable conduct or deliberately manipulate scheduling data. Accordingly, no administrative actions are warranted against the CBOC Director.

   Recommendation 3: We recommended the Veterans Integrated Service Network 16 Director ensure the Director of the Michael E. DeBakey VA Medical Center provides training on when to use clinic versus patient cancellation options and how to identify the clinically indicated appointment date.

   VISN 16 Response: Concur. In July 2015, the Michael E. DeBakey VA Medical Center provided 25 training sessions for all scheduling staff at the medical center and additional sessions for the outpatient clinics. The training included the information regarding cancelling appointments by clinic and by patient. The medical center has established an 'MSA Academy' to train all new Medical Support Assistants (MSAs) as well as refresher training for current scheduling staff in need of refresher training as determined by their supervisor. The curriculum includes information on when to use clinic versus

patient cancellation options and how to identify the clinically-indicated appointment date. 99% of schedulers received the training in July 2015 or their scheduling keys were removed; the remaining 1% (3 schedulers) had their keys removed in April 2016.

Beginning this fiscal year, the Houston VAMC established a new process wherein a Medical Administration Specialist in Health Administration Service and the GPM Office review all requests to assign scheduling keys requested through an electronic portal. No scheduling key is authorized without evidence that the requestor has completed the training. In addition, the facility tracks the results of scheduling audits on a monthly basis. Schedulers who are not audited or entering appointments will have their scheduling menu options removed. During the month of March 2016, we removed scheduling keys from 18 individuals.

The MSA Academy will also provide training to all supervisors of schedulers. Schedulers have been instructed to notify the Executive Assistant to the Medical Center Director, the service chief, or the GPM office if they believe they are getting direction from their supervisor that is not consistent with policy; this will also be added to the on-going training.

The Assistant Deputy Under Secretary for Health for Clinical Operations disseminated a revised standard procedure for usage of "cancel by clinic" vs. "cancel by patient" on February 16, 2016. This memorandum was distributed to facilities by VISN 16 the same day.

Target date for completion: Process in place, ongoing training and review of scheduling process.

Recommendation 4: We recommended the Veterans Integrated Service Network 16 Director ensure the Director of the Michael E. DeBakey VA Medical Center improves scheduling audit processes to ensure that managers conduct a complete review of appointment data to ensure scheduling staff are using the correct cancellation type and clinically indicated or preferred appointment date.

VISN 16 Response: Concur. In October 2015, the medical center implemented monthly audits for all schedulers, using both electronic and manual audits. Five appointments per scheduler are audited by the supervisor each month. The audits are tracked through the GPM office and reported to senior leadership during the morning report meeting. The audits include review of the clinically indicated or preferred appointment date. We have greatly improved completion of our audits, 100% of schedulers for the month of March 2016 were audited. Effective April, 2016, we will incorporate into the process audits to ensure scheduling staff are using the correct cancellation type.
Target date for completion: May 31, 2016

Recommendation 5: We recommended the Veterans Integrated Service Network 16 Director ensure the Director of the Michael E. DeBakey VA Medical Center makes sure managers take corrective action where audits identify deficiencies in scheduling staff's use of appointment cancellation type and clinically indicated or preferred appointment dates.

VISN 16 Response: Concur. The Medical Center will continue to take appropriate corrective actions when supervisors identify deficiencies in scheduling staff's use of appointment cancellation. In compliance with "Request for Wait Time Case Information for OIG Update" received in March 2016, all disciplinary actions taken as a result of scheduling irregularities will be entered into the VA-Wide Adverse Employment Action Database. We are currently reviewing [redacted] and if [redacted] is issued, it will be entered into the database.

If any error is found during monthly audits of all schedulers, additional training will be provided. Whenever the scheduler's error rate exceeds >15%, an expanded audit will be completed with administrative actions taken as appropriate.

Any concerns reported regarding the actions taken by scheduling supervisors will be shared with the Medical Center Director for appropriate administrative action.
Target date for completion: May 31, 2016

Recommendation 6: We recommended the Veterans Integrated Service Network 16 Director conduct a scheduling audit within 3 months after recommendations 3 through 5 are implemented to ensure corrective actions taken were effective.

VISN 16 Response: Concur. An external VISN team made up of access and scheduling subject matter experts will conduct an onsite scheduling audit. The team will ensure the facility has implemented a process to train and provide refresher training to scheduling staff on appropriate documentation for appointment cancellations and preferred appointment dates. The team will review a minimum of 500 scheduled appointments to determine appropriateness. The results of the audit will be shared with leadership. If deficiencies are identified, a corrective action plan for monthly reporting to the VISN office will be required.
Target date for completion: August 31, 2016

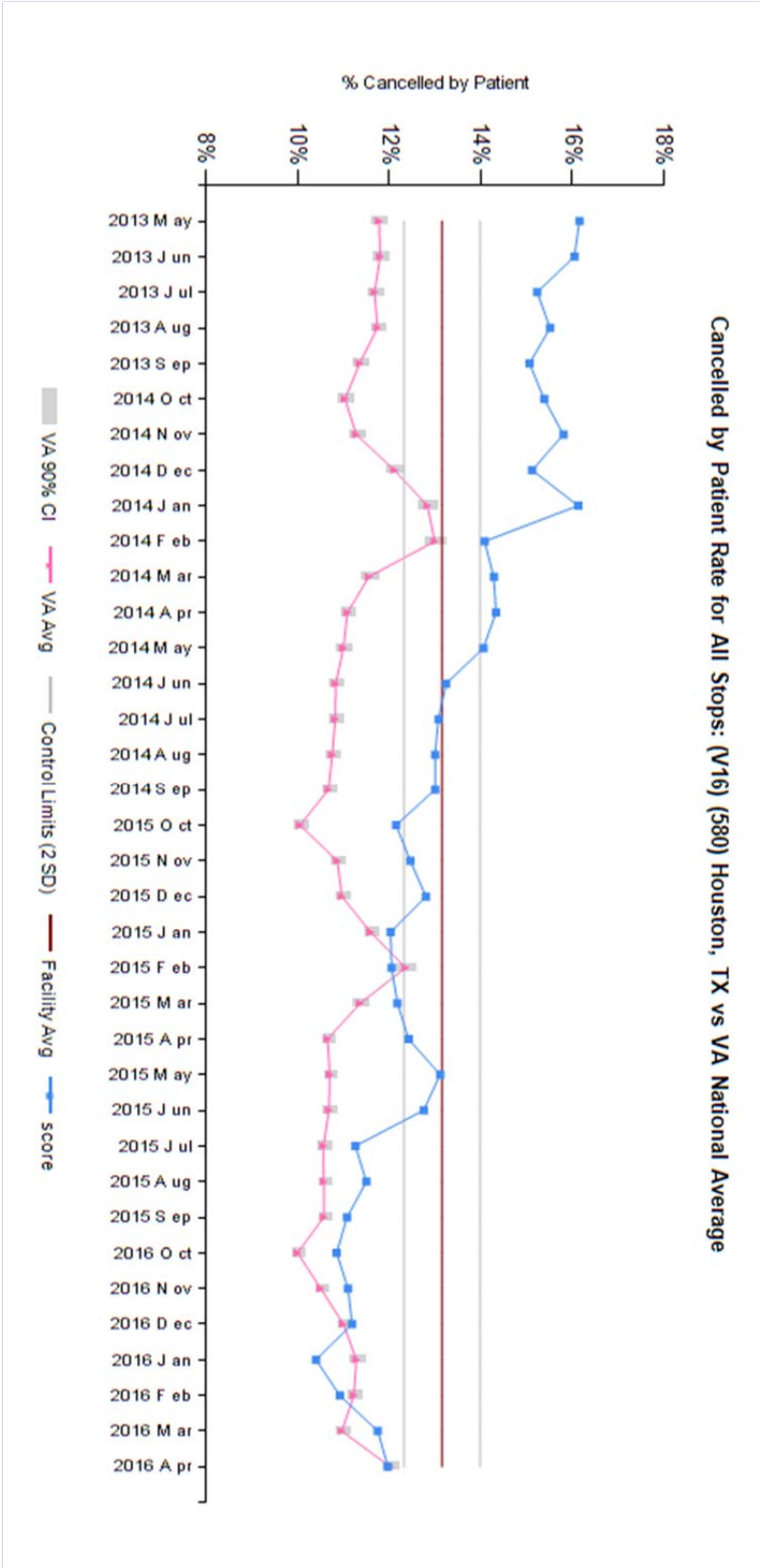
6. If you should have any questions regarding this information, please contact Bonnie Kilpatrick, Acting Quality Management Officer at 601.206.6994.

(original signed by:)

Shannon Novotny
for:

SKYE McDOUGALL, PhD

Attachment


Cancelled by Patient Rate for All Stops: (V16) (580) Houston, TX vs VA National Average
% Cancelled by Patient
8%
10%
12%
14%
16%
18%
2013 May
2013 Jun
2013 Jul
2013 Aug
2013 Sep
2014 Oct
2014 Nov
2014 Dec
2014 Jan
2014 Feb
2014 Mar
2014 Apr
2014 May
2014 Jun
2014 Jul
2014 Aug
2014 Sep
2015 Oct
2015 Nov
2015 Dec
2015 Jan
2015 Feb
2015 Mar
2015 Apr
2015 May
2015 Jun
2015 Jul
2015 Aug
2015 Sep
2016 Oct
2016 Nov
2016 Dec
2016 Jan
2016 Feb
2016 Mar
2016 Apr
VA 90% CI
VA Avg
Control Limits (2 SD)
Facility Avg
score

Appendix C OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Larry Reinkemeyer, Director Josh Belew Meredith Majerle Ken Myers

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