DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

PODCAST TRANSCRIPT

Management and Oversight of the Electronic Wait List for Healthcare Services

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INTRODUCTION

Hello listeners! Thank you for listening to this companion podcast produced by the Department of Veterans Affairs Office of Inspector General. Companion podcasts summarize and increase awareness of VA OIG published reports and regularly feature those OIG employees who conducted the report, inspection, or investigation. Find all VA OIG podcasts online at va.gov/oig.

Daniel Morris:

Hello, my name is Daniel Morris, an OIG director and joining me today is Auditor Jennifer Leonard to talk about the December 2020 report titled: *Management and Oversight of the Electronic Wait List for Healthcare Services*. The electronic wait list was the official tool used by the Veterans Health Administration to manage patient appointments that couldn't immediately be scheduled and allowed employees to record, track, and provide reports on patients who were unable to obtain appointments within 90 days at a VA medical facility. The wait list also included administrative entries, such as patients receiving care at one VA facility who are waiting for a transfer to another.

Since 2014, VA has posted wait list numbers and data about the wait times for medical appointments on a public website as required by law.

Jennifer, when did these concerns with the electronic wait list arise?

Jennifer Leonard:

Thank you for speaking with me today. This was an important audit and I welcome the opportunity to discuss it with our listeners.

In May 2019, a Veterans Health Administration (VHA) employee alerted the media and the VA OIG alleging that the VHA was reporting inaccurate wait list data on VA's public website. The complainant's

allegations focused on two issues: (1) that wait list data didn't include entries older than 24 months, and (2) the wait list entries from three administrative stop codes, or VHA designations for types of clinical work, were not included on the public website. We found that the employee first presented these concerns to VHA leaders in September 2018.

The OIG conducted this audit to assess those allegations, but also to examine whether VHA managed the wait list in accordance with scheduling requirements for veterans' care and whether VA medical facilities complied with wait list management policies.

Daniel Morris:

Were the allegations substantiated?

Jennifer Leonard:

Yes, the OIG substantiated that entries older than 24 months had not been included on the wait list as required, and that there was a discrepancy in wait list figures reported on VA's public website versus what was included in VA's internal data reports.

VA began publicly reporting wait list data in 2014 but the data didn't include entries that were older than 24 months until around October 2018. VHA's Office of Veterans Access to Care (OVAC's) national director of field support said the decision to exclude entries older than 24 months was made before she took over and she was unaware of why the entries were excluded. Around September 2018, VHA personnel identified about 22,400 wait list records that had been on the wait list more than 24 months.

Of those, the audit team determined most of these records were from the administrative stop codes. However, we did find that just over 500 records were from clinical stop codes and should have been included in the public wait list. OVAC personnel explained that entries older than 24 months were assumed to be false positives—meaning they were entries where the patient received an appointment but were never removed from the wait list. However, excluding entries older than 24 months from the wait list hindered VHA's oversight of those entries and their ability to ensure those patients were identified and served, which is the wait list's primary function.

Daniel Morris:

Sounds like policy played a role too. Can you explain how VHA policy impacted the wait list?

Jennifer Leonard:

Sure. VA's policy is to try to schedule patients within 30 days or the patient would be offered an appointment with a community care provider. However, some patients prefer to wait for a VA appointment even if it takes longer than 30 days. During the scope of our audit, VA policy was to only schedule patients up to 90 days out. So, if that patient was waiting for an appointment at the VA facility, and there were no appointments available within 90 days, that patient should be added to the wait list. When an appointment became available, the patient should be scheduled at the VA facility and removed from the wait list.

To summarize, the purpose of the wait list, was to allow VA employees to record, track, and provide reports on patients who couldn't be scheduled within 90 days at a VA medical facility.

I'd also like to clarify clinical versus administrative wait list entries. The clinical wait lists were used to track patients waiting for clinical services, such as mental health care, primary care, or podiatry. The administrative wait lists were used to predominately to track patient transfer requests. On June 1, 2019, there were about 37,600 total entries on the wait list based on internal data reports and of those, about 25,700 were administrative and about 11,800 were clinical entries.

Daniel Morris:

Thank you for clarifying that. Now, on to the second allegation.

Jennifer Leonard:

For the second allegation, that VHA didn't include the administrative wait list data on its public website, the OIG found that this was the case. However, we found that federal law doesn't specifically require administrative entries to be reported publicly. The law requires that VA publish wait times for the scheduling of appointments for primary care, specialty care, and hospital care and medical services, but the law doesn't distinguish between administrative and clinical wait times. In addition, we found that VHA policy required employees use the wait list to track administrative entries, but the policy also noted "they are not official wait lists" subject to the rules of clinical entries.

To provide some additional context, of the 25,700 administrative entries the audit team identified, 99 percent were for patients were waiting to be transferred from one VA facility to another within the same service area. So, these were patients that VHA monitored data for but not as closely as they did for clinical entries. This was because VHA and facility personnel assumed these patients were already receiving care at a facility while they waited for their transfer to their requested facility.

Daniel Morris:

What steps did the VHA take in response to the allegations?

Jennifer Leonard:

In September 2018, when it came to VHA's attention that entries greater than 24 months were being excluded from the wait list data, OVAC worked with VA facility employees to review clinical and administrative wait list entries that were older than 24 months. OVAC required that the facilities determine if the patients had received care or were transferred to their preferred facility, and, if so, the facilities were to remove the entries from the wait list. A VHA data analyst supervisor stated that around October 2018 they removed the data filter so that the wait list included entries over 24 months old.

Prior to the OIG audit, VA's Office of the Medical Inspector reviewed the allegations and provided recommendations to VHA in a June 2019 report. Like the OIG, the medical inspector found that VHA's publicly reported data was different from internal data reports due to administrative stop codes being excluded. The medical inspector recommended that VHA reevaluate wait list data to determine what stop codes should be included in the publicly reported data. The office also recommended that OVAC ensure all clinical entries are included on the wait list, regardless of how old the entry is. They recommended OVAC review the wait list to ensure patients are receiving timely access to care.

Daniel Morris:

Did VHA change its policy and processes as well?

Jennifer Leonard:

Yes, on July 8, 2019, VHA released a memo titled "MISSION Act Electronic Wait List Initiative and Key Electronic Wait List Process Changes." This memo required that facility employees review all wait list entries to identify whether patients were eligible for community care, VA appointment availability, and veteran preference for care. The memo also required facility employees to review and remove administrative entries from the wait list. For administrative transfer entries, VHA employees were to contact veterans and offer a choice to receive care in the community if eligible or continue care at their current location. This review was to be completed by all facilities within 2 weeks of the issuing of the memo. The audit team estimated 3,100 of the 7,200 clinical wait list entries were removed between July 8 and August 31, 2019, indicating that the removals were the result of VA's mandated review.

Then on August 6, 2019, VHA issued another memo that required facilities to remove transfer requests from the wait list and place them on the Light Electronic Administrative Framework, or LEAF, tool, another VHA system. LEAF replaced the use of the administrative wait lists for tracking veterans seeking to transfer their care to a different facility within a VA healthcare system. By eliminating the administrative transfer list and moving it to LEAF, VHA separated the transfer requests from the clinical wait list. And the elimination of the administrative wait lists altogether ensured that only clinical care was tracked on the wait list, internally and publicly.

Daniel Morris:

In addition to the allegations, what else did you review and identify?

Jennifer Leonard:

While examining the allegations and VA responses related to wait list reporting, the OIG found insufficient oversight of the wait list at the local and national levels, based on analyses of all entries as of June 1, 2019. Lack of oversight creates a risk that patients will not receive care in a timely manner. It also puts patients at risk of being overlooked for appointments or transfers to receive care at their preferred facility and could lead to excess entries on the wait list.

The audit team found patients were not removed from the wait list when appropriate, which indicated to us that VA employees didn't review entries daily and supervisors didn't validate the list weekly, as required. As a result, entries were not accurately represented in VHA's web-based tracking database—the VHA support service center.

The entries that remained on the list when they should have been removed created the appearance that the patients were still waiting for care. VHA policy requires that employees remove patients from the wait list when they've determined a patient received an appointment for at a VA facility or care in the community, transferred to care to another VA medical center, no longer needs care, or died. The team concluded that neither OVAC nor facility leaders consistently monitored the wait list to ensure facilities were routinely reviewing it as required by policy. If they had been, these patients likely would have been removed earlier.

The OIG also found wait list entries were not always removed as required because VA lacked clearly defined oversight controls to ensure entries on the wait list were being reviewed daily by facility employees and validated weekly by supervisors or managers, as required.

With proper oversight, veterans like these would be more easily identified and served. When employees didn't remove patients from the wait list when appropriate, it created the appearance that patients were experiencing longer delays in accessing care than was actually the case.

Daniel Morris:

As you mentioned earlier, the wait list was quite large. How did the team approach the audit and what were some of the outcomes from the analysis of the wait list data?

Jennifer Leonard:

It was large, as there were over 37,600 entries for patients that were on the wait list nationwide. We pared it down by focusing on older, clinical entries. From there, we analyzed a population of about 7,200 clinical entries that were already over 30 days old.

From that population, we conducted an analysis of a statistical sample of clinical entries from 10 VA medical facilities to assess whether a patient received the requested appointment and if the entry was removed from the wait list on time. We did this by reviewing patient medical records in VHA's Compensation and Pension Record Interchange. This is how we identified if the patient had a reason to be removed from the wait list, such as they received the care, and the date when they should have been removed. In addition, we shared our results with the facilities to verify our results and obtain additional information.

What we found through our sample review was that patients were not always being removed from the wait list when appropriate. Of the nearly 11,800 clinical entries on the wait list, the audit team determined an estimated 2,400 entries remained on the list an estimated average of 277 days after they should have been removed.

To give an example, we found one patient in our sample who was placed on the wait list on September 17, 2018, for an audiology appointment. A facility employee sent a letter to the patient on July 19, 2019, regarding scheduling an audiology appointment. The patient was removed from the wait list on July 31, 2019, after the patient didn't respond to the letter. A facility employee stated that July 19, 2019, was the first time the patient was contacted about the appointment and claimed that there had been no significant changes in appointment availability before that date. Before the removal, the patient had been on the wait list for 317 days.

We also found there were still some patients who were waiting long periods for care on the list. On January 31, 2020, 14 patients in the audit team's sample had been waiting for an appointment or service for an average of 545 days. Twelve were waiting for home and community-based services. These

services are for patients who need skilled or unskilled services such as case management, help with activities of daily living, or health care in their home. For example, your father may be receiving care at a VA facility, but also requests a home health aide to assist with some of his daily living activities. While a patient may be found eligible for home- and community-based services, for various reasons such as lack of staffing, budget, and community resources, these services may be delayed resulting in that being placed on the wait list. Patients who require these services will remain on the wait list until the services are available. The two other patients were waiting for individual mental health counseling, one of which received mental health group counseling in the meantime, and the other patient opted not to receive care in the community.

These examples, as well as the example I gave about the patient who was on the wait list almost a year for an audiology appointment before a VA employee ever contacted them, shows the importance of monitoring patients on the wait lists.

Daniel Morris:

How did VHA clear the large administrative list?

Jennifer Leonard:

As mentioned before, the administrative wait list was used primarily to track patients that were receiving care at one VA facility, but the patient wished to transfer care to a different facility within their VA health system. Beginning August 2019, VA facilities started to track them with the LEAF tool, instead of the wait list. But prior to that, in June 1, 2019, there were 25,770 administrative entries on the wait list. Of these, 99 percent, were patients waiting to be transferred from one VA facility to another within the same service area. In addition, we found that most of these were on wait lists at a few facilities. For example, 11,800, almost half of all the administrative entries, were at the South Texas Veterans Health System.

We visited the South Texas Veterans Health System to understand why the transfer list was so high there. The administrative officer for primary care at this healthcare system told us that managing the transfer entries had not been a priority because those patients were assumed to be receiving care with their assigned providers while they awaited transfers to their requested facility. The facility had to review all 11,800 entries and act on them as needed. Earlier I mentioned that VA required all the transfer requests be reviewed and moved from the wait list to the LEAF tool. Because South Texas had so many entries, they moved them to LEAF first, then conducted their review.

When they reviewed them, employees identified almost 800 entries that didn’t have an assigned VA primary care provider. The primary care administrative officer told us this can occur if the patient didn’t have a primary care appointment within the prior 24 months at the assigned medical center. He said employees

attempted to contact patients to determine whether they still wanted to be transferred, had moved, or were being seen in the community. By reviewing patient records and calling patients, employees determined that about 260, or 32 percent, of the almost 800 patients without assigned VA primary care providers had either received care outside of VA or had moved and were receiving care in a different healthcare system. About 50 other patients' records showed evidence of VA referrals for care in the community.

Significantly though, facility employees were not able to contact the remaining patients and therefore couldn't determine if the patients were receiving care. Facility employees later mailed letters to those patients to provide information on receiving VA care and enrollment.

The audit team concluded that the facility's failure to monitor the administrative wait list meant patients were not given an opportunity to transfer their care to their desired facility and created a risk that patients without a primary care provider assigned were no longer receiving care in the VA healthcare system. If the wait list entries had been reviewed and validated, employees might have reached out to patients earlier and determined if patients were receiving care in the community or if those patients still wanted or needed VA care.

Daniel Morris:

Ok, to recap—since the initial allegations, the filters that altered the public waiting list were removed, the waiting list was scrubbed for accuracy, administrative entries tracking transfers are no longer tracked on the waiting list—they now use the LEAF system.

Where does that leave the waiting list today?

Jennifer Leonard:

VHA continued to make changes. In June 2020, the assistant under secretary for health for operations issued a memo to Veterans Integrated Services Network (VISN) directors explaining that VHA planned to eliminate the use of the electronic wait list. The memo stated this was "in an effort to simplify and expedite scheduling of new patients." According to the memo, by December 1, 2020, all clinical entries on the wait list should be reviewed and scheduled or removed if care has been received or is no longer needed. The memo stated that VHA plans to use its consult toolbox to identify and track new patients that can't be scheduled in a timely manner, and no longer use the electronic wait list. VHA's consult toolbox allows users to understand the overall status of consult management and identify specific services needing attention or resources.

Even though VHA has eliminated the electronic wait list, the audit team made recommendations that addressed concerns about oversight and management of the new method for tracking patients that can't

be scheduled. Also, we made recommendations related to oversight and management of LEAF, for tracking transfer requests.

The OIG made three recommendations in total to the under secretary for health to improve the monitoring and oversight of patients waiting for healthcare services. The recommendations include developing and implementing clearly defined oversight controls and standard operating procedures to monitor and routinely review patients waiting to be scheduled for care. The OIG also recommended facility leaders clearly define and oversee procedures on how to routinely review and monitor transfer entries that had been moved to LEAF.

I should also mention, although the OIG substantiated the allegations that entries older than 24 months were excluded from the public website, and that the administrative entries were not included, we didn't make any additional recommendations beyond what OMI recommended because as I noted earlier, they removed the filter that excluded the ones older than 24 months. Also, they stopped using the wait list to manage administrative entries.

Daniel Morris:

How did VHA respond to the recommendations?

Jennifer Leonard:

VHA concurred with all the recommendations. Regarding recommendation 1, VHA responded that they will implement oversight controls developed to monitor all medical center patient care requests that are identified as "unable to schedule." Primary monitoring and oversight responsibilities will be managed at the medical center and VISN levels respectively. National program offices serve as a resource to support medical centers not meeting thresholds.

For recommendation 2, VHA stated OVAC and national program offices will collaborate with VISNs to ensure implementation of standard operating procedures focused on use of the Consult Toolbox. Additionally, OVAC will collaborate with national program offices to set expectations for care when there are limited options in a medical center and when there is a lack of comparable service in the community. OVAC will monitor "unable to schedule" entries and ensure that standard operating procedures are clear, in place, and followed. Trainings, webinars, and other materials will be shared to ensure oversite controls are being sustained with VISNs and medical centers.

For recommendation 3, the undersecretary responded that OVAC and VISNs will continue to monitor transfer entries on a quarterly basis. OVAC will ensure follow up with sites to ensure appropriate transfers from one site to another site of care. A VA memo will be forthcoming specifying expectation medical center LEAF entries reported to VISNs and OVAC.

The target for completion for all three is March 2021.

Daniel Morris:

What else should our listeners know about the status of the electronic wait list today?

Jennifer Leonard:

Now that VHA uses its consult toolbox to identify and track new patients that can't be scheduled in a timely manner, and has conducted significant reviews of the wait list, there are only a small number of entries left on the electronic wait list. VA continues to publish patient wait times publicly at www.accesstocare.va.gov. There, anyone can view average wait times by facility and clinic type.

As for current status of LEAF for tracking patient transfer requests, according to OVAC data as of July 2020, 21 facilities were using LEAF and had a combined total of over 7,700 entries. As you may recall, on June 1, 2020 there were over 25,000 transfer requests on the wait list, so the number of requests being tracked is down significantly.

Daniel Morris:

Jennifer, thank you for your time today. If you would like more information about this audit, visit va.gov/oig and enter its report number, VA OIG 19-09161-02, in the search box.

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