VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Veterans Health Administration

Review of Alleged Use of Inappropriate Wait Lists for Group Therapy and Post-Traumatic Stress Disorder Clinic Team, Eastern Colorado Health Care System

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ACRONYMS

CBOC	Community Based Outpatient Clinic
ECHCS	Eastern Colorado Health Care System
EWL	Electronic Wait List
FAQ	Frequently Asked Questions
FY	Fiscal Year
OIG	Office of Inspector General
PCT	Post-Traumatic Stress Disorder Clinic Team
PTSD	Post-Traumatic Stress Disorder
SOP	Standard Operating Procedures
VA	Department of Veterans Affairs
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Highlights: Review of Alleged Use of Inappropriate Wait Lists for Group Therapy and PTSD Clinic Team, ECHCS

Why We Did This Review

In September 2016, the OIG received a complaint that the Eastern Colorado Health Care System (ECHCS) used unofficial wait lists for veterans waiting for various mental health group therapies. The complaint also alleged that the Colorado Springs Community Based Outpatient Clinic (CBOC) did not take timely action on Post-Traumatic Stress Disorder Clinic Team (PCT) consults. The OIG also received letters from Senators Michael Bennet, Cory Gardner, and Ron Johnson, and from House of Representatives members Mike Coffman and Doug Lamborn. These letters requested the OIG review these allegations and an additional allegation from the complainant that Colorado Springs PCT staff falsified medical documentation following a veteran's suicide. The OIG's objective was to evaluate the merits of the allegations.

According to ECHCS mental health leadership, mental health providers refer veterans to group therapies once the provider validates the veteran's eligibility for the therapy. These therapies can promote significant improvement in symptoms and recovery and are held in conjunction with other mental health services. The PCT provides individual and group therapies for veterans with post-traumatic stress disorder (PTSD).

What We Found

The OIG substantiated ECHCS staff improperly used unofficial wait lists to record referrals for mental health care. Mental health staff from ECHCS used these unofficial wait lists to track referrals for various mental health group therapies. In addition, staff did not always document adequate referral information to determine if care was provided or how long veterans waited for that care. These unofficial lists violated Veterans Health Administration (VHA) policies prohibiting unofficial wait lists and requiring the use of VHA's approved electronic wait list.

The inappropriate use of unofficial wait lists occurred because ECHCS mental health service management misinterpreted national guidance by not applying VHA's outpatient scheduling policies to group therapy appointment requests, which is required.

By using unofficial wait lists, ECHCS management did not have access to accurate wait time data to help make informed staffing decisions and lacked assurance that staff scheduled all requests for care. Without accurate wait time data, ECHCS management did not know if veterans were provided timely access to care or the opportunity to seek care through The Veterans Choice Program.

The OIG substantiated Colorado Springs PCT staff did not timely process PCT consults. In fiscal year (FY) 2016, staff did not initiate scheduling consults within VHA's goal of seven days for an estimated 38 percent of PCT consults. In an estimated 64 percent of cases when care occurred, the OIG found the Colorado Springs PCT staff did not provide care within VHA's goal of 30 days. The OIG also determined Colorado

Springs PCT staff inaccurately recorded the clinically indicated date for calculating wait times for an estimated 91 percent of consults that resulted in care, and improperly closed an estimated 40 consults without adequate documentation of scheduling efforts.

These conditions occurred for a variety of reasons, including that PCT staff did not prioritize consult processing, have sufficient staffing resources, properly record the clinically indicated date, or always record scheduling attempts as required by VHA policy.

As a result, veterans experienced underreported delays in receiving PCT care of an estimated 50 days for initial treatment, and management did not have assurance that staff attempted to schedule veterans for appointments. Without this assurance, staff may have denied or further delayed access to the PCT. Additionally, veterans in an estimated 210 consults were inappropriately denied an opportunity to receive care through VHA's Choice Program.

The OIG did not substantiate Colorado Springs PCT staff falsified medical documentation after a veteran's suicide. The OIG reviewed medical documentation, interviewed the complainant, and ensured that the Office of Healthcare Inspections reviewed the records. No indication of falsification was identified.

What We Recommended

The OIG recommended the ECHCS Director ensure that mental health staff schedule veterans for appointments or add them to the electronic wait list when acting on all care requests. The OIG also recommended the ECHCS Director ensure Colorado Springs staffing resources are sufficient to process consult requests within seven days of receipt as required by VHA policy. Staff should also properly enter the clinically indicated date when scheduling appointments and document scheduling efforts in the official electronic health records.

Agency Comments

The ECHCS Director concurred with the report recommendations and reported ECHCS had completed actions to address each recommendation. The director's full response is included in Appendix C.

The director's planned corrective actions are acceptable. As of October 2017, ECHCS management had not provided us with the evidence necessary to close Recommendations 1 and 2. Once the OIG receives such evidence, it will determine whether the actions taken are sufficient to close these recommendations. The OIG considers Recommendations 3 and 4 closed based on evidence provided in the director's corrective action plan.

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INTRODUCTION

Allegations From Complainant

In September 2016, an individual filed two complaints with the Office of Inspector General regarding Eastern Colorado Health Care System (ECHCS) mental health services. The first complaint alleged the ECHCS mental health staff were using secret wait lists in the form of Microsoft Excel spreadsheets, which were labeled "interest lists" by facility staff. This complaint specified that veterans from these lists were not on the VA-approved electronic wait list (EWL) and that members of mental health leadership openly discussed the need to avoid referring to the lists as wait lists. The complaint stated that the clinic inappropriately managed the lists, resulting in inconsistent and untimely care. The second complaint alleged the Colorado Springs Post-Traumatic Stress Disorder Clinic Team (PCT) was not processing consults timely, claiming that the clinic sometimes waited months to contact veterans to schedule an appointment. This complaint also stated that a veteran committed suicide while waiting for contact from the Colorado Springs PCT. The OIG's objective was to evaluate the merits of the allegations.

Congressional Referrals

Senators Michael Bennet, Cory Gardner, and Ron Johnson and House of Representatives members Mike Coffman and Doug Lamborn provided us similar allegations based on letters they received from the complainant. These letters contained an allegation that Colorado Springs PCT staff falsified medical documentation following the veteran's suicide, which was included in the complaint filed with the OIG. These letters also contained allegations that the complainant had been the subject of retaliation for drawing attention to these wait list issues. The Office of Special Counsel was reviewing the retaliation claims, which were not covered by the OIG's review.

Eastern Colorado Health Care System

ECHCS is part of Veterans Health Administration's (VHA) Veterans Integrated Service Network (VISN) 19 Rocky Mountain Network. ECHCS includes the medical center located in Denver, CO, and provides veterans with primary, specialty, and long-term care. This care is provided in conjunction with a telehealth clinic, two Community Living Centers, and eight community based outpatient clinics (CBOC). These CBOCs are located in Alamosa, Aurora, Burlington, Colorado Springs, Golden, La Junta, Lamar, and Pueblo, CO.

Group Therapies

According to ECHCS mental health leadership, mental health providers refer veterans to group therapies once the provider validates the veteran's eligibility for the therapy. These therapies can promote significant improvement in symptoms and recovery and are held in conjunction with other mental health services. According to the Colorado Springs PCT Director, the PCT provides individual and group therapies for veterans with post-traumatic stress disorder (PTSD).

RESULTS AND RECOMMENDATIONS

Finding 1 ECHCS Mental Health Staff Used Unofficial Wait Lists for Various Forms of Mental Health Care

The OIG substantiated ECHCS improperly used unofficial wait lists for various mental health group therapies, but predominately for evidence-based psychotherapies.[1] The unofficial wait lists did not always identify the veteran or the request date for care. Even with the assistance of facility staff, the lists could not be used to determine how many veterans were waiting to receive care or for how long. VHA guidance dating back to 2010[2] states that veterans requesting outpatient care must be scheduled or placed on the EWL and that unofficial wait lists are prohibited.

The use of unofficial lists occurred because ECHCS mental health service management misinterpreted national guidance by not applying VHA's outpatient scheduling policy to mental health group therapy appointment requests. As a result, facility and mental health managers did not have access to accurate wait time data to help make informed staffing decisions and did not have assurance that all requests for care were adequately addressed. Without accurate wait time data, ECHCS management did not know if veterans were provided access to timely care from VA or the opportunity to seek care through The Veterans Choice Program.

Unofficial Wait Lists Were Used at Three ECHCS Facilities

ECHCS managers and staff improperly used unofficial wait lists in the mental health clinic to record referrals for group therapies. These lists were primarily for evidence-based psychotherapies in group settings, but included other therapies like anxiety management and enhanced mood. VHA Handbook 1160.05[3] states facilities must make evidence-based psychotherapies available, as these therapies can promote significant improvement in symptoms and recovery for many veterans.

According to the group descriptions provided by ECHCS staff, 11 of the 55 different groups using unofficial wait lists did not require structured attendance and allowed veterans to walk in without an appointment. Veterans were able to attend any desired session because these 11 groups were open, eliminating a need for placing them on the EWL. For the

[1] The unofficial wait lists were used at the ECHCS parent facility in Denver, CO, as well as the Colorado Springs and Golden CBOCs. According to the chiefs of Primary and Specialty Mental Health at ECHCS, other ECHCS CBOCs referred patients to those three facilities for mental health services.
[2] VHA Directive 2010-027, *Outpatient Scheduling Processes and Procedures*, June 9, 2010, was replaced by VHA Directive 1230, *Outpatient Scheduling Processes and Procedures*, July 15, 2016.
[3] *Local Implementation of Evidence-Based Psychotherapies for Mental and Behavioral Health Conditions*, October 5, 2012.

remaining 44 therapies with structured attendance,[4] facilities should have followed VHA's outpatient scheduling policy. The policy required facilities to schedule veterans for appointments or place the veterans on the EWL. These policies prohibited facilities from using unofficial wait lists like paper or spreadsheet wait lists for tracking outpatient appointment requests.

In addition to staff improperly recording requests for care on unofficial wait lists, staff did not document adequate or consistent information to eventually contact the veteran to offer the desired care. Many entries contained partial or missing names and other pertinent information. For example, one entry on the Golden CBOC list identified the patient only as male, with no other identifying information.

In total, the unofficial lists for the 44 structured group therapy clinics provided by the complainant and facility contained 3,775 individual entries. Since these lists did not always document adequate patient identifying information or request dates, the OIG could not reliably determine if the lists were complete with all veterans requesting care, how long veterans had been waiting for care, or if care had been provided. For example, the OIG inquired about the status of patients' requests for care through the Golden CBOC group therapy clinics, and the Golden CBOC Chief of Mental Health was unable to use the lists to accurately determine which veterans had received care, which were actively waiting to receive care, or for how long. When asked about entries where portions of names or other identifying data were missing, the chief acknowledged an inability to identify some veterans on the list. When asked about the same information missing from the lists, ECHCS management also acknowledged they could not identify some veterans entered on the unofficial wait lists.

Why This Occurred

ECHCS staff used these unofficial wait lists because ECHCS management misinterpreted VHA's scheduling policy and did not believe it was applicable for these appointment requests. Multiple ECHCS leaders and managers—including the ECHCS Director, chiefs of Primary and Specialty Mental Health, the regional manager for Southern CBOCs, and the VISN 19 Business Implementation Manager—stated they used these unofficial lists to track the veteran's interest in these therapies, if and when the facility could provide the therapy to the veteran. However, 44 of the therapies did not allow veterans to immediately join established groups and required veterans to wait for future group offerings. Placement on these lists generally occurred through a recommendation from each veteran's provider and was included in the veteran's treatment plan.

[4] According to mental health management, certain groups require veterans to attend a number of sessions in progressive order. Therefore, veterans cannot join a group after the first session and need to wait for the next group offering to begin therapy.

According to a senior consultant at VHA's Office of Mental Health Operations, VHA released a Frequently Asked Questions (FAQ) email in June 2015 that directed facilities to follow the outpatient scheduling procedures[5] when veterans are referred to or request specific psychotherapy groups. The FAQ instructed facilities to schedule veterans for appointments or place them on the EWL. The VISN 19 Business Implementation Manager, who has been employed by the VISN since 2013, claimed neither the VISN nor its facilities were aware of the FAQ until September 6, 2016, when the VISN sought guidance on the facility's unofficial wait lists from an Office of Mental Health Operations representative. This FAQ reinforced the established outpatient scheduling procedures' applicability to group therapy and did not change procedures on scheduling veterans for appointments or placing them on the EWL. The chiefs of Primary and Specialty Mental Health corroborated they were unaware of the FAQ or the requirement to place veterans who participated in group therapy on the EWL until after the allegations emerged.

Recommendation 1 addresses the actions ECHCS needs to take to ensure mental health staff schedule veterans for appointments or place them on the EWL as required by policy.

ECHCS Had No Assurance That Veterans Received Timely Care

As a result of using the unofficial wait lists, ECHCS management lacked an effective process to adequately oversee veteran care. An effective process needs to provide assurance that staff adequately address requests for care and report accurate wait times to help make informed staffing decisions.

Additionally, ECHCS staff may have failed to provide access to The Veterans Choice Program. VHA's *Choice First Standard Operating Procedure (SOP): Non-VA Medical Care Referral Process for Services Unavailable and 30-Day Wait Time*, November 2, 2015, states that staff should offer access to Choice care when the VA Medical Center cannot schedule a VA appointment within 30 days. Without accurate wait time data, staff could not determine if these veterans were eligible for The Veterans Choice Program.

Conclusion

ECHCS used unofficial wait lists to track veterans waiting for mental health care. The lists did not effectively identify veterans waiting for care or the length of their wait time. This occurred because ECHCS management misinterpreted VHA scheduling guidance. As a result, facility management could not make effective staffing decisions to ensure it addressed all requests

[5] The FAQ instructed facilities to place veterans seeking group therapies on the EWL if they did not have capacity to schedule the veteran within 90 days, which is consistent with VHA Directive 2010-027 *Outpatient Scheduling Processes and Procedures*, June 9, 2010, and VHA Directive 1230, *Outpatient Scheduling Processes and Procedures*, July 15, 2016, which superseded Directive 2010-027.

for care. In addition, ECHCS staff may have failed to provide veterans the opportunity to seek care through VA's Choice program.

Recommendation

1. The OIG recommended the director of the Eastern Colorado Health Care System ensure mental health staff schedule veterans for appointments or add them to the electronic wait lists when acting on care requests.

Management Comments

The director concurred with Recommendation 1, but expressed disagreement with any characterization that the unofficial wait lists were secret waiting lists. The director stated that as of January 2015—before the OIG conducted this audit—ECHCS leadership, VISN, and VHA Central Office staff were aware of this practice and believed them to be acceptable at the time. ECHCS mental health providers used interest trackers to identify veterans who were actively receiving care in Mental Health and were interested in a specific group therapy. This practice occurred to ensure mental health providers had an adequate number of patients to conduct customized group therapy. Additionally, the director noted that key stakeholders were not formally notified of the release of the 2015 FAQ.

The director reported that ECHCS completed action to address Recommendation 1, including training all mental health staff and schedulers; discontinuing the use of interest lists; and reviewing veterans on the interest lists to ensure the therapy was completed, scheduled, or discontinued if no longer desired. The director's full response is included in Appendix C.

OIG Response

The director's corrective action plan is responsive to the intent of the recommendation. Although the director requested closure of Recommendation 1, the action plan did not include sufficient evidence that corrective actions had been completed as of October 2017. The OIG will continue to monitor implementation of planned actions and will close the recommendation upon receipt of sufficient evidence demonstrating progress in addressing the recommendation.

Regarding the director's comments on the characterization of the unofficial wait lists as secret waiting lists, the OIG deemed these lists as unofficial wait lists and made no declaration the lists were secret, as stated in the original complaint. The OIG determined the wait lists used by ECHCS mental health staff were violations of VHA policy. These lists were not part of any official VHA scheduling or patient tracking mechanism and they were not subject to the oversight and accountability that occurs when patients are scheduled or placed on an official wait list.

Regarding the director's comments that VACO was aware of the interest tracker practice and believed it to be acceptable at the time, ECHCS

leadership provided us documentation of discussions with a VACO subject matter expert in a phone call made on January 26, 2015. The documentation suggests the VACO subject matter expert stated that these lists were scheduling aids and were not a violation of policy. The same documentation defined scheduling aids as an electronic log, calendar, or sheet of veterans who need care coordination of resources where the scheduling aid is not stand-alone and contains information readily available within VHA's electronic health record. The OIG determined the unofficial wait lists reviewed for this report were stand-alone and contained information that was not readily available within VHA's electronic health record system. Therefore, use of these unofficial wait lists was not appropriate since they did not meet the definition of a scheduling aid.

Regarding the director's comment that key stakeholders were not formally notified of the release of the 2015 FAQ, the dissemination of the FAQ did not offer new guidance or alter facilities' responsibilities to follow existing guidance when scheduling outpatient appointments, including group mental health appointments.

Finding 2 Colorado Springs PCT Staff Did Not Promptly Act on Consults

The OIG substantiated PCT staff at Colorado Springs did not timely process PCT consults for veterans to receive care. Additionally, the OIG found PCT staff inaccurately recorded the clinically indicated date for calculating wait times and improperly closed consults without adequate documentation of scheduling efforts. For the consults entered in FY 2016, the OIG estimated PCT staff did not initiate scheduling efforts within VHA's goal of seven days for about 38 percent of the nearly 590 consults. Of the approximately 350 consults resulting in care, the OIG estimated about 64 percent resulted in veterans waiting longer than VHA's wait time goal of 30 days, which was significantly different from VHA's reported results showing that all veterans waited less than 30 days. In all, the OIG projected just over 91 percent of appointments were scheduled using inaccurate clinically indicated dates.

Approximately 240 consults were closed without care. Of these, the OIG estimated PCT staff inappropriately closed more than 40 consults when staff did not adequately document attempts to schedule veterans as required by VHA policy. PCT staff did not timely or appropriately process consults because PCT staff did not:

- Prioritize taking action on PCT consults
- Have sufficient support
- Properly record the clinically indicated date when scheduling
- Always record scheduling attempts in VHA's electronic health record, as required by VHA's scheduling policies

As a result, veterans experienced underreported delays in receiving PCT care by an estimated 50 days for initial treatment. Facility management also did not have assurance that staff made sufficient attempts to schedule veterans, which means staff may have failed to provide or further delayed veterans' access to PCT therapy. In addition, the OIG estimated staff did not offer veterans access to Choice care for about 210 PCT consults of the nearly 590 PCT consults entered in FY 2016.

PCT Staff Did Not Process Consults Timely

PCT staff did not always take action to schedule consults within seven days of the consult creation or provide care within 30 days of the clinically indicated date. VHA directives require facilities to take initial action within seven days of the date the consult was created.[6] Of the nearly 590 PCT consults entered in FY 2016, the OIG estimated that the clinic did not initiate

[6] VHA Directive 2008-056, *VHA Consult Policy*, September 16, 2008, and VHA Directive 1232, *Consult Processes and Procedures*, August 23, 2016.

efforts to act on consults within seven days for about 220 consults (38 percent).

PCT Staff Underreported Wait Times

PCT staff inaccurately recorded the clinically indicated date when scheduling veterans for appointments from consults. The OIG measured the wait time from the referring provider's clinically indicated date entered on the PCT consult to the date the appointment was completed.[7] If the patient canceled or failed to attend the first scheduled appointment, the OIG measured from the veteran's preferred appointment date entered as the clinically indicated date on the rescheduled appointment to the date the rescheduled appointment was completed.[8] Of the almost 590 consults entered in FY 2016, veterans received care for about 350 consults. For the veterans who received care, the OIG estimated PCT staff inaccurately recorded the clinically indicated date for almost 320 appointments (91 percent). For the 320 consults, the OIG estimated VHA reported an average zero-day wait time because PCT staff frequently entered the scheduled appointment date in place of the clinically indicated date to calculate the start of the wait time. However, the OIG estimated veterans from the 350 consults waited an average of 50 days to receive care when measured from the appropriate clinically indicated date. The OIG also estimated 220 consults (64 percent) were scheduled more than 30 days beyond the appropriate clinically indicated date, while it was reported through VHA's data that none of the veterans waited over 30 days.

PCT Staff Improperly Closed Consults

Of the estimated 240 consults that did not result in care, staff improperly closed about 40 consults without adequate documentation of at least two scheduling attempts in the electronic health record. On June 8, 2015, VHA issued a memo[9] that included the Outpatient Scheduling SOP. The SOP stated staff must make a minimum of three documented attempts—usually two phone calls and a letter—on separate days to contact the veteran to schedule the appointment. The SOP was replaced by VHA Directive 1230, *Outpatient Scheduling Processes and Procedures*, on July 15, 2016, which stated facilities must document at least two attempts to contact a veteran when scheduling an outpatient appointment. For its analysis, the OIG used a standard of a minimum of two attempts. Example 1 shows consult processing delays where staff improperly closed the consult without documenting contact attempts.

[7] VHA Directive 1230, *Outpatient Scheduling Processes and Procedures*, July 15, 2016.
[8] Prior to VHA Directive 1230, facilities were to follow VHA Memorandum, *Inappropriate Scheduling Practices*, April 26, 2010, that stated the desired date should be entered in the appointment comments. For the OIG's review that included consults scheduled prior to the release of VHA Directive 1230, the OIG followed VHA Directive 1230 guidance that facilities did not have to document preferred dates in the comments when scheduling.
[9] *CORRECTION: Clarification of Veterans Health Administration (VHA) Outpatient Scheduling Policy and Procedures and Interim Guidance*.

Example 1

The Colorado Springs PCT Director received a consult requesting evidence-based psychotherapy for a veteran with PTSD. No other actions were documented until more than four months later when the PCT Director closed the consult, annotating on the consult that the veteran had not responded to numerous contact attempts for scheduling. PCT staff had not documented the contact attempts mentioned in the PCT Director's note.

Why This Occurred

PCT staff did not always timely or appropriately process consults because they did not prioritize timely action on consults, did not have sufficient support staffing resources, improperly recorded the clinically indicated date for wait times, and did not always record scheduling attempts in VHA's electronic health record.

Untimely Action on Consults

The PCT Director stated that efforts to track requests for care were overwhelming and additional support staff was needed to help with case management and documenting clinical activities. The PCT Director also stated the PCT did not have support staff to assist in administrative tasks like scheduling new patients. The PCT Director explained that more than half of her time was spent performing these administrative tasks, which limited the ability to act timely on consults and provide clinical care. Facility management authorized the PCT Director to hire a part-time employee; however, the PCT Director declined, stating a full-time employee was needed. Without the part-time employee, the OIG considers the PCT resources insufficient to provide timely action on consults. Therefore, PCT staff could not always take prompt action given other competing tasks like providing care.

A staff psychologist stated she scheduled new patient appointments for veterans with consults using lists provided by the PCT Director. The staff psychologist claimed that, on occasion, significant time elapsed between when the PCT Director provided these lists, contributing to delayed action on consults. For instance, the staff psychologist provided an email where she had requested a new list from the PCT Director. In a response email, the PCT Director acknowledged it had been about three months since she last provided the staff psychologist a list of veterans with PCT consults.

Recommendation 2 addresses the need for the ECHCS Director to ensure resources are sufficient to process PCT consults within seven days.

Improperly Recorded Clinically Indicated Dates

The scheduling staff improperly recorded the clinically indicated date when scheduling veterans' appointments. VHA uses the clinically indicated date as the starting point to measure wait times. Instead of complying with VHA policy to use the clinically indicated date from the PCT consult, the staff psychologist stated that she gave instructions for schedulers to enter the date the veteran chose from a list of available appointments. According to the staff psychologist, she was not provided scheduling or consult training. She

believed her instructions provided schedulers the day of the appointment and not the clinically indicated date used to measure wait times. The sample review of PCT consults corroborated this statement. The OIG estimated schedulers incorrectly entered the date of the appointment as the clinically indicated date for almost 320 of the 350 consults. VHA reported an average zero-day wait for these 320 appointments, which did not represent the actual wait times veterans experienced.

Recommendation 3 addresses the need for the ECHCS Director to ensure staff properly record the clinically indicated date when scheduling veterans for PCT appointments.

Staff Did Not Record Scheduling Attempts

The PCT Director stated that scheduling attempts were not always entered into the official electronic health record. According to the PCT Director, the PCT clinic sometimes used a volunteer staff member to make phone calls scheduling veterans' appointments. This volunteer recorded scheduling attempts on paper for PCT staff to enter into the electronic health record. However, the PCT Director admitted that she and the clinic staff did not always enter these appointment scheduling attempts or others they completed personally in the electronic health records.

Recommendation 4 addresses the need for the ECHCS Director to ensure staff enter all consult actions in the electronic health record, including scheduling attempts.

Veterans Experienced Delays

As a result of PCT staff not following VHA policy on appointment scheduling, veterans experienced underreported delays and may not have received, or may have experienced delayed access to, PCT treatment. Additionally, PCT staff did not always offer access to The Veterans Choice Program. For FY 2016, the OIG estimated almost 320 veterans (91 percent) waited an unreported average of 50 days from the clinically indicated date on the PCT consult to their first appointment to initiate PCT treatment or care. Without accurate wait times, PCT staff could not determine who would be eligible for Choice. The OIG estimated staff did not offer access to Choice to eligible veterans for about 210 PCT consults that were scheduled more than 30 days past their clinically indicated date.

Conclusion

PCT staff did not take timely action on consults, did not provide timely care in response to consults, underreported wait times, and inappropriately closed consults when appointment scheduling attempts were not documented. This occurred because PCT staff did not prioritize consults to take timely action, did not have sufficient staffing resources, inaccurately recorded the clinically indicated date, and did not always document contact attempts. As a result, veterans experienced underreported delays in receiving PCT care by an estimated 50 days for initial treatment in the PCT clinic, and staff did not offer access to Choice for an estimated 210 consults.

Recommendations

2. The OIG recommended the director of the Eastern Colorado Health Care System ensure that Colorado Springs resources are sufficient to process PCT consult requests within seven days of receipt.

3. The OIG recommended the director of the Eastern Colorado Health Care System ensure that Colorado Springs PCT staff enter the clinically indicated date from the consult when scheduling veterans' appointments.

4. The OIG recommended the director of the Eastern Colorado Health Care System ensure that Colorado Springs PCT staff enter consult actions, including scheduling efforts, in the electronic health record.

Management Comments

The director concurred with Recommendations 2, 3, and 4. The director reported that ECHCS had completed action to address each recommendation. The director's full response is included in Appendix C.

For Recommendation 2, the director reported that ECHCS hired a new mental health chief for Colorado Springs, realigned staffing for a second psychologist PCT consult reviewer, hired a Health Administration Services chief to oversee Colorado Springs scheduling and clinic administration, and was in the process of recruiting for vacant scheduling positions.

For Recommendation 3, the director reported that ECHCS maintains scheduling training compliance rates of 100 percent for new schedulers and more than 95 percent for refresher training. The director also reported that ECHCS scheduling audits have demonstrated compliance with entering the appropriate clinically indicated date in 92 percent of appointments audited.

For Recommendation 4, the director reported that ECHCS has educated and trained the appropriate staff on consult management. VHA Directive 1232 has also been disseminated to Health Administration Services employees and all scheduling supervisors.

OIG Response

The director's corrective action plans are responsive to the intent of the recommendations. Although the director requested closure of Recommendation 2, the action plan did not include sufficient evidence that corrective actions had been completed. The OIG will continue to monitor implementation of planned actions and will close this recommendation when the OIG receives sufficient evidence demonstrating progress in addressing the recommendation. The OIG considers Recommendations 3 and 4 closed based on the documentation provided in the director's action plan.

Finding 3 Insufficient Evidence To Substantiate Alleged Falsification of Medical Documentation

The OIG found insufficient evidence to substantiate that Colorado Springs PCT staff falsified medical documentation following a veteran's suicide. The complainant alleged that entries into a deceased veteran's electronic medical record were falsified, in that entries were made in an attempt to cover up for staff who did not respond timely to a consult placed for the veteran by his mental health care provider.

The veteran's mental health care provider entered a routine consult for PCT in June 2016, which was 13 days prior to the veteran's suicide. VHA policy requires staff to take action on all consults within seven days. One day after the veteran's death, an ECHCS staff member documented an attempted call to the veteran to schedule the appointment. Over the next three weeks, two different ECHCS mental health care providers documented two additional attempts to call the veteran and schedule the appointment. These calls were made after a note from an outreach specialist stating they were contacted about the veteran's death, and a note confirming the death and cause of death as suicide. During an interview, the complainant stated that reports of a veteran's suicide would spread quickly and that in this smaller facility the complainant expected that all staff would have been aware of the veteran's death by suicide. Because the complainant could provide no additional support for the allegation of medical records falsification, the OIG did no further work.

Since the patient experienced a scheduling delay, the OIG requested the Office of Healthcare Inspections review the veteran's mental health care. They determined that while a delay in scheduling the veteran for PCT did occur, the veteran was otherwise actively engaged in mental health care at the facility. During a June 22, 2017 appointment with his psychologist, he was found to be a "low acute and chronic suicide risk." In addition, he attended several mental health therapy groups on June 27, 2017. Following the Office of Healthcare Inspection's review of the electronic health records, staff concluded the veteran's mental health care was appropriate but the plan to provide PCT care to the veteran was delayed.

Appendix A Scope and Methodology

Scope

The OIG conducted its review from October 2016 through August 2017. The OIG focused on the use of existing unofficial wait lists for various mental health group therapy services at ECHCS and on consult processing at the Colorado Springs PCT clinic from October 1, 2015 through September 30, 2016.

Methodology

The OIG reviewed applicable national and local policies, procedures, and guidance related to scheduling appointments, wait lists, and consult processing. The OIG conducted a site visit to the ECHCS to obtain an understanding of the facility's scheduling and consult practices and to obtain additional documentation pertaining to the allegations. The OIG interviewed staff, including the VISN 19 Business Implementation Manager, the ECHCS Chief of Primary Mental Health, the ECHCS Chief of Specialty Mental Health, the Chief of Mental Health at the Golden CBOC, and the director of the Colorado Springs PCT. The OIG obtained unofficial wait lists used by ECHCS staff for tracking requests for mental health care, and the OIG reviewed Colorado Springs PCT consults for timeliness and appropriateness of actions taken during consult processing.

The OIG attempted to evaluate the unofficial wait lists. Upon attempted review, the OIG found the unofficial wait lists contained insufficient information to determine the number of veterans waiting for care, the number of veterans who had not received the requested care, or how long these veterans had been waiting.

To evaluate PCT consults from Colorado Springs, the OIG reviewed a statistical sample of PCT consults created from October 1, 2015 through September 30, 2016. The OIG used electronic health records to determine whether staff took appropriate and timely action.

Fraud Assessment

During this review, the team assessed the risk that fraud, violations of legal and regulatory requirements, and abuse could occur. The review team exercised due diligence in staying alert to any fraud indicators by taking actions such as:

- Soliciting the OIG's Office of Investigations for indicators
- Performing analyses and conducting interviews designed to identify fraudulent behavior

The OIG did not identify any instances of fraud during this review, but did refer the complainant's allegations of falsification of medical records to the OIG's Office of Investigations.

Data Reliability

The OIG used computer-processed data from the VHA Support Service Center's Completed Appointments Cube and the Corporate Data Warehouse, as well as the electronic Microsoft Excel spreadsheets containing the unofficial wait lists. To assess the reliability of the Completed Appointment Cube and Corporate Data Warehouse, the OIG compared the patient-level details of data selected for a sample review from the Corporate Data Warehouse with the clinical data available for each patient in VHA's Computerized Patient Record System. The OIG also matched data from the Corporate Data Warehouse to data from the Completed Appointments Cube to ensure data entries were consistent. Throughout these comparisons, the OIG reviewed multiple date stamps, clinic names, and other extracted data to ensure the data was valid for review and fairly represented the medical records. The OIG found the information to be sufficiently reliable for its review purpose.

The OIG determined the data from electronic spreadsheets containing the unofficial wait lists to be insufficiently reliable for its review purposes, and made a recommendation for the facility to schedule veterans or use electronic wait lists when acting on care requests.

Government Standards

The OIG 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 Statistical Sampling Methodology

To determine whether the Colorado Springs PCT processed consults appropriately, the OIG evaluated statistical samples to determine:

- Elapsed days between consult submission and first action
- Elapsed days between consult submission and first medical appointment
- Number of consults that did not result in care
- Number of consults that were inappropriately completed/discontinued
- Number of veterans still waiting for care due to inappropriately completed/discontinued consults
- Number of inaccurately recorded clinically indicated dates

Population

The population consisted of 585 PCT consults created from October 1, 2015 through September 30, 2016 for the Colorado Springs PCT clinic.

Sampling Design

The OIG selected a stratified random sample for its sample reviews. The OIG reviewed 50 consults from the population created from October 1, 2015 through June 30, 2016 and 50 consults from July 1, 2016 to September 30, 2016. The OIG used this stratification method to provide more insight into recent procedural activities. All records had a known chance of selection. This allowed the OIG to make estimates over the entire population and by stratum.

Weights

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

Projections and Margins of Error

The margins of error and confidence intervals are indicators of the precision of the estimates. If the OIG repeated this review with multiple samples, the confidence intervals would differ for each sample but would include the true population value 90 percent of the time.

The OIG estimated PCT staff did not initiate scheduling efforts for about 220 consults (38 percent) within VHA's goal of seven days. The OIG estimated PCT staff provided care in about 350 consults and closed about 240 consults without care. Of the 350 consults resulting in care, the OIG estimated veterans waited longer than VHA's wait time goal of 30 days for just over 220 consults (64 percent) and PCT staff inaccurately recorded the clinically indicated date when scheduling almost 320 consults (91 percent). In addition, the OIG determined veterans experienced underreported delays in receiving PCT care by an estimated 50 days for initial treatment. Table 1 shows the projections from the sample results.

Table 1. Statistical Projections—PCT Consults

Description	Estimate	Margin of Error	90% Confidence Interval Lower Limit	90% Confidence Interval Upper Limit
Did Not Initiate Scheduling Within Seven Days	222 (37.9%)	57 (9. 8%)	165 (28.1%)	279 (47.6%)
Consults Resulting in Care	347 (59.3%)	57 (9.8%)	290 (49.5%)	404 (69.1%)
Consults Resulting in Care With Wait Greater Than 30 Days	224 (38.2%)* (64.5%)**	57 (9.8%) (12.5%)	167 (28.5%) (52.0%)	281 (48.0%) (77.0%)
Consults Resulting in Care With Inaccurately Reported Clinically Indicated Dates	315 (90.9%)	58 (6.8%)	257 (84.1%)	373 (97.7%)
Average Underreported Wait Time (Delays) in Days for Consults With Inaccurately Reported Clinically Indicated Dates	50	9	42	59
Consults Without Care	238 (40.7%)	57 (9.8%)	181 (30.9%)	295 (50.5%)
Consults Without Care Closed Inappropriately	44*** (7.5%)	25 (4.2%)	19 (3.3%)	69 (11.8%)
Average Wait Time for Consults Resulting in Care	46****	9	37	54
Consults Where Veterans Not Offered "Choice"	214	57	157	271
Consults VHA Reported Zero Day Waiting Time	328	58	270	386

Source: OIG statistical analysis of sample results projected over the population

** Note: As a percentage of all sampled consults*

***Note: As a percentage of consults resulting in care*

****Note: Rounded to 40 consults for report presentation*

*****Note: Rounded to 50 days for report presentation*

Appendix C Management Comments

Department of Veterans Affairs Memorandum

Date: September 29, 2017

From: Director, VA Eastern Colorado Health Care System (554/00)

Subj: Review of Alleged Use of Inappropriate Wait Lists for Group Therapy and Post Traumatic Stress Disorder Clinic Team, Eastern Colorado Health Care System

To: Division Director, OIG Office of Audits and Evaluations
Director, Management Review Service (VHA 10E1D MRS Action)

1. This Memorandum serves as Eastern Colorado Health Care System's (ECHCS) response to the Office of Inspector General's Office of Audits and Evaluations Draft Report. I concur with the findings and recommendations of the Office of the Inspector General report Inappropriate Wait Lists for Group Therapy and Post Traumatic Stress Disorder Clinic Team, Eastern Colorado Health Care System.

2. I do not agree with the characterization that unofficial wait lists were secret waiting lists. ECHCS, in an effort to meet the needs of Veterans in an environment of inadequate scheduling system software and complex scheduling rules, used interest trackers in order to track potential demand for a variety of mental health groups in January of 2015. The interest trackers allowed mental health providers to accumulate an adequate number of appropriate patients for group therapy to begin. ECHCS mental health providers used interest trackers to identify Veterans actively receiving care in Mental Health in order to identify those who indicated interest in a specific group therapy (e.g., anger management) to ensure they had an adequate number of patients to offer customized group therapy. All patients who indicated interest in this type of therapy (which were not yet scheduled) were already receiving therapy with a VA medical provider. In June 2015, ACAP and OMHO attempted to clarify the issue by creating additional guidance in the form of an FAQ document and communicating it through multiple teleconferences. However, VHA Medical Center Directors were not included in the scheduling clarification nor was the Scheduling Community of Practice (the nationwide POCs to operationalize a scheduling policy). These key stakeholders were not formally notified of the clarification document. ECHCS, VISN and Central Office Staff were aware of the interest tracker practice and believed it to be acceptable at the time.

3. Once VHA's Office of Access and Clinic Administration (ACAP) and Office of Mental Health Operations (OMHO) provided clear scheduling guidance to VISN 19 and ECHCS for mental health groups, ECHCS leadership trained all mental health staff and schedulers and discontinued use of interest trackers.

4. Attached, please find the facility actions and progress for each recommendation. For additional information, please contact Josh Pridgen, Associate Director, at (303) 393-2810 or joshua.pridgen@va.gov.

(Original signed by)
Sallie Houser-Hanfelder, FACHE
Director

(Original marked approved by)
Ralph Gigliotti
Network Director, VISN 19

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)
Action Plan

OIG Draft Report: Review of Alleged Use of Inappropriate Wait Lists for Group Therapy and Post Traumatic Stress Disorder Clinic Team, Eastern Colorado Health Care System

Date of Draft Report: August 25, 2017

Recommendation 1: We recommended the Director of the Eastern Colorado Health Care System ensure mental health staff schedule veterans for appointments or add them to the electronic wait lists when acting on care requests.

VHA Comments: Concur

ECHCS concurs with VHA OIG's recommendation but disagrees with the characterization that unofficial wait lists were used and with their interpretation of why this occurred. Now that VHA's Office of Access and Clinic Administration (ACAP) and Office of Mental Health Operations (OMHO) has provided clear scheduling guidance to VISN 19 and ECHCS for mental health groups, ECHCS leadership has trained all mental health staff and schedulers and discontinued use of interest trackers. All Veterans on the interest trackers were reviewed by a mental health provider to ensure the specific therapy they were interested in was completed, scheduled, or discontinued if the Veteran was no longer interested or the Veteran was added to the Electronic Wait List (EWL).

In an effort to meet the needs of Veterans in an environment of inadequate scheduling software and complex scheduling rules, ECHCS used "interest trackers" in order to track potential demand for a variety of mental health groups. As of January 2015 (before this VHA OIG audit), ECHCS leadership, VISN and VHA Central Office staff were aware of this practice and believed it to be acceptable at the time. ECHCS mental health providers used interest trackers to identify Veterans, who were actively receiving care in Mental Health and were interested in a specific group therapy (e.g., anger management). This practice occurred to ensure mental health providers had an adequate number of patients to conduct customized group therapy. All patients who indicated interest in these types of therapies (which were not yet scheduled) were already receiving therapy with a VA medical provider.

In June 2015, VHA's ACAP and Office of Mental Health Operations attempted to clarify scheduling for mental health groups by creating additional guidance in the form of an FAQ document and communicating it through multiple teleconferences. However, VHA Medical Center Directors were not included in the scheduling clarification nor was the Scheduling Community of Practice (the nationwide POCs to operationalize a scheduling policy). These key stakeholders were not formally notified of the clarification document.

We request closure of this recommendation.

Status Complete Target Completion Date: September 1, 2017

Recommendation 2: We recommended the Director of the Eastern Colorado Health Care System ensure that Colorado Springs resources are sufficient to process PCT consult requests within 7 days of receipt.

VHA Comments: Concur

VHA's goal for the health care system is for 90% of consults to be acted on within 7 days of the consult entry date (VHA has changed to 2 days since the time of this OIG audit). ECHCS consult performance, as of September 1, 2017, is at 94.5% and will continue to implement improvement strategies.

ECHCS has taken the following actions to ensure sufficient clinical review and scheduling resources are available for PCT consults:

- Hired a new Mental Health Section Chief for Colorado Springs in May 2017
- Realigned staffing for a second psychologist PCT consult reviewer
- Currently in recruitment for the remaining 2 vacant scheduling positions within Colorado Springs Mental Health clinic
- Hired a Health Administration Service (HAS) section chief for Colorado Springs in October 2016 to oversee scheduling and clinic administration

We request closure of this recommendation:

Status Complete Target Completion Date: September 1, 2017

Recommendation 3: We recommended the Director of the Eastern Colorado Health Care System ensure that Colorado Springs PCT staff enter the clinically indicated date from the consult when scheduling veterans' appointments.

VHA Comments: Concur

ECHCS leadership continually monitors and ensures appropriate staff are educated and trained on scheduling policy and processes, in accordance with VHA Directive 1232, to include entering the clinically indicated date.

As of February 1, 2017, all new MSAs were mandated to complete the National MSA Onboarding Training prior to assuming job duties. To meet this requirement, ECHCS HAS holds a mandatory 10-day Onboarding Scheduling Training for new staff and offers a 2.5 day National MSA Refresher Training for current staff. Consult scheduling and management are included as part of the 10-day face-to-face training and the 2.5 day National Mandated MSA Refresher Training curriculum.

In addition, VHA has updated three scheduling modules, (Scheduling Training Module 1 - General Scheduling Topics, Scheduling Training Module 2 - Established Patients Topic and Scheduling Training Module 3 - New Patients Topic) and mandated all new schedulers be assigned this training prior to obtaining scheduling access. ECHCS scheduling trainers collaborate with Education service to ensure training is documented appropriately prior to giving access to any scheduling keys. ECHCS maintains a scheduling training compliance rate of 100% for all new schedulers and above 95% for refresher training.

ECHCS completes routine scheduling audits in accordance with VHA policy. Audit results conducted since the time of this OIG audit, demonstrate compliance with entering the appropriate clinically indicated date (92%). Scheduling supervisors monitor scheduler accuracy on a weekly basis and re-train/re-educate schedulers as needed.

We request closure of this recommendation:

Status Complete Target Completion Date: September 26, 2017

Recommendation 4: We recommended the Director of the Eastern Colorado Health Care System ensure that Colorado Springs PCT staff enter consult actions, including scheduling efforts, in the electronic health record.

VHA Comments: Concur

ECHCS leadership has ensured the appropriate staff have been educated and trained on proper consult management, according to VHA Directive 1232. Requirements for training on Consult Directive 1232,

published August 23, 2016, extended to members of ECHCS Consult Steering Committee. Both Chairs of the Consult Steering Committee have completed the training as required.

Education on Consult Directive 1232 has been disseminated to HAS employees and all scheduling supervisors on multiple occasions (October 5, 2016 and again on June 28, 2017, which included the updated Memo on changes to timeliness). Updates to Consult Directive 1232 were also presented in the All Medical Staff meeting on June 23, 2017.

Schedulers are mandated to document all scheduling attempts and other consult actions within the consult in CPRS. VHA has created and rolled out a Consult Toolbox software to assist facilities in standardizing their documentation and scheduling efforts. ECHCS staff began utilizing the Consult Toolbox on November 14, 2016. As of September 1, 2017, a total of 29,568 distinct consults were documented using the Consult Toolbox by a total of 203 ECHCS employees.

ECHCS completes routine scheduling audits in accordance with VHA policy. Audit results conducted since the time of this OIG audit, demonstrate compliance with consult scheduling (92%). Scheduling supervisors monitor scheduler accuracy on a weekly basis and re-train/re-educate schedulers as needed.

We request closure of this recommendation.

Status Complete Target Completion Date: September 8, 2017

For accessibility, the formats of the original memo and plan have been modified to fit in this document, to comply with Section 508 of the Americans with Disabilities Act.

Appendix D OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Ken Myers, Director Josh Belew Latrael Hunter Brad Lewis Eric Sanford

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