Department of Veterans Affairs
Office of Inspector General

Audit of Alleged Manipulation of Waiting Times in Veterans Integrated Service Network 3

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VA Office of Inspector General
Washington, DC 20420

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Introduction

The Chairman, Senate Committee on Veterans' Affairs, requested the VA Office of Inspector General (OIG) review allegations that the leadership of the Veterans Integrated Service Network (VISN) 3 of the Veterans Health Administration (VHA) was manipulating procedures to misrepresent patient waiting times.

Background

We issued two reports questioning the reliability of VHA reported waiting times and waiting lists. In our July 2005 report, Audit of the Veterans Health Administration's Outpatient Scheduling Procedures, we found that schedulers did not follow established procedures for creating appointments, medical facilities did not have effective electronic waiting lists (EWL) procedures, and VHA did not have an adequate training program for schedulers. We made eight recommendations to the Under Secretary for Health to improve the accuracy of reported waiting times and waiting lists. As of the date of this report, five of the eight recommendations remain unimplemented.

In our September 2007 report, Audit of the Veterans Health Administration's Outpatient Waiting Times, we again found that schedulers were not following established procedures for making and recording medical appointments, and that the accuracy of reported waiting times could not be relied upon and the EWL at medical facilities were grossly understated. We made five recommendations to improve the reliability of waiting times and waiting lists. The Under Secretary for Health agreed with four of the recommendations but did not agree with our recommendation to ensure schedulers comply with policy to create appointments within 7 days or revert back to calculating the waiting time of new patients based on the desired date of care. As of the date of this report, all four recommendations remain unimplemented.

Results

We did not substantiate a willful manipulation of procedures with the intent to misrepresent waiting times by the prior VISN Director, who retired in February 2008, or by the Chief Medical Officer. However, we found that scheduling procedures were not followed, which affected the reliability of VISN 3 reported waiting times and caused the EWL to be understated. We projected that approximately 1,900 veterans waited for appointments but were not included on the EWL, and an additional 10,500 veterans received appointments beyond the waiting time standards that were also not placed on the EWL as required by VHA policy. Following are the results of our review by each issue raised in the complaint.

Issue 1: Did VISN 3 officials threaten staff to reduce waiting times?

We found no evidence to support that the prior VISN Director and Chief Medical Officer threatened to take action against staff if waiting time numbers were not in line with the performance measures in the VISN Director's performance standards.

Issue 2: Did VISN 3 officials receive recognition for low waiting times?

We found that the prior VISN Director and Chief Medical Officer were recognized with a Senior Executive Service (SES) bonus. In both cases, waiting times were only 1 of at least 22 performance measures used to support the SES bonuses. However, our review showed the data used to make the SES bonus decision for the waiting time measure could not be relied upon. Specifically, our results supported that 89 percent of new patients and 86 percent of established patients in VISN 3 were seen within 30 days of the desired appointment date compared to 95 percent and 99 percent, respectively, reported in the former VISN Director's bonus justification.

Issue 3: Did VISN 3 officials manipulate waiting times?

We found no evidence that officials willfully manipulated waiting time information. However, we did find that schedulers were not following established procedures for creating outpatient appointments, which affected the reliability of VISN 3's waiting times and waiting list information. Our results showed that VISN and medical facility Directors could not support the number of patients seen within 30 days of their appointment; the understatements ranged from 3 to 16 percent. As a result, we projected that about 28,000 veterans waited over 30 days for medical appointments; as opposed to the 2,900 reported by VHA.

Facility personnel could not show support for 53 percent of the desired dates used when creating established appointments. According to facility personnel, the primary cause was their failure to document the appointment date requested by the patient. Only about 5 percent of all appointments documented the required patient preference date. We also found that:

- Ten percent of the schedulers who responded to our web-based survey said they were directed to use the next available appointment slot as the desired appointment date even if it was later than the date requested by the veteran, which has the impact of underreporting actual waiting times.
- Seventy-six percent of schedulers who responded said they had used a later date as the desired date even though the patient wanted an earlier date.

We also found that for about 1,700 (17 percent) of the projected 10,300 new patient appointments, the scheduler took more than the required 7 days to schedule the appointment.

Issue 4: Did VISN 3 personnel use electronic waiting lists appropriately?

We found no evidence that VISN 3 approved the inappropriate use of EWLs at the medical facilities in order to make it appear they were complying with VHA policy on the use of the EWL. However, VISN 3 did not have effective procedures to ensure EWLs were complete and some facilities kept informal waiting lists which were not reported. We projected that about 12,400 veterans were waiting for appointments but were not included on the EWLs. Our projection consisted of about 1,900 veterans waiting for their consult (referrals for an appointment to see a medical specialist) and about 10,500 veterans who received an appointment past VHA prescribed timeliness standards.

Furthermore, this projection supported that approximately 1,400 (74 percent) of the 1,900 veterans waiting for their consult had been waiting more than 30 days for the facilities to act on their consult requests. None of the medical facilities we reviewed consistently included veterans with active and pending consults that were not acted on within the 7-day requirement on the EWLs. According to facility personnel, the consult tracking report did not always reflect the actual consult status because clinic personnel did not always update the consults after action was taken, as required by VHA policy.

We also projected that approximately 10,500 veterans were given appointments past VHA prescribed timelines without being placed on the facilities' EWLs, consisting of:

- Fifty-three percent (approximately 5,600 veterans) who were at least 50 percent service-connected.
- Thirteen percent (approximately 1,400 veterans) who were less than 50 percent service-connected and being seen for their service-connected conditions.
- Thirty-four percent (approximately 3,500 veterans) who did not meet either of the conditions listed above and waited more than 120 days for their appointment.

This occurred primarily because schedulers were not following established procedures for creating appointments; specifically, schedulers were not using the correct desired dates of care. As a result, facility managers did not have accurate information on the number of veterans that were not being seen in timely manner.

Issue 5: Did VISN 3 personnel maintain informal waiting lists and close consults inappropriately?

We found that a small number of schedulers still maintained informal waiting lists. During interviews, six staff at four of the five primary facilities told us they kept informal waiting lists. In addition, 35 (6 percent) of the schedulers who responded to our web-based survey acknowledged that they currently maintain informal waiting lists. Informal waiting lists, which are prohibited by VHA policy, underreport the actual number of veterans who are waiting for appointments beyond prescribed timeline standards.

We did not identify evidence that inaccurate comments were added to consults stating that the patient missed or did not want the appointment. However, some facility personnel administratively closed consults without adequate support. We identified 55 schedulers that closed a total of 251 consults without adequate support for closing the consult. The following examples highlight scheduling practices negatively impacting the management and data reliability of consult appointments:

- A clinic manager cancelled eight appointments for consults because they were over 30 days old. In two instances where the patients had appointments greater than 30 days, the patients' appointments were cancelled and then rescheduled for the same date and time. Because VHA uses the creation date as the starting point for calculating the waiting time of new patients, this intentional manipulation effectively restarts the patients' waiting time, thereby underreporting actual waiting times.
- Instead of scheduling 29 consults in a cardiology clinic, the clinic expected patients to physically come to the clinic to be scheduled for their appointments. If the patient failed to do so, the clinic closed the consult with no further action. The facility agreed that this was not appropriate and took immediate action to stop it.

Issue 6: Were appointments created on the appointment day?

For one facility, we found evidence at two clinics that some appointments were not entered in the scheduling system until the day of the appointment, even if the appointment date was not what the veteran requested or was over 30 days old. While this practice resulted in underreporting the number of patients who missed appointments in response to a fiscal year (FY) 2007 performance measure, it also had the inappropriate impact of underreporting the amount of time veterans actually waited for their appointments. When VISN 3 officials learned that this practice was occurring, they immediately stopped it.

Issue 7: Were patients unaware of appointments?

We did not find evidence that patients were unaware of appointments because they never received notification in the mail or a call from the facility.

Conclusion

Although we found no evidence to support a willful manipulation of procedures by the prior VISN 3 Director and the Chief Medical Officer to misrepresent waiting times, we determined that the waiting times and EWLs for medical facilities in VISN 3 were inaccurate and understated. This occurred because VISN 3 scheduling personnel were not always complying with established procedures for appointment scheduling and handling of consult referrals. Complying with established procedures is critical to ensuring patients are seen in a timely manner and that VA has accurate and reliable information for its decision making purposes.

Recommendations

1. We recommended that the Under Secretary for Health ensure that the Acting VISN Director establishes procedures to ensure waiting times used to support performance ratings are accurate.
2. We recommended that the Under Secretary for Health ensure that the Acting VISN Director establishes procedures to monitor compliance with policy requirements to ensure patient preferences for desired appointment dates are properly documented.
3. We recommended that the Under Secretary for Health ensure that the Acting VISN Director establishes procedures to monitor compliance with policy requirements to routinely test the accuracy of reported waiting times and completeness of EWLs, and take corrective action when testing shows questionable differences between the desired dates of care shown in medical records and desired dates documented in the Veterans Health Information Systems and Technology Architecture (VistA) scheduling package.
4. We recommended that the Under Secretary for Health ensure that the Acting VISN Director establishes procedures to monitor compliance with policy requirements to ensure veterans are placed on EWLs when appointments cannot be scheduled within the 30- or 120-day requirements.
5. We recommended that the Under Secretary for Health ensure that the Acting VISN Director establishes procedures to monitor compliance with policy requirements to ensure schedulers properly follow-up on appointments that veterans do not keep or the veteran or clinic cancels.
6. We recommended that the Under Secretary for Health ensure that the Acting VISN Director establishes procedures to monitor compliance with policy requirements to ensure active and pending consults are acted on within 7 calendar days or are placed on the EWL.
7. We recommended that the Under Secretary for Health ensure that the Acting VISN Director establishes procedures to monitor compliance with policy requirements to ensure informal waiting lists are not used.
8. We recommended that the Under Secretary for Health ensure that the Acting VISN Director establishes procedures to monitor compliance with policy requirements to ensure facility personnel do not close consults without support.
9. We recommended that the Under Secretary for Health ensure that the Acting VISN Director establishes procedures to monitor compliance with policy requirements to ensure schedulers use the scheduling package to manage appointments.

Under Secretary for Health's Comments

The VHA Under Secretary for Health did not concur with the report's conclusions and recommendations. The Under Secretary stated that the issues we reported reflect the need for policy solutions that VHA is already addressing. Therefore, singling out VISN 3 and holding them accountable is counter-productive. See Appendix D for the full text of the Under Secretary's comments.

OIG Response

Contrary to the Under Secretary's statement, we did not single out VISN 3 for this review. The Chairman of the Senate Veterans' Affairs Committee requested we conduct this audit based on serious allegations the committee received that VISN 3 was intentionally distorting the numbers on waiting times. We also take exception to the Under Secretary's non-concurrence with the report's conclusions and recommendations based merely on the fact that the issues we reported reflect the need for national policy solutions that VHA claims they are already addressing. Our exception is based on the fact that VHA has recognized the need to improve the accuracy of waiting times data, yet has taken no meaningful action to achieve this goal to date. We can only conclude that VHA's stated intention to correct recognized and long-standing problems is not sincere.

We agree with the Under Secretary that VHA leadership needs to develop and implement a national solution to this continuing problem. However, we are concerned that since we first reported the problem of inaccurate waiting times and waiting lists in July 2005 and again in September 2007, VHA has not taken sufficient actions to correct their data reliability problems. In fact, nine of the recommendations for corrective action listed in these reports that the Under Secretary agreed to implement, remain unimplemented. We find it contradictory for VHA to state their agreement with the findings and recommendations in our previous reports and then nonconcur with this report which contains essentially the same findings and recommendations.

This report substantiates that the problems identified in previous OIG reports continue to exist, and that little to no progress has been made to address the long-standing and underlying causes of inaccurate waiting times and incomplete electronic waiting lists. In fact, most everyone in VHA we discussed this matter with during the course of our audits agreed that the data in the scheduling system is not reliable for calculating accurate waiting times. Yet, knowing that reported waiting times are derived from a system that contains inaccurate and incomplete data, VHA continues to report inaccurate waiting time successes in VA's annual *Performance and Accountability Report* (PAR). We believe that VHA has placed itself between the proverbial rock and a hard place in that they acknowledge levels of imprecision in their reported waiting times data, even in their response to this report, yet they find themselves in the awkward position of having to nonconcur with our findings because to do otherwise would be to admit that waiting

times reported in the PAR are not accurate. From our perspective, VHA's nonconcurrence is unsupported.

The Under Secretary expressed strong concern with what he characterized as misleading implications and unfounded innuendo that some of the report statements convey. In regard to this concern he cites our reference to the use of waiting times to support SES performance bonuses by stating that the VHA Deputy Under Secretary for Health for Operations and Management reviews performance associated with eight core competencies and 22 performance measures when making a decision whether an SES bonus should be awarded. The Under Secretary emphasized that VISN 3 has consistently worked to improve patient access and has developed numerous creative tools to monitor and ensure compliance with the scheduling directive. We understand the Under Secretary's point that an SES bonus determination is based on a multitude of factors, but that does not mitigate the fact that the waiting times and waiting list data used to support SES performance ratings in VISN 3 were found to be inaccurate, and that the primary cause of this inaccuracy was noncompliance with the prescribed scheduling procedures. The Under Secretary's failure to acknowledge the errors in reported waiting times or provide evidence to refute our finding raises concern whether data integrity issues may exist for other reported performance measures used in making executive compensation decisions.

The Under Secretary also expressed concern that a reader of the report who does not have an intimate understanding of the complexities involved in scheduling processes would come away with a sense that VISN 3 somehow exemplifies systemic misrepresentation of waiting times reporting and failure to follow scheduling procedures. While our report clearly states that the scope of this audit was limited to VISN 3, the Under Secretary's concern that this report could somehow be misconstrued as illustrative of a systemic problem throughout VHA is puzzling given the fact that this report refers the reader to both of our previous reports on this subject which clearly illustrate that the problems and causes associated with inaccurate waiting times and waiting lists are in fact systemic throughout VHA.

The Under Secretary stated that he was disappointed that the OIG did not attempt to report on the many actions VHA is undertaking nationally to address recognized obstacles in their attempts to accurately measure waiting times. As stated earlier, our tasking from the Senate Veterans Affairs' Committee was to determine the validity of allegations from a complainant that VISN 3 leadership was manipulating patient waiting times. The actions that the Under Secretary is referring to have neither been fully implemented nor validated as actions that will correct the deficiencies identified in our reports.

Our process of providing VHA an opportunity to review and comment on our draft reports is the proper mechanism for the Under Secretary to challenge our findings by providing factual and supportable evidence necessary to refute our findings, or to identify the actions they will take or are taking to implement our recommendations. The Under

Secretary's response did neither. It is not our responsibility to demonstrate that VHA has taken the actions necessary to address the concerns identified in our reports, but we certainly look forward to VHA providing the support necessary to validate that they have implemented our recommendations and have corrected the problems.

The Under Secretary states that established waiting time policies and procedures have been overtaken by the rapidity with which many facilities have implemented new best practices to improve patient access. He adds that VISN 3 has been a leader in initiating new practices and was among the first VISNs to institute an innovative, patient-focused Recall Scheduling System for next appointments, which has now become "routine practice" in many facilities system-wide. Prior to the recall system's implementation, patients often scheduled their next appointment after a visit with their medical provider. The desired date was therefore the Return to Clinic (RTC) date noted by the provider. With the advent of the recall system, the RTC date triggers a recall letter to patients approximately 2 weeks before the RTC date, reminding them of the need to call for an appointment. At that point, patients can request an appointment that is convenient for them. This "patient preference" date, rather than the original RTC date, is understood by facility staff to actually be the desired date and, as such, there is no need to document this. Our concern with this approach is that without documentation of the preferred appointment date, VHA cannot ensure that veterans are receiving medical appointments within the required timeframes.

The Under Secretary stated that when a recall system is used, the agreed upon appointment date is understood by facility staff to be the desired date of care. Although the recall system does have some advantages, VHA's refusal to require schedulers to follow established procedures has the direct impact of distorting actual waiting times. For example, we found that schedulers did not distinguish between a patient preferred date and a patient accepted date. Specifically, if a patient followed recall system procedures and called the clinic to schedule an appointment in 2 weeks but there was no appointment available for 4 months, the patient was given an appointment in 4 months and that was recorded as the patient desired date. Just because the patient accepted the only appointment available does not necessarily make it the patient's preferred or requested date. Furthermore, patients are not placed on a waiting list as required, even though they waited months longer than they wanted to for an appointment.

We disagree with the Under Secretary's comment that documentation is of little value. Specifically, documentation provides reasonable assurance that reported waiting times are accurate. As stated by the Under Secretary, VHA completes almost 40 million appointments a year. Such a large workload does not diminish the need for documentation, rather, it increases the importance of documentation to ensure procedures are complied with and accountability is established. Without sufficient documentation, the Under Secretary will be unable to adequately implement our recommendation to establish a quality assurance process to validate the reliability of data. Statements made by VHA management lead us to conclude that VHA is reluctant to require documentation because it could confirm that VHA's reported waiting times are inaccurate.

The Under Secretary also raises concern with our use of a web-based survey regarding training, scheduling, and electronic waiting list procedures that was provided to the 1,900 employees in VISN 3 with scheduling access. He questions whether the low response rate of 29 percent can be used to support any of the report's conclusions. The results of our web-based survey were not used as the definitive support for any of our conclusions. Rather, the results were used to supplement our review and analysis of 1,500 appointments and oral testimony received from facility personnel. We interviewed 224 employees, including schedulers, supervisors, senior managers, and facility leaders to help substantiate our conclusion that scheduling procedures were not properly followed. The Under Secretary's concern over the use of survey results is confusing since the scope and methodology of our audit, as just described, was clearly articulated in the draft report provided to VHA for comment.

The Under Secretary also stated that 7 of the 17 questions and 3 scenarios presented in the survey were ambiguous, could easily be misinterpreted by schedulers, and did not provide respondents an opportunity to enter comments. Regarding ambiguity, the questions used in this survey were very similar to the questions we used in our July 2005 audit which VHA personnel helped us develop. Also, the Under Secretary's statement that we did not provide respondents an opportunity to enter comments is inaccurate. Not only did many of the specific questions provide space for comments, the last question of the survey provided respondents with the opportunity to enter any additional comments they wanted to make.

The Under Secretary notes that the OIG findings must be put in the proper perspective because no other system in the public or private sectors has even attempted to assess waiting times for almost 40 million annual appointments. He contends that the difficulty in trying to interpret and implement scheduling practices within the confines of a rigid and cumbersome scheduling system is a daunting challenge, and that given the circumstances errors are inevitable. He added that fundamental policy improvements will have to be made and that VHA is in the process of actively addressing identified issues.

We disagree with the Under Secretary's implication that errors of such magnitude should be accepted just because it is difficult to comply with required scheduling procedures. VHA has a defined policy that provides specific training on instructions for schedulers to use when creating outpatient appointments—this policy is not subject to interpretation by facility personnel. During the past few years, VHA has made a significant investment in training over 41,000 schedulers in its policies and procedures. However, it is troubling that our audit confirmed that despite completion of this training, schedulers are still not complying with required scheduling policies and procedures.

Further, despite the Under Secretary's acknowledgement that errors are inevitable, VHA still does not have an effective quality assurance process in place to detect and correct errors as recommended by the OIG in July 2005. We believe saying errors are inevitable, knowing that OIG reports have clearly documented the causes and magnitude of these

errors, is designed to deflect attention away from the fact that VHA knows what the problem is, and has the ability to fix it but lacks the will to do so.

The Under Secretary acknowledges levels of imprecision in VHA's reported waiting times data but states that they have yet to identify a more effective methodology to track and monitor waiting times. He also adds that no one, including OIG auditors, has been able to provide any recommendation to improve data accuracy. His statement is unfounded given the fact that our July 2005 and September 2007 reports, as well as this report, make very specific recommendations aimed at one thing only, which is improving the accuracy of reported waiting times, recommendations that up until now have been agreed to by VHA. We believe that VHA chose to not concur with previously agreed to recommendations because they have no intention of implementing our recommendations.

The Under Secretary's statement that a separate VHA patient satisfaction survey is at odds with our findings has no merit. First, the patient satisfaction rates he quoted only reflect the opinions of patients who received primary care, whereas our report includes both primary and specialty care. Second, there is no comparison between overall patient satisfaction and VHA's compliance with specific policy requirements or the accuracy of the waiting time information reported by VHA. We note that waiting time information reported by VHA was obtained from the same data system that we used to conduct the audit and not from the patient satisfaction survey. To support any level of comparison, a patient satisfaction survey would have had to ask veterans whether they were seen within 30-days of their desired date. Because this question was not posed in the survey, the survey results cannot be construed as an indicator of compliance with established scheduling procedures or the accuracy of reported waiting times. A more troubling aspect of the Under Secretary's statement is that we clearly articulated our rebuttal to the exact same response in our September 2007 report, and yet VHA chose to repeat their same unpersuasive argument without providing any new evidence to refute our position.

Accordingly, we once again strongly recommend that the Under Secretary for Health establish procedures to routinely test the accuracy of reported waiting times and completeness of EWLs, and take corrective action when testing shows questionable differences between the desired dates of care shown in medical records and those documented in the scheduling system. VHA needs accurate waiting times data and waiting lists to ensure every veteran is seen within required timeframes and receives the medical care they need in a timely manner.

(original signed by:)

BELINDA J. FINN
Assistant Inspector General
for Auditing

Introduction

Purpose

The Chairman, Senate Committee on Veterans' Affairs, requested the OIG review the validity of written allegations they received on September 12, 2007, from an anonymous complainant alleging that the leadership of VISN 3 was manipulating procedures to misrepresent patient waiting times. The prior VISN 3 Director retired in February 2008.

We categorized the complaint into the following seven issues:

1. The prior VISN Director and Chief Medical Officer threatened to take action against staff if waiting time numbers were not in line with the performance measures on the VISN Director's performance standards.
2. The prior VISN Director and Chief Medical Officer received national recognition for having the lowest waiting times and were rewarded through their yearend bonuses.
3. Chiefs of Staff manipulated procedures to misrepresent waiting time information.
4. VISN 3 approved the use of a few EWLs at the medical facilities in order to make it appear they were complying with VHA policy on the use of the EWL.
5. Waiting lists were incomplete because personnel maintained informal waiting lists to hide problems with older consult orders and administratively closed consults that had not been acted on after 30 days. In some cases, inaccurate comments were added to consults stating that the patient did not show or did not want the appointment.
6. Appointments were not entered in VistA until the day of the appointment to reduce the number of patients who miss appointments.
7. Patients were unaware of appointments because they never received notification in the mail or calls from the facility.

Background

VHA policy requires that all veterans with service-connected ratings of 50 percent or greater and all other veterans requiring care for service-connected disabilities be scheduled for care within 30 days of desired appointment dates. All other veterans must be scheduled for care within 120 days of the desired dates. Veterans who cannot be scheduled for appointments within the 30- or 120-day requirement should be placed on the EWL immediately. When placing the patient with service-connected priority on the EWL, it must be documented in the comment section of the EWL that care could not be provided within 30 days.

VHA policy also requires that requests for appointments be acted on by the medical facility as soon as possible, but no later than 7 calendar days from the dates of request.

To act on the appointment means to schedule or deny the appointment, or place the veteran on the EWL.

Scheduling Procedures

To ensure reliable waiting times and waiting list information, schedulers must input the correct desired date of care when creating appointments.

- The desired date of care is the earliest date on which the patient or provider specifies the patient needs to be seen. If an appointment is not available at the time originally specified by the provider, but the provider accepts and documents that a later appointment is acceptable, that later appointment date is to be entered as the desired date.
- When the patient requests an appointment date that is not consistent with the date given by the provider as the desired date, a comment needs to be entered in the "Other Info" section in the VistA scheduling package explaining the appointment date used. This requested date becomes the desired date. If the date requested by the patient is not available, and the patient agrees to another appointment that is later, the desired date is still the date the veteran originally requested.

Waiting Times

For measuring waiting times, VHA defines established patients as those who have received care in a specific clinic in the previous 2 years; new patients represent all others. For example, a veteran who has been receiving primary care at a facility within the previous 2 years would be considered an established patient in the primary care clinic. However, if that same veteran was referred to the facility's Cardiology clinic, that veteran would now be classified as a new patient in the Cardiology clinic.

VHA prescribes the following methods to calculate the waiting times for outpatient appointments.

- For established patients (about 90 percent of outpatient appointments), VHA measures the elapsed days from the desired dates of care contained in the VistA scheduling package to the dates of the appointments. Schedulers must enter the correct desired dates of care in the system to ensure the accuracy of this measurement. The desired dates of care are usually established by the providers but can be adjusted based on veterans' requests.
- For new patients, VHA calculates waiting times from the date that the scheduler creates the appointment. Since schedulers have 7 calendar days to create appointments, VHA acknowledges that the actual waiting time for new patients could be understated by the number of days schedulers take to create the appointment.

Waiting Lists

VHA implemented the EWL in 2002 to provide medical facilities with a standard tool to capture and track information about veterans waiting for medical appointments. Veterans who receive appointments within the required timeframes are not placed on the EWL. However, veterans who cannot be scheduled for appointments within the 30- or 120-day requirement should be placed on the EWL immediately. If cancellations occur and veterans are scheduled for appointments within the required timeframes, the veterans are removed from the EWL.

Prior Audit Results and Unimplemented Recommendations

The OIG issued two recent reports questioning the reliability of VHA's reported waiting times and waiting lists. In a 2005 report,[1] the OIG found schedulers did not follow established procedures for creating appointments, medical facilities did not have effective EWL procedures, and VHA did not have an adequate training program for schedulers. The OIG made eight recommendations to the Under Secretary for Health to improve the scheduling process:

1. Ensure that medical facility managers require schedulers to create appointments following established procedures.
2. Monitor the schedulers' use of correct procedures when creating appointments.
3. Monitor consult referrals to ensure that all veterans with referrals either have scheduled appointments within 7 calendar days or are included on the EWL.
4. Establish an automated link from the Computerized Patient Record System (CPRS) consult package to the VistA scheduling module.
5. Ensure medical facilities prohibit the use of informal waiting lists.
6. Develop a standard training package for medical facilities to train schedulers on the EWL and VistA scheduling modules.
7. Ensure all schedulers view the video training titled "VistA Scheduling Software: Making a Difference."
8. Require all schedulers to receive annual training on the EWL and VistA scheduling module.

In a September 2007 report,[2] the OIG found that schedulers still were not following established procedures for making and recording medical appointments. This resulted in unexplained differences between the desired dates as shown in VistA and used by VHA to calculate waiting times and the desired dates shown in the related medical records. As a result, the accuracy of VHA's reported waiting times could not be relied on and the

[1] *Audit of the Veterans Health Administration's Outpatient Scheduling Procedures,* (Report No. 04-02887-169, July 8, 2005).
[2] *Audit of the Veterans Health Administration's Outpatient Waiting Times,* (Report No. 07-00616-199, September 10, 2007).

EWLs at those medical facilities were not complete. In addition, VHA had not fully implemented five of the eight recommendations from the July 8, 2005, report. The 2007 report contained the following five recommendations to the Under Secretary for Health:

1. Establish procedures to routinely test the accuracy of reported waiting times and completeness of EWLs, and take corrective action when testing shows questionable differences between the desired dates of care shown in medical records and documented in the VistA scheduling package.
2. Take action to ensure schedulers comply with the policy to create appointments within 7 days or revert to calculating the waiting time of new patients based on the desired dates of care.
3. Amend VHA Directive 2006-055 to clarify specialty clinic procedures and requirements for receiving and processing pending and active consults to ensure they are acted on timely and, if not, are placed on the EWLs.
4. Ensure all schedulers receive required annual training.
5. Identify and assess alternatives to the current process of scheduling appointments and reporting waiting times, and develop a plan to implement any changes to the current process.

As of May 1, 2008, the five open recommendations from the 2005 report remain unimplemented as well as the four recommendations agreed to by the Under Secretary in the 2007 report.

Scope and Methodology

We conducted our work from October 2007 through March 2008. We performed site reviews and evaluated data for all five primary medical facilities in VISN 3 and their affiliated Community Based Outpatient Clinics. This included the James J. Peters VA Medical Center (Bronx, NY), the Northport VA Medical Center, and three Health Care Systems (HCS) located in Hudson Valley, New Jersey, and New York Harbor.

In addition to reviewing applicable laws, regulations, VHA policies and procedures, and guidelines, we interviewed 224 employees consisting of 103 schedulers, 54 administrative officers and supervisors, 34 information technology and clinical applications coordinators, 6 quality assurance and compliance personnel, 23 senior managers and the 4 senior VISN 3 leaders (prior Director, Deputy Director, Chief Medical Officer, and the Performance Manager). We also asked schedulers at each of the five primary facilities in VISN 3 to take an anonymous web-based survey regarding training, scheduling, and EWL procedures (see Appendix C for the survey results). As of September 30, 2007, the VISN identified approximately 1,900 personnel who had been trained on scheduling. The 1,900 personnel included all employees with scheduling

access—and not just the primary schedulers. Of the 1,900 personnel, 556 (29 percent) completed the survey.[3]

To determine if desired dates and waiting times were accurate, we reviewed the following information:

- Random, statistical samples of 750 new and 750 established patient appointments (see Appendix A for details of the samples). The samples consisted of 150 new and 150 established appointments at each of the 5 primary facilities and were selected from the database of appointments maintained by VHA. This database provided support for the VISN and medical facility directors' reported accomplishments in their FY 2007 performance contract. The universe selected from this database consisted of appointments completed during June through August 2007 for the 10 performance measure clinics at each facility.
- Documentation in VistA, CPRS, and KLF,[4] which provided the appointment creation, desired, and treatment dates, and any documented patient and physician preferences.
- The desired dates of care requested by the providers and documented in the medical records or the veterans' desired dates of care as recorded in the VistA scheduling and consult packages by the schedulers to evaluate if the waiting times of established patients were calculated correctly.
- The desired dates of care for new patients compared to the appointment creation date to determine if schedulers were creating appointments timely.

To determine if medical facility personnel included all patients on the EWL as appropriate, we reviewed random, statistical samples of 355 active and 370 pending consults in total for the 5 primary facilities (see Appendix B for details of the samples). The samples were selected from the VistA Consult Tracking Report and included consults in the 10 performance measure clinics reported to be in active or pending status for at least 7 days as of October 31, 2007.

To determine if VISN 3 and medical facility leaderships were directing employees to circumvent scheduling procedures, we reviewed emails received and sent by the prior VISN Director, Deputy Director, Chief Medical Officer, and management at the five primary facilities.

To determine if medical facility personnel were inappropriately closing consults to minimize waiting lists and waiting times, we:

- Reviewed closed consults, where certain medical center personnel closed more than 20 consults within a day, selected from universes at each of the 5 primary facilities.

[3] The survey response rate is estimated to be 29 percent. The potential for nonresponse bias in the survey results may be high due to the low response rate and the sensitive nature of questions asked in the survey.
[4] KLF is a database maintained by VHA Chief Network Office/VISN Support Service Center and is used to collect the results of many of the performance measures and monitors.

The closed consults were for the 10 performance measure clinics that were released from the requesting provider or service from March through August 2007.

- Determined if consults were appropriately closed by comparing the requested consult for specialty service with the medical information in VistA and CPRS to evaluate whether proper action was taken.

In January 2008, we met with facility leadership to discuss the results of our review. Where appropriate, we made changes to our results based on information the medical facilities provided to us.

We assessed the reliability of automated data by comparing selected data elements—date appointment was created, desired date of care, date of completed appointment—to the electronic medical records. We concluded that the data used to accomplish the audit objective was sufficiently reliable.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Results and Conclusions

Our review did not substantiate any willful actions by VISN leadership to manipulate patient waiting times. However, we found that schedulers were not following established procedures for creating outpatient appointments, which affected the reliability of VISN 3's reported waiting times and caused the EWLs to be understated.

Issue 1: Did VISN 3 officials threaten staff to reduce waiting times?

We found no evidence to support that the prior VISN Director and Chief Medical Officer threatened to take action against staff if waiting time results were not in line with the performance measures on the VISN Director's performance standards. In FY 2007, the VISN Director's standards included an assessment of at least 22 performance measures such as access to care, waiting times, patient satisfaction, and increased revenue generation. The waiting time measures included new and established patients for primary care and nine specialty clinics.

We interviewed 224 personnel at the 5 primary VISN 3 facilities to determine if any of the VISN 3 leadership unduly pressured them and created an intimidating environment to ensure their performance goals were met. We found personnel understood that getting patients their desired care was a priority and were aware of their responsibility in meeting their Directors' performance goals. We found insufficient evidence to support that VISN 3 leadership, to include the medical facility Directors, were threatening staff in a manner that encouraged a willful manipulation of scheduling procedures. We also reviewed emails received and sent by the prior VISN Director and Chief Medical Officer during the period January 2006 through November 2007 and found no evidence to support this allegation.

On our web-based survey, we asked the respondents whether they felt pressure or threat of reprisal from their managers or immediate supervisors to keep waiting times short. Only 20 of the 556 (3.6 percent) answered yes.

Issue 2: Did VISN 3 officials receive recognition for low waiting times?

We found that the prior VISN Director and Chief Medical Officer were recognized with a SES bonus. In both cases, waiting times were 1 of at least 22 performance measures used to support the SES bonuses.

In FYs 2006 and 2007, the Deputy Under Secretary for Health for Operations and Management gave the prior VISN Director ratings that supported SES bonuses, but told us that the rating was based on at least 22 performance measures and 8 key core competencies. We reviewed the prior VISN Director's performance appraisals and found

acknowledgements in quality improvements, Medical Care Collections Fund recoveries, timeliness of fee basis payments, and infrastructure upgrades but no specific mention of reduced waiting times.

In FYs 2006 and 2007, the prior VISN Director gave the Chief Medical Officer ratings that supported a SES bonus. These ratings noted many examples of leadership and management abilities highlighting solid data and performance driven methods and willingness to take on the initiative to assure VISN 3 met its clinical performance measures. The ratings included at least 22 clinical performance measures and key core competencies—waiting times represented one of the measures. Other examples cited the Chief Medical Officer's ability to ensure all facilities received accreditation from the Joint Commission for the Accreditation of Healthcare Organizations, implement a successful pharmacy call center, and co-chair the successful implementation of VISN 3's advanced clinical access initiatives.

The VISN and facility Directors could not support the percentage of patients they claimed were seen within 30 days of their desired appointment dates for 9 of our 10 samples. VISN-wide, we found that 89 percent of new patients and 86 percent of established patients were seen within 30 days of the desired appointment date compared to the prior VISN Director's reported 95 percent and 99 percent, respectively. As a result, the data used to make the SES bonus decision for the waiting times measure could not be relied upon.

Issue 3: Did VISN 3 officials manipulate waiting times?

We found no evidence that Chiefs of Staff willfully manipulated waiting time information. However, we found that schedulers were not following established procedures for creating outpatient appointments, which affected the reliability of VISN 3's waiting times and waiting list information. Specifically, schedulers were not inputting the correct desired appointment dates or documenting patient preferences when appropriate.

We compared the desired dates of care requested by the providers and documented in the medical records to the veterans' desired dates of care as recorded in the VistA scheduling and consult packages by the schedulers. VHA defines the desired appointment date as the earliest date on which the patient or clinician specifies the patient should be seen. Although the definition of desired date applies to both established and new patients, VHA does not use the desired appointment date when calculating the waiting time of new patients instead using the date the appointment was created. In our review of new patient appointments, we identified the desired appointment date to determine if there was a significant affect from VHA's decision to not use the desired date when calculating the waiting time of new patients.

We found the VISN and facility Directors could not support the percentage of patients they claimed were seen within 30 days of their desired appointment dates for 9 of our

10 samples. The difference we identified during our review of new patient appointments at New Jersey HCS was not statistically significant.

Differences in the Percent of Patients Seen in 30 Days or Less Between the OIG and the Facility*

Facility	New Patient			Established Patient		
	Facility	OIG	Difference	Facility	OIG	Difference
Bronx	87	77	10	99	83	16
Hudson Valley HCS	99	87	12	100	89	11
New Jersey HCS	94	91	3	99	79	20
New York Harbor HCS	97	93	4	100	91	9
Northport	95	89	6	97	90	7
VISN 3	95	89	6	99	86	13

* The margin of error for this sample can be found in Appendix A

VISN-wide, we projected that about 28,000 veterans had waiting times of more than 30 days as detailed below; as opposed to the 2,900 reported by VHA.

OIG Analysis of Appointments with Waiting Times of More than 30 Days

Waiting Time	Projected Results					
	New	Margin of Error	Estab-lished	Margin of Error	Total	Margin of Error
31 to 37 Days	1,405	362	5,534	1,995	6,939	1,994
38 to 120 Days	1,276	318	14,618	3,755	15,894	3,780
> 120 Days	128	100	5,108	1,910	5,236	1,918
Total Over 30 Days	2,809	482	25,260	4,220	28,069	4,212

Unsupported Desired Dates for Established Appointments

Facility personnel could not show support for 53 percent of the desired dates used for the established appointments. According to facility personnel, the primary cause was their failure to document patient preference. During our review, we only identified about 5 percent of all established appointments with the patient preference documented in the scheduling package. In all these cases, we used the patient preference as the desired appointment dates.

Additionally, we found that:

- Schedulers were looking ahead in VistA for the next available appointments and using that as the desired date. Ten percent of the schedulers who responded to our web-

based survey answered that they were directed to determine the next available appointment slots and use that as the desired appointment date.

- Schedulers were using the 'patient agreed' date instead of the patient's actual desired date. Seventy-six percent of the schedulers who responded to our web-based survey answered that they would use a date agreed to by the patient as the desired date even though the patient wanted an earlier date.

Untimely Scheduling of New Patient Appointments

For new patient appointments, VHA calculates waiting times from the date that the scheduler creates the appointment to the date of the appointment. VHA requires that schedulers act on all requests for appointments as soon as possible but within 7 days of the request. Since schedulers have 7 days to create appointments, VHA acknowledges that the actual waiting time for new patients could be understated by the number of days schedulers take to create the appointment.

We projected that about 10,300 new patient appointments were existing patients with new referrals from their VHA provider to specialty clinics. The remaining projected almost 14,200 new patient appointments were either new enrollees to the system who did not have desired dates of care or the appointments were the result of previous actions, such as appointment cancellations, where the desired dates of care were actually the appointment creation dates. We found that for about 1,700 (17 percent) of the projected 10,300 new patient appointments with new referrals, the scheduler took more than 7 days to schedule the appointment.

Issue 4: Did VISN 3 personnel use electronic waiting lists appropriately?

We found no evidence that VISN 3 approved the use of a few EWLs at the medical facilities in order to make it appear they were complying with VHA policy on the use of the EWL. However, VISN 3 did not have effective procedures to ensure EWLs were complete. We projected about 12,400 veterans were waiting for appointments who were not included on the EWLs.

Specifically:

- We projected approximately 1,900 veterans with consults (referrals for an appointment to see a medical specialist) that had not been acted on within 7 calendar days were not included on the EWL as prescribed by VHA policy.
- We projected approximately 10,500 veterans who received appointments outside VHA's prescribed 30- and 120-day timeline instead of being placed on the EWL.
- Some individuals maintained informal waiting lists (discussed under Issue 5).

EWLs are a key tool used in determining how well medical facilities are meeting their patient care requirements and are instrumental in making sure all veterans are treated

timely. Incomplete EWLs compromise VHA's ability to access and manage demand for medical care.

Number on Waiting Lists

We obtained the number of veterans VISN 3 reported on their EWL from the 1st quarter of FY 2005 to the 4th quarter of FY 2007. As shown below, VISN 3 reported fewer veterans on their EWL in FY 2006 and FY 2007 than in FY 2005. This contradicts the allegation that managers approved a few waiting EWLs in order to make it appear they were complying with VHA policy on the use of the EWL.

VISN 3 Electronic Waiting List

FY	Date	Less Than 31 Days	Greater Than 30 Days	Total On EWL
2005	Oct. 1, 2004	6	2	8
	Jan. 1, 2005	10	152	162
	Apr. 1, 2005	5	25	30
	Jul. 1, 2005	2	17	19
2006	Oct. 1, 2005	4	1	5
	Jan. 1, 2006	1	2	3
	Apr. 1, 2006	4	0	4
	Jul. 1, 2006	0	0	0
2007	Oct. 1, 2006	0	1	1
	Jan. 1, 2007	1	1	2
	Apr. 1, 2007	4	4	8
	Jul. 1, 2007	1	0	1
2008	Oct. 1, 2007	0	0	0
	Jan. 1, 2008	42	20	62

Timely Action on Consult Referrals

None of the medical facilities we reviewed consistently included veterans with active and pending consults that were not acted on within the 7-day requirement on the EWLs. Active consults have been acknowledged by the receiving clinic, but appointment dates have either not been scheduled or the appointments were cancelled by either the veterans or the clinics. Pending consults are those that have been sent to the specialty clinic, but have not yet been acknowledged by the clinic as being received. VHA policy states that to act on the consult means to schedule or deny the appointment, or place the veteran on the EWL.

According to VistA Consult Tracking Reports as of October 31, 2007, the 5 facilities listed 4,157 consult referrals in their 10 performance measure clinics that were over 7 days old—1,963 active and 2,194 pending consults. In accordance with VHA policy,

veterans associated with these consult referrals should have been on the facilities' EWL. However, according to facility personnel, the consult tracking report did not always reflect the actual consult status because clinic personnel did not always update the consults after action was taken.

To substantiate the data in the consult tracking report, we reviewed medical records and interviewed facility personnel. We found that VISN 3 facilities understated EWLs by about 1,900 veterans—of these, 1,400 (74 percent) had been waiting more than 30 days for the facilities to act on their consult requests.

This occurred primarily because medical facilities were either not aware of or misinterpreted VHA directives. According to facility personnel, the EWL is only used when veterans cannot be seen within VHA's prescribed timeline. Facility personnel agreed that they did not have sufficient oversight in place to track active and pending consults over 7 days old. At some of the medical facilities, efforts are currently underway to improve the timeliness of acting on consults. For example, staff will be assigned to each clinic to monitor active and pending consults on the consult tracking report. Other clinics will ensure that appropriate scheduling staff are notified when consult referrals are sent to their clinic.

Ineffective Scheduling Procedures Caused Waiting Lists to be Understated

Veterans received appointments outside VHA's prescribed timelines instead of being placed on the EWL. VHA policy requires that veterans with service connections of 50 percent or more and veterans being seen for their service-connected conditions be given appointments within 30 days of their desired dates of care or be placed on the EWLs. All other veterans (primarily those that are non-service connected) should be given appointments within 120 days of their desired dates of care or be placed on the EWLs.

We projected that approximately 10,500 veterans were given appointments past VHA's prescribed timelines without being placed on the facilities' EWLs, consisting of approximately:

- Fifty-three percent (approximately 5,600 veterans) who were at least 50 percent service-connected.
- Thirteen percent (approximately 1,400 veterans) who were less than 50 percent service-connected and being seen for their service-connected conditions.
- Thirty-four percent (approximately 3,500 veterans) who did not meet either of the conditions listed above and waited more than 120 days for their appointment.

This occurred primarily because schedulers were not following established procedures for creating appointments; specifically, schedulers were not using the correct desired dates of care. As a result, facility managers were unaware of the number of veterans that were not being seen within VHA's prescribed timelines.

Issue 5: Did VISN 3 personnel maintain informal waiting lists and close consults inappropriately?

We found evidence that a small number of schedulers still maintained informal waiting lists and some facility personnel administratively closed consults without support. However, we did not identify evidence to support inaccurate comments were added to consults stating that the patients missed or did not want the appointments.

Informal Waiting Lists

During interviews, six staff at four of the five primary facilities told us they kept informal waiting lists. For example, a scheduler at one facility was instructed by a nurse to maintain an informal waiting list because the clinic was only available once a month and the demand for the service exceeded clinic availability. At the time of our review, 49 veterans were on that scheduler's informal waiting list. In addition, 35 (6 percent) of the schedulers who responded to our web-based survey acknowledged that they currently maintain informal waiting lists. Informal waiting lists are prohibited by VHA policy.

Number of Schedulers that Used Informal Waiting Lists

Facility	From Interviews	From Web-Based Survey
Bronx	1	11
Hudson Valley HCS	0	2
New Jersey HCS	1	9
New York HCS	1	4
Northport	3	9
Total	6	35

Administratively Closed Consults

To determine whether facility personnel administratively closed consults without support, we obtained a listing of all closed consults (completed, cancelled, and discontinued) relating to the 10 performance measure clinics. We sorted the listing by the personnel responsible for closing the consults and then looked for occasions where personnel had closed more than 20 consults in a day. We reviewed documentation in VistA and CPRS to determine why the consult was closed and interviewed the personnel who closed the consults.

VHA policy allows personnel to close consults provided the receiving service personnel document the necessary reasons consistent with the action taken, such as the patient requires other tests or procedures. We identified 55 schedulers that closed a total of 251 consults without adequate support. The following examples highlight scheduling practices negatively impacting the management and data reliability of consult appointments:

- A clinic manager discontinued 8 consults because the consults were over 30 days. In 2 instances where the patients had appointments greater than 30 days out, the patients' appointments were cancelled and then rescheduled for the same date and time. Because VHA uses the creation date as the starting point for calculating the waiting time of new patients, this effectively restarted the patients' waiting time.
- A cardiology clinic did not attempt to schedule 29 consults prior to closing the consults. The clinic expected patients to physically come to the clinic to be scheduled for their appointments. If the patient failed to do so, the clinic closed the consults with no further action. The facility agreed that this was not appropriate and took immediate action to stop it.

At two facilities, personnel stated it was routine that when duplicate consults were identified, the older consult was closed. This resulted in reduced waiting times.

Inaccurate Comments Entered Into System

We found no evidence that anyone altered comments in the system to make it appear as if the patient did not want the appointment, or requested a later date for appointments outside the 30-day period. None of the 224 personnel interviewed and only 3 (less than 1 percent) of the 556 respondents to our web-based survey indicated they were directed to enter an inaccurate comment that a patient did not show or did not want an appointment for a consult.

Issue 6: Were appointments created on the appointment day?

For one facility, we identified evidence at two clinics that some appointments were not entered in VistA until the day of the appointment. Specifically:

- Personnel in the cardiology clinic used the recall system to establish an unofficial appointment and cancelled the consult. If the patient showed up for the appointment, medical facility personnel resubmitted the consult and then scheduled the appointment in VistA.
- Three days prior to patients' appointments, personnel in the dermatology clinic called patients to confirm the appointments. If medical facility personnel were not able to contact the patient, the appointment and consult were cancelled in VistA. However, the appointment slot was left open in case the patient showed up for the appointment. If the patient showed up, medical facility personnel created a new appointment resulting in a 0-day waiting time.

Although, this practice was initiated to reduce the number of patients who missed appointments (a FY 2007 performance measure), it also misrepresented the amount of time veterans actually waited for their appointment. When VISN 3 officials learned that this practice was occurring, they immediately stopped it.

Issue 7: Were patients unaware of appointments?

We did not find evidence that patients were unaware of appointments because they never received notification in the mail or a call from the facility. We contacted 28 patients where the VistA scheduling package showed the patients had either cancelled or missed the appointments. Twenty-five told us they could not make their scheduled appointments. The other three told us they did not know about their appointments, but did not believe there was an issue. One was in the process of moving and the letter he normally received may have been delivered to the old address. The other two patients were hospitalized for extended times, so may not have been home to receive letters or phone calls.

Additionally, only 7 (1 percent) of the 556 respondents to our web-based survey stated they had been directed to mark an appointment or consult as cancelled by the patient without a request from the patient.

Conclusion

Although we found no evidence to support a willful manipulation of procedures by the prior VISN Director and Chief Medical Officer to misrepresent waiting times, we determined that the waiting times and EWLs for medical facilities in VISN 3 were understated. These understatements occurred because VISN 3 personnel were not always complying with established procedures for appointment scheduling and handling of consult referrals. Complying with established procedures is critical to ensuring patients are seen in a timely manner and that VA has accurate and reliable information for its decision making purposes.

Recommendations

Recommendation 1. We recommended that the Under Secretary for Health ensure that the Acting VISN Director establishes procedures to ensure waiting times used to support performance ratings are accurate.

Recommendation 2. We recommended that the Under Secretary for Health ensure that the Acting VISN Director establishes procedures to monitor compliance with policy requirements to ensure patient preferences for desired appointment dates are properly documented.

Recommendation 3. We recommended that the Under Secretary for Health ensure that the Acting VISN Director establishes procedures to monitor compliance with policy requirements to routinely test the accuracy of reported waiting times and completeness of EWLs, and take corrective action when testing shows questionable differences between the desired dates of care shown in medical records and desired dates documented in the VistA scheduling package.

Recommendation 4. We recommended that the Under Secretary for Health ensure that the Acting VISN Director establishes procedures to monitor compliance with policy requirements to ensure veterans are placed on EWLs when appointments cannot be scheduled within the 30- or 120-day requirements.

Recommendation 5. We recommended that the Under Secretary for Health ensure that the Acting VISN Director establishes procedures to monitor compliance with policy requirements to ensure schedulers properly follow-up on appointments that veterans do not keep or the veteran or clinic cancels.

Recommendation 6. We recommended that the Under Secretary for Health ensure that the Acting VISN Director establishes procedures to monitor compliance with policy requirements to ensure active and pending consults are acted on within 7 calendar days or are placed on the EWL.

Recommendation 7. We recommended that the Under Secretary for Health ensure that the Acting VISN Director establishes procedures to monitor compliance with policy requirements to ensure that informal waiting lists are not used.

Recommendation 8. We recommended that the Under Secretary for Health ensure that the Acting VISN Director establishes procedures to monitor compliance with policy requirements to ensure facility personnel do not close consults without support.

Recommendation 9. We recommended that the Under Secretary for Health ensure that the Acting VISN Director establishes procedures to monitor compliance with policy requirements to ensure schedulers use the scheduling package to manage appointments.

Under Secretary for Health's Comments

The VHA Under Secretary for Health did not concur with the report's conclusions and recommendations. The Under Secretary stated that the issues we reported reflect the need for policy solutions that VHA is already addressing. Therefore, singling out VISN 3 and holding them accountable is counter-productive. See Appendix D for the full text of the Under Secretary's comments.

OIG Response

Contrary to the Under Secretary's statement, we did not single out VISN 3 for this review. The Chairman of the Senate Veterans' Affairs Committee requested we conduct this audit based on serious allegations the committee received that VISN 3 was intentionally distorting the numbers on waiting times. We also take exception to the Under Secretary's non-concurrence with the report's conclusions and recommendations based merely on the fact that the issues we reported reflect the need for national policy

solutions that VHA claims they are already addressing. Our exception is based on the fact that VHA has recognized the need to improve the accuracy of waiting times data, yet has taken no meaningful action to achieve this goal to date. We can only conclude that VHA's stated intention to correct recognized and long-standing problems is not sincere.

Appendix A

Review of Outpatient Appointments

Universe

The universe for new and established appointments consisted of completed appointments from the 10 performance measure clinics. The timeframe selected was June through August 2007, which is the performance period defined in the VISN and five primary facility Directors' performance plans.

Universe of Outpatient Appointments

Facility	New	Established	Total
Bronx	3,524	21,116	24,640
Hudson Valley HCS	3,095	26,574	29,669
New Jersey HCS	6,797	48,282	55,079
New York Harbor HCS	7,209	57,744	64,953
Northport	3,836	32,163	35,999
Total Universe	24,461	185,879	210,340

Sample Design

We used a random statistical sample for each of the 10 universes (new and established appointments at 5 facilities). The sample size of 150 was determined using a 90 percent confidence interval with a 10 percent error rate. Random number generation software was used to select 150 appointments for each of the 10 samples. In total, we reviewed 750 new and 750 established patient appointments.

Sample Results

For established patient appointments, directors were evaluated on their facilities' ability to schedule appointments within 30 days of the desired dates of care. For new patient appointments, the directors were evaluated on their staff's ability to schedule appointments within 30 days of the dates the schedulers created the appointments.

To evaluate the accuracy of the VISN and facility directors' reported performance in scheduling appointments within 30 days of the desired appointment date, we compared the desired date recorded in VistA to related medical records. When we used the desired dates as supported by the medical records, the percentage of patient appointments the VISN and facility directors claimed were seen within 30 days was overstated.

Percent of Appointments in 30 Days or Less

	Facility	VA Reported	OIG Projection	Difference	Margin of Error
Established Appointments	Bronx	99	83	16	5
	Hudson Valley HCS	100	89	11	4
	New Jersey HCS	99	79	20	6
	New York Harbor HCS	100	91	9	4
	Northport	97	90	7	4
	VISN 3	99	86	13	2
New Appointments	Bronx	87	77	10	6
	Hudson Valley HCS	99	87	12	5
	New Jersey HCS	94	91	3	4
	New York Harbor HCS	97	93	4	4
	Northport	95	89	6	4
	VISN 3	95	89	6	2
Total		99	87	12	2

Of the 1,500 appointments reviewed, 198 veterans waited more than 30 days. The table below groups the 198 veterans based on the number of days they waited for their appointments. Based on the sample results, we projected about 28,000 veterans had waiting times of more than 30 days.

Appointments with Waiting Times of More than 30 Days (Based on OIG Analysis)

	Sample Results			Projected Results					
Waiting Time	**New**	**Estab-lished**	**Total**	**New**	**Margin of Error**	**Estab-lished**	**Margin of Error**	**Total**	**Margin of Error**
31 to 37 Days	48	23	71	1,405	362	5,534	1,995	6,939	1,994
38 to 120 Days	43	57	100	1,276	318	14,618	3,755	15,894	3,780
> 120 Days	5	22	27	128	100	5,108	1,910	5,236	1,918
Total Over 30 Days	96	102	198	2,809	472	25,260	4,112	28,069	4,212

Of the 198 veterans who waited more than 30 days for appointments, we found that 56 should have been on the EWL. The table below groups the number of veterans by their service-connection percentage, which determines the length of waiting time before VHA policy prescribes that they should be placed on the EWL. We projected that approximately 10,500 veterans were given appointments past VHA's prescribed timelines instead of being placed on the facilities' EWLs.

Veterans that Should Have Been Placed on the EWL

VISN-Wide	Sample Results	Projection	Margin of Error
Greater than 50% Service-Connected	29	5,598	1,969
Less than 50% being seen for Service-Connected Condition	7	1,368	972
Greater than 120 Days	20	3,522	1,456
Veterans that Should Be on EWL	56	10,488	2,656

To accurately calculate outpatient appointment waiting times for established patients, schedulers must use the correct desired dates. We compared the desired dates of care recorded by schedulers in VistA to the desired dates of care supported by medical records or patient preference and found desired date discrepancies in 397 (53 percent) of the 750 established patient appointments.

Appendix A

Desired Date Discrepancies in Established Patient Appointments

					Increase to Waiting Time		
Results	**Desired Date Discrep-ancies**	**Percent**	**No Effect On Waiting Time**	**Patient Seen Sooner than Required**	**1-7 days**	**8-30 days**	**More than 30 days**
Bronx							
Sample	82	55		24	13	23	22
Projection	11,544	55		3,379	1,830	3,238	3,097
Error +/-	1,425	7		1,050	806	1,032	1,013
Hudson Valley HCS							
Sample	83	55		26	20	23	14
Projection	14,704	55		4,606	3,543	4,075	2,480
Error +/-	1,791	7		1,364	1,225	1,298	1,048
New Jersey HCS							
Sample	90	60		18	19	21	30
Projection	28,969	60		5,794	6,116	6,759	9,656
Error +/-	3,207	7		2,127	2,177	2,272	2,619
New York Harbor HCS							
Sample	75	50		11	24	26	13
Projection	28,872	50		4,235	9,239	10,009	5,004
`Error +/-	3,915	7		2,041	2,870	2,964	2,203
Northport							
Sample	67	45		20	24	14	9
Projection	14,366	45		4,288	5,146	3,002	1,930
Error +/-	2,168	7		1,483	1,599	1,269	1,036
VISN 3							
Sample	397	53	3[5]	99	100	107	88
Projection	98,455	53		22,302	25,874	27,083	22,168
Error +/-	6,076	3		3,671	4,370	3,983	4,145

[5]For three appointments, there was no effect on waiting times and results were too small to project.

Of the 750 new patient appointments we reviewed, 304 were existing patients with referrals from their VHA provider to a specialty clinic. The remaining 446 new patient appointments were either new enrollees to the system who did not have desired dates of care or the appointments were the result of previous actions, such as appointment cancellations, where the desired dates of care were actually the cancellation dates. We found for 54 (18 percent) of 304 appointments with desired dates of care, the scheduler took more than 7 days (average of 29 days) to schedule the appointments.

Timeliness in Creating New Patient Appointments Where Patient Had a Referral

	Sample Results			Projected Results		
		No. of Days Schedulers Took To Schedule the Appointment			No. of Days Schedulers Took To Schedule the Appointment	
Facility	**New Referrals**	**8 -30 Days**	**More Than 30 Days**	**New Referrals**	**8 -30 Days**	**More Than 30 Days**
Bronx	44	2	5	1,034	47	117
Error +/-				218	55	86
Hudson Valley HCS	45	12	5	929	248	103
Error +/-				192	114	75
New Jersey HCS	68	7	5	3,081	317	227
Error +/-				459	194	165
New York Harbor HCS	67	6	3	3,220	288	144
Error +/-				486	192	137
Northport	80	7	2	2,046	179	51
Error +/-				260	110	60
VISN 3	304	34	20	10,310	1,079	642
Error +/-				841	338	251

Appendix B

Review of Active and Pending Consults

Universe

The universe for active and pending consults was obtained from the VistA Consult Tracking Report for consults not acted on for at least 7 days as of October 31, 2007, for the 10 performance measure clinics for the 5 primary facilities in VISN 3.

Universe of Active and Pending Consults

Facility	Active	Pending	Total
Bronx	587	815	1,402
Hudson Valley HCS	65	93	158
New Jersey HCS	473	470	943
New York Harbor HCS	303	464	767
Northport	535	352	887
Total Universe	1,963	2,194	4,157

Sample Design

We used a random statistical sample for each of the 10 universes. The sample size was determined using a 90 percent confidence interval with a 10 percent error rate. Random number generation software was used to select consults for each of the 10 samples. The following table shows the sample size for each facility by the active and pending consult universe.

Consult Sample Size at Each Primary Facility

Facility	Active	Pending	Total
Bronx	82	86	168
Hudson Valley HCS	39	48	87
New Jersey HCS	80	80	160
New York Harbor HCS	73	80	153
Northport	81	76	157
Total Sample	355	370	725

To determine if medical facility personnel included all patients on the EWL as appropriate, we reviewed random, statistical samples of 355 active and 370 pending consults in total for the 5 primary facilities. We verified the reliability of computer-generated data by comparing the data to information found in the CPRS and VistA and information obtained through employee interviews at the medical facilities.

We identified 325 (78 active and 247 pending) consults that were not acted on within 7 days and were not placed on the medical facilities' EWLs. VISN 3 understated the EWLs by about 1,900 consults—1,400 veterans had been waiting more than 30 days for facility staff to act on their consult requests.

Consults That Should Be on the EWL

Facility	Number Not Acted on Within 7 Days	Projection	Margin of Error	Number Not Acted on Within 30 Days	Projection	Margin of Error
Active Consults						
Bronx	13	93	40	6	43	28
Hudson Valley HCS	8	13	8	5	8	6
New Jersey HCS	15	89	35	5	30	21
New York Harbor HCS	15	62	24	3	12	12
Northport	27	178	48	15	99	39
Total	78	435	73	34	192	49
Pending Consults						
Bronx	53	502	71	44	417	73
Hudson Valley HCS	31	60	14	26	50	14
New Jersey HCS	43	253	46	36	212	45
New York Harbor HCS	68	394	37	55	319	43
Northport	52	241	35	45	208	36
Total	247	1,450	103	206	1,206	112
Grand Total	325	1,885	135	240	1,398	127

Appendix C

Scheduler Survey Results

Over the course of a year, what percentage of your time is spent scheduling appointments?

	Number	Percent
75 to 100%	161	29.0
50 to 74%	73	13.1
25 to 49%	64	11.5
Less than 25%	244	43.9
No Answer	14	2.5
Totals	556	100.0

How long have you been scheduling appointments?

	Number	Percent
Less than 3 months	40	7.2
3 to 6 months	28	5.0
7 to 12 months	35	6.3
13 to 24 months	60	10.8
Over 24 months	374	67.3
No Answer	19	3.4
Totals	556	100.0

Do you supervise schedulers?

	Number	Percent
Yes	99	17.8
No	448	80.6
No Answer	9	1.6
Totals	556	100.0

For the following questions, unless otherwise stated, please limit all responses to actions that have occurred since July 2005.

When scheduling appointments have your managers or supervisors directed you to schedule the appointment contrary to written VHA guidance or VHA directives established for scheduling patients' appointments?

	Number	Percent
Yes	27	4.9
No	520	93.5
No Answer	9	1.6
Totals	556	100.0

Have you ever been directed to change or cancel an appointment to avoid having waiting times greater than 30 days and to avoid using EWL?

	Number	Percent
Yes	48	8.6
No	504	90.7
No Answer	4	0.7
Totals	556	100.0

Do you feel there is pressure or threat of reprisal from your management (including your immediate supervisors) to keep the wait times short causing you to circumvent the established procedures for scheduling appointments?

	Number	Percent
Yes	20	3.6
No	534	96.0
No Answer	2	0.4
Totals	556	100.0

Have you been directed to determine when the next available appointment slot is open and use that as the desired appointment date?

	Number	Percent
Yes	57	10.3
No	495	89.0
No Answer	4	0.7
Totals	556	100.0

How many consult referrals do you have over 7 calendar days old that have not been scheduled?

	Number	Percent
None	446	80.2
1 to 25	76	13.6
26 to 50	11	2.0
More than 50	7	1.3
No Answer	16	2.9
Totals	556	100.0

Have you been directed to not use the electronic waiting list so that patients waiting more than 30 days cannot be tracked in VistA?

	Number	Percent
Yes	11	2.0
No	537	96.6
No Answer	8	1.4
Totals	556	100.0

Do you currently maintain an informal waiting list instead of using the electronic waiting list? This could include paper copies on your desk, excel spreadsheet(s), or referrals held by your physician(s).

	Number	Percent
Yes	35	6.3
No	518	93.2
No Answer	3	0.5
Totals	556	100.0

If you do not currently maintain an informal waiting list, have you ever maintained an informal waiting list since July 2005?

	Number	Percent
Yes	22	4.0
No	512	92.0
No Answer	22	4.0
Totals	556	100.0

Have you ever changed a patient's desired appointment date without a request from the patient?

	Number	Percent
Yes	45	8.1
No	504	90.6
No Answer	7	1.3
Totals	556	100.0

Have you ever been directed to change a patient's desired appointment date without a request from the patient?

	Number	Percent
Yes	39	7.0
No	513	92.3
No Answer	4	0.7
Totals	556	100.0

Have you been directed to cancel an appointment and re-establish the appointment in order to reduce wait times?

	Number	Percent
Yes	39	7.0
No	511	91.9
No Answer	6	1.1
Totals	556	100.0

For the following three questions, please indicate which desired appointment date you would record in VistA: (* – indicates the correct answer)

On February 1, a primary care provider refers a patient to the eye clinic. On February 5 you create an appointment for February 18 which is the first available appointment. The desired appointment date is:

	Number	Percent
February 1*	145	26.1
February 5	102	18.4
February 18	291	52.3
No Answer	18	3.2
Totals	556	100.0

On February 1, the primary care provider refers a patient to the eye clinic. On February 5 you tell the patient that the first available appointment is February 18 and the patient agrees to the February 18 appointment. On February 5 you create the appointment. The desired appointment date is:

	Number	Percent
February 1*	59	10.6
February 5	60	10.8
February 18	420	75.5
No Answer	17	3.1
Totals	556	100.0

On February 1, the primary care provider refers a patient to the eye clinic. On February 5 you tell the patient that the first available appointment is February 18. The patient does not accept the February 18 appointment and would prefer to wait until March 20. On February 5 you create an appointment for March 20. The desired appointment date is:

	Number	Percent
February 1	21	3.8
February 5	19	3.4
February 18	58	10.4
March 20*	442	79.5
No Answer	16	2.9
Totals	556	100.0

Have you been directed to enter a false comment stating that the patient did not show or didn't want an appointment for a consult?

	Number	Percent
Yes	3	0.5
No	549	98.8
No Answer	4	0.7
Totals	556	100.0

Have you been directed to schedule appointments on the same day of service other than walk-in appointments so that patients waiting more than 30 days are not tracked in VistA?

	Number	Percent
Yes	13	2.3
No	538	96.8
No Answer	5	0.9
Totals	556	100.0

Have you been directed to cancel consults to keep patients off the waiting list because providers are unable to handle the workload?

	Number	Percent
Yes	1	0.2
No	552	99.3
No Answer	3	0.5
Totals	556	100.0

Have you been directed to mark an appointment or consult as cancelled by patient without a request from the patient?

	Number	Percent
Yes	7	1.3
No	546	98.2
No Answer	3	0.5
Totals	556	100.0

Since October 2006, have you completed VHA's Comprehensive Scheduler's Training Program?

	Number	Percent
Yes	472	84.9
No	75	13.5
No Answer	9	1.6
Totals	556	100.0

To your knowledge, since October 2006, have you received a competency assessment to evaluate your knowledge of scheduling?

	Number	Percent
Yes	238	42.8
No	97	17.5
Not sure	218	39.2
No Answer	3	0.5
Totals	556	100.0

Appendix D

Under Secretary for Health's Comments

Department of Veterans Affairs **Memorandum**

Date: April 23, 2008

From: Under Secretary for Health (10)

Subject: **OIG Draft Report: Review of Alleged Manipulation of Waiting Times in Veterans Integrated Service Network (VISN) 3 (Project No. 2007-03505-R5-0165/WebCIMS 400732)**

To: Assistant Inspector General for Auditing (52)

1. I have carefully reviewed your report on scheduling practices within VISN 3, and I do not concur with your conclusions and recommendations. Because the issues you cite reflect the need for national solutions to acknowledged policy-related concerns that VHA is already addressing in response to your previous reports, it is counterproductive to single out VISN 3 in your recommendations for accountability issues that apply to every other VISN, as well. While I am pleased that anonymous complaints about alleged manipulation of waiting times by VISN 3 leadership were totally unsubstantiated, I nevertheless have strong concerns about the misleading implications and unfounded innuendo that some of your report statements convey. In regard to your references to the use of waiting times to support Senior Executive Service (SES) bonuses, I appreciate your willingness to change the original wording of this draft report to better reflect that waiting times is just 1 of 22 other performance measures that are included to support the bonuses. However, it should be noted that the bonuses also encompass eight core competencies and a multitude of monitors and other information that is available to the Deputy Under Secretary for Health for Operations and Management in making the determinations. I emphasize that VISN 3 has consistently worked to improve patient access and has developed numerous creative tools to monitor and ensure compliance with the scheduling directive.

Reported waiting times were based on the most accurate data that were available when performance decisions were made.

2. I am particularly concerned that a reader of your report who does not have an intimate understanding of the complexities that are involved in scheduling processes within a system as massive as VA would come away with a sense that VISN 3 somehow exemplifies systemic misrepresentation of waiting times reporting and failure to follow scheduling procedures. Because VISN 3 is the subject of this audit, I requested that the Acting VISN Director also provide comments to your report from the VISN and facility perspectives, and the key points made in those comments are also highlighted in my response.

3. I am also disappointed that your auditors did not attempt to report on the many actions that VHA is undertaking nationally to address recognized obstacles in our attempts to accurately measure waiting times, including completion of a comprehensive analysis by a national contractor of all components of VHA's scheduling processes. A report from that contractor is due in May 2008. Important scheduling software modifications have been completed, and other planned modifications are underway. The scheduling directive is also undergoing revision. In addition, more than 41,000 VHA employees have successfully completed the five web-based scheduler training modules that were initiated within the past year.

4. VHA acknowledges that established waiting times policies and procedures have frequently been overtaken by the rapidity with which many of our facilities have implemented new best practices to improve patient access. This is certainly true in VISN 3, which has been a leader in initiating new practices. For example, VISN 3 was among the first VISNs to institute an innovative, patient-focused Recall Scheduling System (RECALL) for next appointments, which has now become "routine practice" in many facilities system wide. RECALL, in turn, led to process changes that are not reflected in established VA policies.

5. To elaborate this point, it is necessary to understand how the processes involved with this improved administrative tool conflicted with the methodology used by your auditors in determining if facilities in VISN 3 were complying with scheduling procedures for established patients. Prior to RECALL's implementation, patients often scheduled their next appointment after a visit with their provider. The

desired date was therefore the Return to Clinic (RTC) date noted by the provider. With the advent of RECALL, the RTC date triggers a recall letter to patients approximately 2 weeks before the RTC date, reminding them of the need to call for an appointment. At that point, patients can request an appointment that is convenient for them. This "patient preference" date, rather than the original RTC date, is understood by facility staff to actually be the desired date, and there is no need to document this. Your auditors, however, focused on the RTC date as the desired date, unless there was documentation of the patient preference date in the "Other Info" section of the scheduling system. Of course, the RTC date could remain the patient's preferred date, but there is frequently a change in the scheduled date. Because the RECALL system has become part of the routine practice, such documentation is now of little relative value, since it is understood that the date of patient preference is the desired date. In the case of RECALL, it is clear that calculations by OIG and the VISN for established patients (representing approximately 90 percent of patient workload) would be at variance since different methodologies were actually used in the determination of desired date.

6. Another concern I have involves the web-based survey regarding training, scheduling and electronic wait list procedures that you provided to 1,900 VISN 3 employees with scheduling access. The extremely low response rate of only 29 percent calls into question the validity of any report conclusions that reflect survey findings. In addition, many of the questions asked were ambiguous and did not provide respondents an opportunity to enter comments. VISN program managers reviewed the 17 survey questions and the three scenarios that were used to determine desired date interpretation, and concluded that seven of the questions could be easily misinterpreted by the schedulers. In addition, as evidenced in my comments above regarding the RECALL system, the desired date scenarios used in the scheduler survey could also be misinterpreted based on the differing calculations used by your auditors.

7. At the same time, I recognize that the difficulties in trying to interpret and implement scheduling practices within the confines of a rigid and cumbersome scheduling system can be a daunting challenge for all of us, but most of all for our scheduling staff, many of whom are the newest and least experienced employees in the system. Given the circumstances, errors are inevitable. As we have reported in previous comments to you, fundamental policy improvements will have to be made, and VHA is in the process of actively addressing

identified issues. Nevertheless, I continue to emphasize the importance of putting your findings in perspective. As I have said before, I know of no other system in the public or private sectors that has even attempted to assess waiting times for almost 40 million annual appointments.

8. While VHA acknowledges levels of imprecision in our reported waiting times data, we have yet to identify a more effective methodology to track and monitor waiting times, and no one, including your auditors, has been able to provide any recommendation that would help to improve data accuracy. In my August 21, 2007, response to your previous report on outpatient waiting times, I cited that VA's national patient satisfaction survey continues to be one of our most valid and objective measurements of the quality of care we provide. I am extremely pleased that our most recent survey results from Fiscal Year (FY) 2007 show that 88.4 percent of all new patients and 89.2 percent of established patients, reported that they had access to primary care appointments when they needed them. In terms of your report findings, it is even more important to highlight recent survey findings for VISN 3 from the first quarter of FY 2008. Fully 91.6 percent of new patients and 92.3 percent of established patients responded that they had timely access to primary care. Although current survey figures are not yet available for specialty care access, we anticipate that the high level of satisfaction that we reported to you in our previous response, i.e., eighty-one percent, will remain stable. This ongoing positive feedback from actual veteran patients appears to be at odds with your audit findings.

9. Thank you for the opportunity to respond to this report. If additional information is required, please contact Margaret M. Seleski, Director, Management Review Service (10B5), at 565-7638.

(original signed by:)

Michael J. Kussman, MD, MS, MACP

Appendix D

Under Secretary for Health's Comments to Office of Inspector General's Report

The following comments are submitted in response to the recommendations in the Office of Inspector General's Report:

Recommendation 1. We recommended that the Under Secretary for Health ensure that the Acting VISN Director establishes procedures to ensure waiting times used to support performance ratings are accurate.

Non-concur

Recommendation 2. We recommended that the Under Secretary for Health ensure that the Acting VISN Director establishes procedures to monitor compliance with policy requirements to ensure patient preferences for desired appointment dates are properly documented.

Non-concur

Recommendation 3. We recommended that the Under Secretary for Health ensure that the Acting VISN Director establishes procedures to monitor compliance with policy requirements to routinely test the accuracy of reported waiting times and completeness of EWLs, and take corrective action when testing shows questionable differences between the desired dates of care shown in medical records and desired dates documented in the VistA scheduling package.

Non-concur

Recommendation 4. We recommended that the Under Secretary for Health ensure that the Acting VISN Director establishes procedures to monitor compliance with policy requirements to ensure veterans are placed on EWLs when appointments cannot be scheduled within the 30- or 120-day requirements.

Non-concur

Recommendation 5. We recommended that the Under Secretary for Health ensure that the Acting VISN Director establishes procedures to monitor compliance with policy requirements to ensure schedulers properly followup on appointments that veterans do not keep or the veteran or clinic cancels.

Non-concur

Recommendation 6. We recommended that the Under Secretary for Health ensure that the Acting VISN Director establishes procedures to monitor compliance with policy requirements to ensure active and pending consults are acted on within 7 calendar days or are placed on the EWL.

Non-concur

Recommendation 7. We recommended that the Under Secretary for Health ensure that the Acting VISN Director establishes procedures to monitor compliance with policy requirements to ensure informal waiting lists are not used.

Non-concur

Recommendation 8. We recommended that the Under Secretary for Health ensure that the Acting VISN Director establishes procedures to monitor compliance with policy requirements to ensure facility personnel do not close consults without support.

Non-concur

Recommendation 9. We recommended that the Under Secretary for Health ensure that the Acting VISN Director establishes procedures to monitor compliance with policy requirements to ensure schedulers use the scheduling package to manage appointments.

Non-concur

Appendix E

OIG Contact and Staff Acknowledgments

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