VA OIG Wait Time Reports

As of 30 March 2016

The Department of Veterans Affairs, Office of Inspector General (OIG), conducted extensive work related to allegations of wait time manipulation after the allegations at the Phoenix VA Health Care System in April 2014. Since that event and through fiscal year 2015, they received numerous allegations related to wait time manipulation at VA facilities nationwide from veterans, VA employees, and Members of Congress that were investigated by OIG criminal investigators.

As the VA OIG stated at Congressional hearings, at this time they have completed 77 criminal investigations related to wait times and provided information to VA's Office of Accountability Review for appropriate action. It has always been their intention to release information regarding the findings of these investigations at a time when doing so would not impede any planned prosecutive or administrative action. OIG began a rolling publication of these administrative summaries of investigation by state so that veterans and Congress have a complete picture of the work completed in their state. Their website www.va.gov/oig/publications/administrative-summaries-of-investigation.asp lists all reports in state sequence. As additional reviews are completed/reported this attachment will be updated accordingly. Following is a summary of the investigations in state order as reported to date:

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Alabama

VAMC Tuscaloosa AL ► OIG Wait Time Report

This investigation was initiated based on allegations received through the Department of Veterans Affairs (VA) Office of Inspector General (OIG) Hotline from an anonymous source claiming that clerks in the Primary Care Clinics at the VA Medical Center (VAMC) in Tuscaloosa, AL, were being instructed to contact veterans to cancel and reschedule appointments in order to improve the appearance of access to care.

The report's conclusion noted that their investigation found that several individuals claimed the MSA wrote the names of established veterans who were being transferred from one Mental Health Clinic to another, on a separate paper list, and then scheduled an appointment for a later date—even though the MSA denied maintaining a paper list

when interviewed. Prior to VA OIG's involvement, the VAMC Tuscaloosa senior leadership initiated a fact-finding inquiry that confirmed that this had occurred. The interviews revealed there did not appear to be any kind of guidance from immediate supervisors and service line chiefs/managers to VAMC Tuscaloosa employees regarding VA policies for scheduling. The supervisors could not clearly articulate the scheduling directives outlined in VHA Directive 2010-027, dated June 9, 2010. The investigation did not find any evidence that senior leadership was aware of the inappropriate scheduling practices. The OIG referred the Report of Investigation to VA's Office of Accountability Review on September 28, 2015. The entire report is available at http://www.va.gov/oig/pubs/ims/wait-times-14-02890-193.pdf. [Source: OIG Admin summary | Quentin G. Aucoin | March 16, 2016 ++]

Arizonia

VA CBOC Lake Havasu City, AZ ► OIG Wait Time Report

This investigation was initiated in response to a letter sent to Senator John McCain by a Department of Veterans Affairs (VA) employee alleging medical, administrative, and clerical violations, including "paper scheduled appointments," at the VA Community Based Outpatient Clinic (CBOC) in Lake Havasu City, AZ. The report conclusion revealed that the "paper scheduling" alleged by the complainant was actually an encounter form given to patients to provide to an MSA for current appointment and next appointment information. The investigation did not reveal that any CBOC Lake Havasu City personnel were keeping separate scheduling lists and also determined that the alleged "clerical violations" were in fact a misunderstanding between the complainant and other employees. The OIG referred the Report of Investigation to VA's Office of Accountability Review on February 26, 2015. The entire report is available at http://www.va.gov/oig/pubs/ims/wait-times-14-02890-191.pdf. [Source: OIG Admin summary | Quentin G. Aucoin | March 9, 2016 ++]

Arkansas

VAMC Little Rock AR ► OIG Wait Time Report

This investigation was initiated pursuant to information received from a whistleblower complaint to the Office of Special Counsel, alleging inappropriate scheduling practices at the Department of Veterans Affairs Medical Center (VAMC), Little Rock, AR.

The report's conclusion noted that the investigation substantiated that both non-supervisory and supervisory VAMC employees were improperly scheduling patient appointments by manipulating the appointment dates in the VA computer system, resulting in the appearance of significantly lower wait times for veterans' clinical appointments. Two VAMC supervisory employees displayed a lack of candor while making statements to special agents of VA Office of Inspector General regarding their knowledge and/or participation in the manipulation of patient waiting times. This was based on testimonial evidence and a review of email. The OIG referred the Report of Investigation to VA's Office of Accountability Review on February 24, 2015. The entire report is available at http://www.va.gov/oig/pubs/ims/wait-times-14-02890-197.pdf. [Source: OIG Admin summary | Quentin G. Aucoin | March 3, 2016 ++]

California

VAMC Los Angeles CA ► OIG Wait Time Report

An investigation was initiated because a House Committee on Veterans' Affairs staffer referred a complaint from an employee at the Los Angeles Ambulatory Care Center (LAACC) who reported that a medical support assistant (MSA) supervisor was involved in inappropriate scheduling practices. The employee alleged that the supervisor printed out a list of patient appointments and was in the habit of rescheduling any appointment with a wait time exceeding 14 days, in a systemic effort to misrepresent wait times by making them appear lower.

The report's conclusion noted that the allegation that SPS1 was accessing the VistA scheduling system and rescheduling patients in violation of VA policy was substantiated. Although this was an intentional deviation from VA policy, the investigation did not substantiate that this was being done specifically to manipulate data in order to artificially lower wait times. VISN 22 investigated the allegations before the VA OIG investigation and took corrective action. VA OIG Administrative Summary 14-02890-236 8. The OIG referred the Report of Investigation to VA's Office of Accountability Review on August 9, 2015. The entire report can be accessed for review at http://www.va.gov/oig/pubs/ims/wait-times-14-02890-236.pdf. [Source: OIG Admin summary | Stephen M. Jones | March 30, 2016 ++]

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VAMC Palo Alto CA ► OIG Wait Time Report

On February 25, 2015, a House Committee on Veterans' Affairs staffer notified the Department of Veterans Affairs (VA) Office of Inspector General (OIG) of the existence of several allegations and issues raised by the committee members from California regarding the VA Medical Center (VAMC) Palo Alto and Stanford University. One of the allegations claimed that there were three lists for scheduling Gastroenterology (GI) Clinic appointments for patients. The first list was described as a "legal" list of patients waiting for doctors' appointments. The second list was described as an "illegal list of patients that was created in order to make the waiting time with the required performance measures." The third list was described as a "List of patients who are scheduled to have substandard test or care in order to make the first list meeting the performance measures." This allegation was reviewed separately by the VA OIG's Office of Healthcare Inspections. The report, Healthcare Inspection: Alleged Colorectal Cancer Screening and Administrative Issues VA Palo Alto Health Care System Palo Alto, California, detailed its findings.

The report's conclusion noted that the allegations were not substantiated. The investigation found no evidence that there were hidden patient wait lists in the PAD GI Clinic. All employees interviewed during the investigation stated they were not aware of any secondary or hidden patient wait lists. No VA employees stated that they were instructed to keep any secondary patient wait lists. The PAD GI Clinic appeared to have the capacity to handle the number of patients requiring appointments. The employee responsible for scheduling most of the patient appointments for GI Clinic stated that the majority of the time she was able to schedule a patient on the actual day requested by the patient or very close to the actual day requested. The OIG referred the Report of Investigation to VA's Office of Accountability Review on August 9, 2015. At http://www.va.gov/oig/pubs/ims/wait-times-14-02890-224.pdf the entire report can be accessed for review. [Source: OIG Admin summary | Quentin G. Aucoin | March 30, 2016 ++]

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VAMC San Diego CA ► OIG Wait Time Report

This investigation was based on two complaints filed with the Department of Veterans Affairs (VA) Office of Inspector General (OIG) Hotline in May 2014 alleging misconduct and manipulation of the "desired dates" by medical support assistants (MSAs) at the VA Medical Center (VAMC) in San Diego and its Community Based Outpatient Clinics (CBOCs). OIG investigated both allegations simultaneously as they related to the same issues.

The report's conclusion noted that interviews, along with the analysis of scheduling data pulled from VistA, revealed many MSAs were initially altering the desired dates of patients or scheduling veteran appointments with zero-day wait times. Testimonial evidence from multiple MSAs regarding the MAO's involvement in directing manipulation of wait times and analysis results from scheduling reports contrasted sharply with the MAO's denials of responsibility. In addition, emails from a Health Program analyst sent to MSAs included specific instructions to zero out wait times if patients did not wish to change to an earlier appointment. These instructions explicitly violated VHA Scheduling Directive 2010-027. The OIG referred the Report of Investigation to VA's Office of Accountability Review on March 18, 2015. At http://www.va.gov/oig/pubs/ims/wait-times-14-02890-247.pdf the entire report can be accessed for review. [Source: OIG Admin summary | Stephen M. Jones | March 30, 2016 ++]

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VAMC San Diego CA Update 01 ► OIG Wait Time Report

The Department of Veterans Affairs (VA) Office of Inspector General (OIG) investigation was initiated by a confidential source who alleged that four supervisors at the VA Medical Center (VAMC), San Diego, were pressuring the employee to "fudge the desired date" for veterans appointments. The investigation did not substantiate the allegation that employees were being told by their supervisors to alter/manipulate desired dates or wait times. The OIG referred the Report of Investigation to VA's Office of Accountability Review on February 27, 2015. The entire report can be accessed for review at http://www.va.gov/oig/pubs/ims/wait-times-14-02890-227.pdf. [Source: OIG Admin summary | Stephen M. Jones | March 30, 2016 ++]

Colorado

VAMC Denver CO Update 03 ► OIG Wait Time Report | Dental Clinic

The investigation was initiated based upon an anonymous complaint received through the Department of Veterans Affairs (VA) Office of Inspector General (OIG) Hotline alleging that a manager in the VA Medical Center (VAMC) Denver Dental Clinic instructed an employee to destroy/dispose of all information and charts related to patients on the waiting list. The report's conclusion noted that their investigation did not substantiate the allegation that a manager in the VAMC Denver Dental Clinic instructed an employee to destroy/dispose of all information and charts related to patients on the waiting list.The OIG referred the Report of Investigation to VA's Office of Accountability Review on February 23, 2015. The entire report is available at http://www.va.gov/oig/pubs/ims/wait-times-14-02890-214.pdf. [Source: OIG Admin summary | Quentin G. Aucoin | March 17, 2016 ++]

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VAMC Grand Junction CO Update 01 ► OIG Wait Time Report | Endoscopy Clinic

An investigation was initiated based upon information obtained from the Department of Veterans Affairs (VA) Access Audit-System-Wide Review of Access. While conducting this audit, VA staff interviewed employees at the Grand Junction, CO, VA Medical Center (GJVAMC). The employees who were interviewed by VA staff were not identified.

One interviewee told the VA audit team that a spreadsheet was being used by the GJVAMC Endoscopy Clinic to track appointments. This statement led to concerns that the spreadsheet might be an inappropriate scheduling tool, thus triggering an Office of Inspector General (OIG) investigation.

The report's conclusion noted that their investigation substantiated that a spreadsheet was being maintained in the GJVAMC Endoscopy Clinic but was not used for scheduling appointments. Rather, the spreadsheet was used to capture data for tracking purposes only. The spreadsheet captured patient information from various consults from the time patients were referred by a Primary Care provider to the time of the actual endoscopy procedure. The spreadsheet was featured as part of a VHA national collaborative and was considered a tracking measure worthy of consideration by VHA for use as the national benchmark. The OIG referred the Report of Investigation to VA's Office of Accountability Review on September 2, 2014. At http://www.va.gov/oig/pubs/ims/wait-times-14-02890-215.pdf he entire report is available. [Source: OIG Admin summary | Quentin G. Aucoin | March 17, 2016 ++]

Deleware

VAMC Wilmington DE Update 04 ► OIG Wait Time Report

This investigation started as a proactive initiative on the keeping of separate, non-electronic wait lists at VA medical centers nationwide. On May 13, 2014, a Department of Veterans Affairs (VA) Office of Inspector General (OIG) special agent received a call from an official at the VA Medical Center (VAMC) Wilmington, DE, who stated that issues pertaining to scheduling procedures at the VAMC were uncovered as a result of the recent Veterans Health Administration (VHA) Stand Down review at that facility. The OIG referred the Report of Investigation to VA's Office of Accountability Review on September 29, 2014

The report's conclusion noted that their investigation revealed that the identified scheduling errors by MSAs were primarily those in which a patient's desired date and the appointment creation date were shown to be the same. This error, which resulted from not changing the scheduling application's desired date default, had the potential to create inaccurate wait time information if in fact the desired date had not been recorded appropriately by the MSA. The investigation also identified that it was not uncommon for MSAs to negotiate desired dates with patients based on clinic availability (a process, which resulted in zero-day wait times); in fact, one supervisor stated that negotiated desired dates had to be input into the system based on clinic availability even if this was not the veteran's requested date, while another stated that there are certain scenarios whereby the desired date is uncertain/a "gray area." Upper-level management stated that the aforementioned practice of inputting a patient's desired date based on clinic availability was not mandated. The investigation also identified the following "lists," which had not been specifically tracked by VA's scheduling system:

- A paper list of patients requesting appointments at CBOC Dover
- A separate list of Behavioral Health patients at CBOC Dover, a folder of return-to-clinic routing slips regarding the recall list at CBOC Dover, and a list of Orthopedic patients requesting joint replacement surgery, which originated from VAMC Wilmington.

None of the aforementioned lists were identified as having been maintained as a result of wait time manipulation or other malevolent purposes. In addition, all identified lists have been addressed by VAMC Wilmington and no specific patient harm was identified as a result of keeping the aforementioned. The entire report is available at http://www.va.gov/oig/pubs/ims/wait-times-14-03128-158.pdf. [Source: OIG Admin summary | Quentin G. Aucoin | March 3, 2016 ++]

Florida

VA OPC Tallahassee FL Update 04 ► OIG Wait Time Report

This investigation was initiated pursuant to information received from a former Tallahassee employee who previously worked as a Medical Administration Services (MAS) clerk at the VA Outpatient Clinic (OPC) in Tallahassee, FL. The complainant stated that he had information that Medical Administration Services (MAS) clerks at the OPC in Tallahassee were purposely manipulating the patient "desired date" for an appointment in Veterans Health Information Systems and Technology Architecture (VistA) to reflect the actual date of the appointment, versus the desired date, when the two dates were greater than 14 days apart. In addition, information was provided by another VA employee that a paper waiting list was self-reported on May 23, 2014, by a dietician, OPC Tallahassee, for a program called "Be Active and Move."

The report's conclusion noted that the investigation confirmed that several employees at OPC Tallahassee were improperly entering scheduled appointments and improperly inputting the desired dates. It was further determined that the employees had all received the proper training as to the correct method, but were making unintentional errors. Once the inquiry took place and their supervisors began implementing the proper procedures, these employees felt that the supervisors were possibly covering up these scheduling actions that were previously done improperly. However, there was no evidence to support this belief. The employees who reported inconsistencies in scheduling practices represent less than 25 percent of the employees responsible for scheduling. The training records and job descriptions documented that these employees had been instructed on the proper procedures. All of the other employees and supervisors interviewed were scheduling and entering the desired dates in accordance with VHA policy.

The dietician who was maintaining the paper wait list, for the Be Active and Move program, was corrected by a supervisor, and all of the participants were scheduled into VistA immediately. The paper waiting list for the Be Active and Move program was determined to be a list maintained by a dietician who delayed scheduling the participants properly until the class was 3 weeks away from occurring. This was done so that the dietician could call and make sure the participants still wanted to attend the class before they were entered into the system. The entire report is available at http://www.va.gov/oig/pubs/ims/wait-times-14-02890-136.pdf. [Source: OIG Admin summary | Quentin G. Aucoin | February 26, 2016 ++]

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VA CBOC St. Augustine FL ► OIG Wait Time Report

A senior manager, North Florida/South Georgia Veterans Health System (NF/SG VHS), notified the Department of Veterans Affairs (VA) Office of Inspector General (OIG) that a paper waiting list was being used at the Community Based Outpatient Clinic St. Augustine, FL. The senior manager obtained the list from an employee at this location who self-reported that she was maintaining it. The OIG referred the Report of Investigation to VA's Office of Accountability Review on September 8, 2014. The report's conclusion noted that the investigation determined that the employee did not violate any Veterans Health Administration directives. The entire report is available for review at http://www.va.gov/oig/pubs/ims/wait-times-14-02890-124.pdf [Source: OIG Admin summary | Quentin G. Aucoin | February 26, 2016 ++]

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VA OPC Daytona Beach FL ► OIG Wait Time Report

This investigation was initiated after the Department of Veterans Affairs (VA) Office of Inspector General (OIG) received allegations that clerks at the Outpatient Clinic (OPC) Daytona Beach were deleting consults without checking with the physicians, resulting in patients not being seen. In addition, the VA OIG Hotline received an anonymous complaint alleging excessive wait times for new patients and that performance objectives were linked to leaders' compensation which could lead to potential misconduct at the VA Medical Center (VAMC) in Orlando, FL. The OIG referred the Report of Investigation to VA's Office of Accountability Review on September 8, 2014.

Interviews from both the VAMC Orlando and the OPC Daytona Beach disclosed that although the employees were not deleting consults without first discussing the situation with a physician, employees were manipulating the EWL to show a reduced wait time for veterans consults. Our investigation did not show any evidence that this was done at the direction of VAMC management. The allegation of excessive wait times was not substantiated at the VAMC Orlando; however, there were access to care issues identified at the OPC Daytona Beach that fall under the administrative control of the VAMC. The director of the Orlando VAMC was aware of the memo, Inappropriate Scheduling Practices. The OIG's review of patient records did not substantiate the allegation of harm to patients. The entire report is available at http://www.va.gov/oig/pubs/ims/wait-times-14-02890-134.pdf. [Source: OIG Admin summary | Quentin G. Aucoin | February 26, 2016 ++]

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VA-OPC Jacksonville FL ► OIG Wait Time Report

This investigation was initiated pursuant to information received through the Department of Veterans Affairs (VA) Office of Inspector General (OIG) Hotline. A complainant alleged that employees at the Outpatient Clinic (OPC) Jacksonville Prosthetics Department had been instructed to create a new consult for prescription eyeglasses in the Veterans Health Information Systems and Technology Architecture (VistA), the VA's scheduling system, if more than 30 days had elapsed from the time the patient received a prescription for eyeglasses to the time the veteran acted on the prescription. The OIG referred the Report of Investigation to VA's Office of Accountability Review on September 8, 2014.

The report's conclusion noted that the investigation confirmed that Prosthetic employees at VAMC Gainesville and its affiliated institutions had been instructed by his managers to recreate consults in lieu of cloning them per the business practice guidelines. During interviews, both Prosthetics managers stated that they made a decision at their level to have employees create new consults in lieu of cloning them. The entire report is available at http://www.va.gov/oig/pubs/ims/wait-times-14-03403-128.pdf . [Source: OIG Admin Summary | Quentin G. Aucoin | February 26, 2016 ++]

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VA CBOC Marianna FL ► OIG Wait Time Report

This investigation was initiated in response to information received from an employee at the North Florida/South Georgia Veterans Health System (NF/SG VHS), Gainesville, FL, concerning two issues at the Community Based Outpatient Clinic (CBOC) Marianna, FL. The first issue involved a psychiatrist providing the facility Medical Administrative Services (MAS) clerks scheduling notices for patient follow-up visits via a paper list instead of using the Veterans Health Information Systems and Technology Architecture (VistA) system. The second issue involved a telehealth nurse who was maintaining a list of patients requiring scheduling in VistA for telehealth services. The OIG referred the Report of Investigation to VA's Office of Accountability Review on September 8, 2014.

The report's conclusion noted that the investigation into both issues revealed that the paper lists were maintained in a secure environment. The issues were brought to the attention of facility management by the employees who maintained the lists prior to the investigation. In addition, the practice of using the lists ceased immediately after the staff identified the practice of using the lists. The lists were used to further patient care and the relevant information

was timely entered into VistA. No delay or denial of patient care was identified due to the use of the lists. Prior to the investigation, the employees involved were informed of proper scheduling procedures in accordance with facility and Veterans Health Administration directives and policy. The entire report is available for review by going to http://www.va.gov/oig/pubs/ims/wait-times-14-02890-121.pdf. [Source: OIG Admin Summary | Quentin G. Aucoin | February 26, 2016 ++]

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VAMC Lake City FL ► OIG Wait Time Report

This investigation was initiated pursuant to information received from the deputy director, North Florida/South Georgia Veterans Health System (NF/SG VHS) regarding a paper scheduling list that had been discovered at the VA Medical Center (VAMC), Lake City, FL. The OIG referred the Report of Investigation to VA's Office of Accountability Review on September 8, 2014. The report's conclusion noted that the investigation revealed that a health care provider had requested that the paper list be used in addition to (not in lieu of) VistA for scheduling patients. We found no evidence to indicate that the use of this list had any effect on patient care or that this was a "secret" wait list. The entire report is available at http://www.va.gov/oig/pubs/ims/wait-times-14-02890-120.pdf. [Source: OIG Admin summary | Quentin G. Aucoin | February 26, 2016 ++]

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VAMC Miami FL Update 03 ► OIG Wait Time Report

This investigation was initiated based upon information provided by the House Committee on Veterans' Affairs (HVAC) Majority Staff, alleging that VA Medical Center (VAMC) Miami, FL, maintains double patient scheduling lists and manipulates patient wait times to meet the 14-day scheduling policy. The OIG referred the Report of Investigation to VA's Office of Accountability Review on October 28, 2014.

The report's conclusion noted that the investigation found VAMC Miami schedulers violated Veterans Health Administration (VHA) Directive 2010-027 when they used the next available clinic date instead of the veteran's desired date to meet the 14-day goal, resulting in inaccurate veteran access assessments for VAMC Miami. The allegation regarding double lists was a misunderstanding, as the double lists were the active and access lists maintained by the facility. Interviews initially suggested that the VAMC Miami appeared to have issues with MAS clerks incorrectly discontinuing provider consults. The OHI review determined that the consults were completed properly and in accordance with VA policies. The entire report is available at http://www.va.gov/oig/pubs/ims/wait-times-14-02890-151.pdf. [Source: OIG Admin summary | Quentin G. Aucoin | February 26, 2016 ++]

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VAMC West Palm Beach FL Update 01 ► OIG Wait Time Report

The investigation was conducted in response to three separate complaints:

- A confidential complainant informed a Department of Veterans Affairs (VA) Office of Inspector General (OIG) employee that the VA Medical Center (VAMC) West Palm Beach engaged in "gaming" veterans' desired dates for appointments.
- Another confidential complainant, who is a veteran and an employee, confirmed that schedulers use the "next available date" as a veteran's "desired date" for an appointment.
- A third anonymous complainant contacted the VA OIG Hotline in June 2014 and alleged that the chief of staff and the director at the VAMC West Palm Beach pressured Medical Administration Service (MAS) staff and the chief of MAS to adjust the patients' desired appointments for gastrointestinal (GI) test consults because these patients were waiting for appointments beyond the 30-day measure and this would cause a decrease in management's bonuses.

The OIG referred the Report of Investigation to VA's Office of Accountability Review on September 29, 2014. The report's conclusion noted that the investigation substantiated that MAS schedulers were using the clinic's next available date as a veteran's desired date and changed appointments that fell outside of the 14-day desired date policy outlined in VHA Directive 2010-027. Schedulers did not understand the overall effect of gaming access on department resource allocations. A review of CAARs corroborated the use of the next available date as a patient's desired date. VAMC West Palm Beach schedulers violated VHA Directive 2010-027 when they used the clinic's next available date, instead of a veteran's desired date, to meet the 14-day goal, resulting in inaccurate veteran access assessments for VAMC West Palm Beach.

The investigation did not substantiate that VAMC West Palm Beach management directed schedulers to game appointment times or that the MAS Chief was pressured by VAMC West Palm Beach management to change GI appointments. A review of the director's personnel file provided no indication that any bonuses or appraisal ratings were tied solely to facility access levels. The investigation also found no indication that VAMC West Palm Beach staff inappropriately destroyed any records. The entire report is available at http://www.va.gov/oig/pubs/ims/wait-times-14-02890-127.pdf. [Source: OIG Admin summary | Quentin G. Aucoin | February 26, 2016 ++]

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VAMC Gainesville FL Update 02 ► OIG Wait Time Report 1

A former Department of Veterans Affairs (VA) employee alleged that Medical Administration Services (MAS) clerks at the VA outpatient clinic (OPC) in Tallahassee, FL, were purposely manipulating scheduling data in the VA scheduling system, known as the Veterans Health Information Systems and Technology Architecture (VistA). Due to Tallahassee VA OPC falling administratively under the Malcolm Randall VA Medical Center (VAMC), VA Office of Inspector General (OIG) agents decided to interview MAS clerks at the Malcolm Randall VAMC Gainesville to determine if similar issues allegedly occurring in Tallahassee were present there. During the course of the investigation, a current VAMC employee reported that a paper wait list file existed in the Malcolm Randall VAMC pharmacy in Gainesville, FL. The OIG referred their Report of Investigation to VA's Office of Accountability Review on September 8, 2014.

The report's conclusion noted that their Investigation into the scheduling practices of MAS clerks identified two employees who were not determining the patient's desired date correctly under VHA directives or policies, specifically VHA Directive 2010-027. In addition, a pharmacy employee was maintaining a paper file system for 23 patients waiting to be scheduled for treatment instead of entering the patients into the VistA system recall list, as required. This issue was addressed by VAMC staff. The entire report is available at http://www.va.gov/oig/pubs/ims/wait-times-14-02890-135.pdf. [Source: OIG Admin Summary | Quentin G. Aucoin | February 26, 2016 ++]

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VAMC Gainesville FL Update 03 ► OIG Wait Time Report 2

This investigation was instigated pursuant to information received from a reporter. The reporter inquired about a "secret waiting list" found at the Malcolm Randall Veterans Affairs Medical Center (VAMC) Gainesville, FL, by an inspection team—later determined to be the VA Access Audit Team. The OIG referred the Report of Investigation to VA's Office of Accountability Review on September 8, 2014.

The report's conclusion noted that their investigation revealed that on May 13, 2014, during the VA Access Audit conducted at the Malcolm Randall VAMC, a paper wait list of 219 patients awaiting recall for future appointments was found at the VAMC MHC. Further investigation showed that Supervisor 3 failed to ensure that the MHC clerks under her supervision had the correct training on, and access to, the VA's scheduling system module for recalling patients who need future appointments. A review of appointment histories for the 219 patients showed that no patients

were denied treatment because of the paper wait list. All clerks now have training and access to the Recall module in VistA and all patient appointments have been entered. The entire report is available for review at http://www.va.gov/oig/pubs/ims/wait-times-14-02890-143.pdf. [Source: OIG Admin Summary | Quentin G. Aucoin | February 26, 2016 ++]

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VAMC Bay Pines FL ► OIG Wait Time Report

This investigation was initiated pursuant to information received by the Department of Veterans Affairs (VA) Office of Inspector General (OIG) Hotline. The anonymous complainant alleged that the former VA Medical Center (VAMC) Bay Pines (now C. W. Bill Young [CWBY] VAMC) was "changing and destroying records and appointments" at the Outpatient Clinic Lakeside in order to cover mistakes before the OIG could review its records. During the course of this investigation, investigators received three additional anonymous complaints through the VA OIG Hotline alleging the widespread cancellation of Gastroenterology (GI) Clinic consults and procedures. One complainant reported that more than 500 such consults had been canceled while the other two complaints placed the figure at 1,000 or more. All complaints were made anonymously and no supporting documentation was provided. The OIG referred the Report of Investigation to VA's Office of Accountability Review on September 8, 2014.

The report's conclusion noted that their investigation did not substantiate the allegations. All those interviewed denied that there were any paper or other unofficial lists designed to circumvent official patient lists and there was no indication that anyone had been directed to destroy or manipulate records of any kind. However, the acting HAS Chief and an MSA Scheduler stated that schedulers have entered the next available appointment dates in VistA as patients' desired dates for the medical treatment. With regard to the cancellation of GI consults and procedures, the chief of staff reported that there had been no mass cancellation of GI consults in an effort to improve statistics; he also stated that an administrative conversion of some consults and removal of other completed consults in the wake of a recent review may have led to that belief. The MSA for GI said consult requests were entered by a provider and then reviewed by a nurse who nearly always indicated the patients should be seen within 2 weeks. She was usually able to schedule patients within that time frame. She said they did not have a wait list or use the RRL. The entire report is available at http://www.va.gov/oig/pubs/ims/wait-times-14-02890-133.pdf. [Source: OIG Admin summary | Quentin G. Aucoin | February 26, 2016 ++]

Bay Pines HCS FL

C.W. Bill Young VA Medical Center (i.e. Bay Pines)

Hawaii

VAMC Honolulu HI ► OIG Wait Time Report

On September 29, 2014, an anonymous complainant contacted the Department of Veterans Affairs (VA) Office of Inspector General (OIG) Hotline regarding various violations at VA Medical Center (VAMC) Honolulu, HI. The complainant alleged that a Health Administration Service (HAS) specialist for the Pacific Islands Healthcare System (PIHCS) provided PIHCS schedulers with the following instructions:

- Not to schedule veteran appointments more than 30 days in advance; and
- Not to input the veteran's "desired date" into the system when offering appointments due to critical short staffing. Schedulers instead offered available appointments to veterans, which was contrary to VA policy at the time.

The report's conclusion noted that Data analysis regarding scheduling practices at PIHCS determined that patients were scheduled further than 30 days in advance, contrary to the allegations of the anonymous complaint. Interviews of VA PIHCS MSAs and supervisors at HAS did not develop any information that management instructed staff to disregard patient desired dates when inputting appointments; however, one MSA identified situations in which veterans would accept the next available appointment dates, which would be listed as the patients' desired dates in order to move patients from the EWL. The OIG referred the Report of Investigation to VA's Office of Accountability Review on September 24, 2015. The entire report is available at http://www.va.gov/oig/pubs/ims/wait-times-14-02890-157.pdf. [Source: OIG Admin summary | Quentin G. Aucoin | March 3, 2016 ++]

Idaho

VAMC Boise ID ► OIG Wait Time Report

This investigation was initiated based on information received through the Department of Veterans Affairs (VA) Office of Inspector General (OIG) Hotline from an anonymous source alleging that non-VA medical consultations that had not been scheduled from 14 to 90 days were being canceled by staff per the direction of a manager in Health Administration Services (HAS) at VA Medical Center (VAMC) Boise.

The report's conclusion noted that VAMC Boise did sustain delays in providing ophthalmology and orthopedic care to patients primarily due to lack of VA providers in these clinics. Patients were appropriately placed on the EWL when consults could not be scheduled. VA OIG review of records indicated VAMC Boise closed consults per VA policy. The recent VA ACI has significantly decreased the number of outstanding consults in the system. The OIG referred the Report of Investigation to VA's Office of Accountability Review on February 3, 2015. The entire report is available at http://www.va.gov/oig/pubs/ims/wait-times-14-02890-233.pdf. [Source: OIG Admin summary | Quentin G. Aucoin | March 22, 2016 ++]

Illinois

VAMC Shreveport IL Update 01 ► OIG Wait Time Report

This investigation was initiated based upon information reported to the Department of Veterans Affairs (VA) Office of Inspector General (OIG) Hotline by an employee at the VA Medical Center (VAMC) in Shreveport, Louisiana, that a manager in Mental Health Services instructed employees in the Mental Health Care Line not to use the Veterans Health Information Systems and Technology Architecture (VistA) Electronic Waiting List (EWL), and to keep a

"secret" list instead. The complainant also referred to a secret wait list kept on the Mental Health Clinic's shared network drive.

The investigation was expanded proactively to include whether schedulers outside the Mental Health Clinic were manipulating wait times in VistA. The proactive review did not include Mental Health because the OIG Office of Healthcare Inspections (OHI) was conducting an inspection of Mental Health in response to allegations from Senator Richard Burr, who at the time was the Ranking Member of the Senate Committee on Veterans' Affairs. The inspection results were published on January 7, 2016, Healthcare Inspection: Patient Care Deficiencies and Mental Health Therapy Availability Overton Brooks VA Medical Center Shreveport, Louisiana, Report No. 14-05075-447. The OIG referred the Report of Investigation to VA's Office of Accountability Review on June11, 2015.

The report's conclusion noted that their investigation did not corroborate complainant's allegation that employees in the Mental Health Care Line were instructed not to use the VistA. The evidence revealed that there was a spreadsheet used in the Mental Health Clinic, VAMC Shreveport, identifying approximately 2,700 veterans who needed to be assigned to a Mental Health provider. However, it was not a list used in place of scheduling patients who wanted to be seen, nor was it used as a substitute for the EWL. There was no evidence that the manager instructed employees in the Mental Health Clinic to avoid using the EWL or to keep a secret list. None of the witnesses interviewed, who had knowledge of the subject matters in the complaint, corroborated the complainant's allegations that the employees in the Mental Health Care Line were instructed not to use VistA, EWL, and to keep a secret list instead. With regard to the spreadsheet, no one denied the existence of the spreadsheet but did deny allegations regarding the purpose of the list and that it was a secret list.

Regarding the proactive review of non-Mental Health evidence was found that some schedulers outside the Mental Health Clinic at VAMC Shreveport were inputting patients' appointments into VistA in a way that manipulated the actual wait time between the desired date and the actual date of the appointment. However, there was no evidence that schedulers were intentionally manipulating wait times. Evidence indicated that there had been inappropriate training years ago that carried through into present day work activities. There was also some evidence of a culture existing in the past, more than 2 years ago, which may have promoted manipulation of wait times. But that culture was not apparent at the time of this investigation or in the recent past. There was no evidence of specific patient harm. The entire report is available at http://www.va.gov/oig/pubs/ims/wait-times-14-02890-173.pdf. [Source: OIG Admin summary | Quentin G. Aucoin | March 3, 2016 ++]

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VAMC Danville IL ► OIG Wait Time Report

This investigation was initiated based upon a report from the Department of Veterans Affairs (VA) Veterans Integrated Service Network (VISN) 11 National Stand Down Team "Heads Up" memo regarding a visit to the VA Medical Center (VAMC) Danville on May 15, 2014. The OIG referred their Report of Investigation to VA's Office of Accountability Review on January 19, 2015. The report's conclusion noted that their investigation revealed that a list was emailed weekly by the former Primary Care coordinator to MSAs containing patients with wait times greater than 14 or 30 days between the desired dates and the actual appointment dates. Upon receiving such lists, one MSA changed dates within VistA to reduce wait times to zero. Nobody told her to do this; she just assumed that it should be done. That MSA felt if such changes were not made, there would be repercussions by management against those which she deemed to be on a black list. Another MSA said she was instructed to change dates within the system to zero out wait times greater than 14 days, but she could not remember who told her to do so. Yet another MSA said a supervisor told her that desired dates should always match appointment dates. This supervisor denied ever giving such instructions. The entire report is available at http://www.va.gov/oig/pubs/ims/wait-times-14-02890-174.pdf. [Source: OIG Admin summary | Quentin G. Aucoin | March 3, 2016 ++]

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VAMC Hines IL Update 04 ► OIG Wait Time Report

Allegations made publicly by the complainant were the focus of the investigation at the Hines, IL, Veterans Affairs Hospital (VAH) conducted by the Department of Veterans Affairs (VA) Office of Inspector General (OIG). The complainant primarily alleged that the VAH Hines Mental Health Division maintained "secret backlog lists." The complainant also alleged that she had been told that wait times were manipulated to ensure that the staff received large bonuses and that, because of this, patients were harmed. The complainant was interviewed by the VA OIG prior to the referral dated June 5, 2014, that the Office of Special Counsel sent to the VA Secretary pursuant to Title 5, United States Code, Section 1213, with allegations from the same complainant. Therefore, the investigation focused on the complaints she raised during her interview with the VA OIG. The OIG referred their Report of Investigation to VA's Office of Accountability Review on January 26, 2015.

The report's conclusion noted that although delays in access to care remain an ongoing issue at VAH Hines, this investigation uncovered no evidence to substantiate the existence of secret wait lists at VAH Hines. With respect to the Priscilla Report mentioned by witnesses, we found that the report, which was generated at the VAH, identified scheduled appointments that fell outside the established acceptable 14-day wait time. It was not a secret report. In regards to the complainant's primary allegations of Mental Health treatment delays and usage of any secret lists associated with Mental Health programs, there is no evidence to suggest the tracking tools or group introductory sessions used by that department were in conflict with the aforementioned scheduling directives or used with intent to hide delays in treatment.

It appears the Trauma Services database was used to assist in the tracking of modern mental health treatment in a way that worked around deficiencies in antiquated VA scheduling software. On May 8, 2014, the VAH director issued a memo to all employees VA OIG Administrative Summary 14-02890-180 10 Administrative Summary of Investigation by VA OIG in Response to Allegations. Regarding Patient Wait Times at the VAMC in Hines, IL notifying them that taking steps to make wait times look good without actually improving the timeliness of appointments was inappropriate. VA OIG determined that there was a violation of Veterans Health Administration (VHA) Directive 2010-027, VHA Outpatient Scheduling Process and Procedures. The investigation showed that MSAs throughout Hines were changing data within the VistA system under the direction of MSA supervisors, who asserted these orders originated from the service chief.

Although the existence of MSA clerical errors due to antiquated confusing scheduling software appears valid, the service chief denied giving orders for MSAs to go back into VistA and change data subsequent to wait time IRM Data Reports being issued (Priscilla Report). The results of these changes, whether by design or by unintentional and indirect effect, resulted in decreased wait time datasets. The interpretation of scheduling processes, in specific regard to desired date interpretation and negotiation of desired date with veterans, appears to vary among the MSAs interviewed. The service chief admitted to implementing scheduling methods in which the MSAs could encourage agreement from veterans for alternate desired dates closer to the scheduled appointment dates. While arguably practical, this violates VHA Scheduling Directive 2010-027. There is no evidence to suggest management above the service chief had knowledge of these practices. The entire report is available at http://www.va.gov/oig/pubs/ims/wait-times-14-02890-180.pdf. [Source: OIG Admin summary | Quentin G. Aucoin | February 26, 2016 ++]

Iowa

VAMC Des Moines IA Update 02 ► OIG Wait Time Report

This investigation was initiated based on an anonymous complaint to the Office of Inspector General (OIG) Hotline advising of a "secret waiting list" at the VA Medical Center (VAMC) for Psychotherapy Service in Des Moines, IA. The caller advised that a spreadsheet was kept on the shared drive for Psychotherapy Service and was destroyed by a VAMC Des Moines clinical psychologist, the keeper of the list, prior to Veterans of Health Administration's (VHA) May 2014 audit. The OIG referred the Report of Investigation to VA's Office of Accountability Review on January 30, 2015. The report's conclusion noted that their investigation did not substantiate the existence of a "secret" wait list. What was alleged to be a "secret waiting list" was in fact two spreadsheets created by the Psychotherapy Service Line to track wait times for initial consults and later for the more specific treatment of psychotherapy. VAMC management was aware of the spreadsheets. The entire report is available at http://www.va.gov/oig/pubs/ims/wait-times-14-02890-122.pdf. [Source: OIG Admin summary | Quentin G. Aucoin | March 3, 2016 ++]

Kansas

VAMC Topeka KS Update 01 ► OIG Wait Time Report

The investigation was initiated based on information provided by an anonymous complainant via the Department of Veterans Affairs (VA) Office of Inspector General (OIG) Hotline regarding the improper canceling of appointments by clinics within VA Medical Center (VAMC) Leavenworth and VAMC Topeka. The complainant asserted that the clinics/facilities have a long-standing unofficial policy to report clinic appointments that are canceled by doctors or other staff members as "cancelled by patient," instead of correctly listing those appointments as "cancelled by clinic." The clinic/facility is allegedly paid for the provider's time if the appointment is canceled by patient, instead of not getting paid if the clinic was canceled by the provider.

The report's conclusion noted that their investigation revealed no evidence to support the anonymous allegations. VA clinics do not receive funding based on appointments being canceled by patient and not by clinic. The VA funding and reimbursement process was not based on the classification of canceled appointments, but rather on the completion of appointments, which would increase the amount of dollars to the VISN and not to the specific facility under the VERA system. The VISN then decided how to distribute the funds to the VAMCs within its area of responsibility. Cancellation of appointments, whether by the patient or the clinic, had no bearing on funding at the facility because the work was not completed. Furthermore, there was no indication that appointments canceled by clinics had increased over the past year. The OIG referred the Report of Investigation to VA's Office of Accountability Review on January 30, 2015. . The entire report is available at http://www.va.gov/oig/pubs/ims/wait-times-14-02890-225.pdf. [Source: OIG Admin summary | Quentin G. Aucoin | March 22, 2016 ++]

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VAMC Wichita KS ► OIG Wait Time Report

This investigation was initiated based upon information provided by a senior official at the Department of Veterans Affairs Medical Center (VAMC) Wichita regarding the alleged deletion of a "non-sanctioned" or unauthorized Home Based Primary Care (HBPC) patient consult list by two VAMC HBPC employees (HBPC1 and HBPC2). HBPC1 and HBPC2 allegedly deleted a patient consult list after a litigation hold memo was sent out by VA Central Office (VACO) to all VA employees on or about May 14, 2014. During the course of this investigation, the senior official referred to the VA Office of Inspector General (OIG) additional allegations he received regarding incorrect scheduling training provided by a Primary Care Lead medical support assistant (MSA) to Community Based Outpatient Clinic (CBOC) Salina staff.

The report's conclusion noted that their investigation confirmed the existence of two HBPC patient lists, which were located on the VAMC's SharePoint drive. However, all HBPC patients were entered into VistA and nothing indicative of intentional and/or malicious falsification of wait time data was discovered. One list was deleted at the direction of HBPC1, who said she was not aware of the litigation hold memo at the time. An internal review conducted by VAMC personnel concluded that no veterans experienced an adverse effect as a result of being placed on the HBPC lists. The investigation did not substantiate that the Primary Care Lead MSA was fraudulently providing incorrect scheduling instructions to CBOC Salina staff. The OIG referred the Report of Investigation to VA's Office of Accountability Review on January 30, 2015. The entire report is available at http://www.va.gov/oig/pubs/ims/wait-times-14-02890-171.pdf. [Source: OIG Admin summary | Quentin G. Aucoin | March 22, 2016 ++]

Kentucky

VAMC Louisville KY Update 02 ► OIG Wait Time Report

This investigation was initiated by allegations sent to the Department of Veterans Affairs (VA) Office of Inspector General (OIG) Office of Investigations regarding manipulation of wait times and scheduling data at the VA Medical Center (VAMC), Louisville, KY. Specifically, a supervisory medical support assistant (MSA Supervisor) allegedly instructed other MSAs in the Outpatient Surgery Clinic to use a different "desired date" in order to show a reduction in wait times and avoid scrutiny on the facility's AEG*

The report's conclusion noted that their investigation found that with regard to the desired date determination, MSAs in the clinic were scheduling patient appointments correctly, in accordance with VA directives or policies, specifically Veterans Health Administration Directive 2010-027. Furthermore, all MSA employees reported that the MSA Supervisor never instructed them to use a date other than the correct desired date when scheduling appointments. The OIG referred the Report of Investigation to VA's Office of Accountability Review on June 23, 2015. The entire report is available at http://www.va.gov/oig/pubs/ims/wait-times-14-02890-192.pdf. [Source: OIG Admin summary | Stephen M. Jones | March 25, 2016 ++]

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CBOC Louisville KY ► OIG Wait Time Report

An investigation was initiated pursuant to information received by the Department of Veterans Affairs (VA) Office of Inspector General (OIG) from a senior leader (Senior Leader 1), regarding potential improper appointment scheduling and falsification of audit data at the Community Based Outpatient Clinic (CBOC) Dupont, VA Medical Center (VAMC), in Louisville, KY. The allegation specifically stated that a supervisory medical support assistant (Supervisory MSA1) for the CBOC, altered a business office audit to change her clinic's monthly scheduling accuracy.

The report's conclusion noted that their investigation found that MSAs at CBOC Dupont were scheduling patient appointments correctly with respect to the desired date determination, in accordance with VHA Directive 2010-027. Although Supervisory MSA1 did change column 2 in the audit from a "No" to a "Yes," the information in this column was more subjective or interpretive. The change was the result of a difference of interpretation between two supervisors and was found to have no effect on the scheduled appointment's desired date or appointment wait times. The OIG referred the Report of Investigation to VA's Office of Accountability Review on June 28, 2015. The entire report is available at http://www.va.gov/oig/pubs/ims/wait-times-14-02890-217.pdf. [Source: OIG Admin summary | Quentin G. Aucoin | March 25, 2016 ++]

Louisiana

VA HCS New Orleans/Baton Rouge ► OIG Wait Time Report

This case was initiated in May 2014 based on information provided by an anonymous source to the Department of Veterans Affairs (VA) Office of Inspector General (OIG) Hotline alleging that the scheduling staff members at the VA Outpatient Clinic (OPC) New Orleans and the Community Based Outpatient Clinic (CBOC) Baton Rouge were manipulating patient appointment information. The alleged manipulation was intended to make patient access to care appear to be more timely than the actual wait time experienced by patients. The OIG referred the Report of Investigation to VA's Office of Accountability Review on April 17, 2015.

The report's conclusion noted that their investigation revealed that OPC New Orleans VA and CBOC Baton Rouge scheduling staff did not properly use patients' desired dates when scheduling appointments for patients. The agreed-upon dates, or next available dates, were used as patients' desired dates. As a result, the true wait times were not recorded. This was caused by incorrect training and a lack of understanding of the system. The scheduling staff was not pressured or instructed by management to misuse the desired date. The investigation did not identify any schemes or "gaming" of the system that appeared to be intended to improve VA employee performance measures. No specific patient harm was identified as a result of the above allegations. The entire report is available at http://www.va.gov/oig/pubs/ims/wait-times-14-02890-168.pdf. [Source: OIG Admin summary | Quentin G. Aucoin | March 3, 2016 ++]

Massachusetts

VAMC Northampton MA Update 01 ► OIG Wait Time Report

This case was initiated based on information provided by a Department of Veterans Affairs (VA) National Stand Down Team, which was assembled by the Veterans Health Administration (VHA) to evaluate scheduling practices at VA medical facilities. The VHA National Stand Down Team informed the VA Office of Inspector General (OIG) that an employee alleged that management at the VA Medical Center (VAMC) in Northampton, MA, was "gaming" access numbers in Mental Health by (1) encouraging the entry of inaccurate desired dates, and (2) repetitively creating and canceling clinic appointments to ultimately achieve a "desired date" closer to the actual appointment date. The VA OIG investigation initially focused on Mental Health but expanded to Primary Care, based on new allegations received from confidential sources regarding concerns about the lack of responsiveness to consults and the failure to use the Electronic Wait List (EWL).

The report's conclusion noted that their investigation revealed that Mental Health scheduling staff misused the desired date when scheduling in response to consults. Evidence indicates that the misuse was primarily caused by a lack of understanding of the system and not pressure from management to meet performance measures. The investigation also revealed that the EWL was generally not used throughout Service Lines although there were opportunities when it could have been applied. The investigation did not identify any schemes or gaming of the system that was intended to improve performance measures. No specific patient harm was identified as a result of the above allegations. The entire report is available at http://www.va.gov/oig/pubs/ims/wait-times-14-02890-216.pdf . The OIG

referred the Report of Investigation to VA's Office of Accountability Review on October 31, 2014. [Source: OIG Admin summary | Quentin G. Aucoin | March 22, 2016 ++]

Michigan

VAMC Battle Creek MI Update 01 ► OIG Wait Time Report

An anonymous Department of Veterans Affairs (VA) Office of Inspector General (OIG) Hotline complainant alleged that Healthcare for Homeless Veterans (HCHV) Program supervisors at the VA Medical Center (VAMC) Battle Creek asked HCHV employees to retroactively schedule appointments for veterans who had been seen as part of outreach work. This scheduling method gave the appearance that veterans were seen more quickly. The complainant asserted that this practice was unethical in that the veterans did not have scheduled appointments.

The report's conclusion noted that their investigation found no irregularities with the scheduling practices used in the HCHV Program. Both program social workers and supervisors clearly described why their scheduling and documentation methods were consistent with best practices. They emphasized that there were no veterans waiting for services in their program, and that services were provided when veterans presented at the office for the walk-in program. The OIG referred the Report of Investigation to VA's Office of Accountability Review on June 28, 2015. The entire report is available at http://www.va.gov/oig/pubs/ims/wait-times-14-02890-228.pdf. [Source: OIG Admin summary | Quentin G. Aucoin | March 22, 2016 ++]

Minnesota

VAMC Minneapolis Update 07 ► OIG Wait Time Report | Dental Clinic

This investigation was initiated based on information reported to the Office of Inspector General (OIG) Hotline alleging that the Dental Service in VA Medical Center (VAMC) Minneapolis was manipulating data associated with patient wait times. In particular, the complainant alleged that the chief of Dental Services (CDS) "strongly advised" employees to hide patient records and to falsely report waiting times.

The report's conclusion was that their interviews failed to substantiate the allegation that the CDS instructed staff to manipulate patient waiting list data to hide the fact that patient wait times exceeded the 14-day objective enumerated in VA policy. Though there was communication about complying with the 14-day objective, there is no indication the data were manipulated to hide any wait times. The OIG referred the Memorandum for Record to VA's Office of Accountability Review on February 23, 2015. At http://www.va.gov/oig/pubs/ims/wait-times-14-02890-125.pdf the entire report is available for review . [Source: OIG Admin summary | Quentin G. Aucoin | February 29, 2016 ++]

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VAMC Minneapolis Update 08 ► OIG Wait Time Report | GI Clinic

This investigation was initiated based on information provided by two former employees of the U.S. Department of Veterans Affairs Medical Center (VAMC) in Minneapolis, MN. The employees alleged that while they worked as medical support assistants (MSAs) in the VAMC Minneapolis Gastroenterology (GI) Clinic, they were instructed to

alter appointment and scheduling records. They also alleged that they were instructed by management to cancel veterans' appointments without the veterans' knowledge, but made entries in the computerized scheduling system indicating that the veterans were contacted. Both employees had previously been removed from Federal service and claimed that they brought these concerns up to management prior to their removal

The report's conclusion was the investigation did not substantiate that a spreadsheet was used for scheduling purposes. According to the clinic director, as well as others, the GI Clinic uses a Microsoft Access database for the sole purpose of tracking its patients. This database is used for those patients who need to be seen for follow-up care in the future, such as 3-year, 5-year, or 10-year follow-up appointments. The VA's scheduling system does not allow for scheduling appointments that far into the future, so this database is used to ensure no veterans are forgotten or lost. It is a well-known program, is not a secret to anyone, and is accessible by all GI Clinic staff. It is maintained by the clinic director. The allegations made by the complainants were not substantiated. For example, statements by both complainants that MSAs sent out the results letters contradicted all other information regarding the results letters. The OIG agents were consistently told that results letters were only sent out by the medical providers, through Medical Media.

At no time did an MSA have anything to do with results letters. Through other interviews, it was discovered that prior to April/May 2014, GI Clinic patients were only being sent letters asking them to schedule appointments and the only telephone calls were to the patients whose medical issue was deemed urgent. As another example, when asked what happens to a consult when it is canceled, complainant 2 stated it is just simply closed out. Other interviews disputed this. If a consult is discontinued or canceled, the referring physician is notified via system-generated email. The physician then re-schedules the patient by creating another consult. The OIG referred the Report of Investigation to VA's Office of Accountability Review on June 26, 2015. At http://www.va.gov/oig/pubs/ims/wait-times-14-02890-154.pdf the entire report is available for review. [Source: OIG Admin summary | Quentin G. Aucoin | February 29, 2016 ++]

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VAMC Minneapolis Update 09 ► OIG Wait Time Report | Deceased Vet

This investigation was conducted based on information reported in the news media insinuating that the VA Medical Center (VAMC) Minneapolis had manipulated the date in which an appointment was canceled. The media reported that the VA computer system showed that the veteran called to cancel his appointment on the date in question, but in fact, the veteran had died prior to the date indicated in the VA system.

The report's conclusion was that the allegations were not substantiated. The OIG sent the Memorandum for Record to VA's Office of Accountability Review on June 4, 2015. At http://www.va.gov/oig/pubs/ims/wait-times-14-02890-126.pdf the entire report is available for review. [Source: OIG Admin summary | Quentin G. Aucoin | February 29, 2016 ++]

Missouri

VAMC Kansas City MO ► OIG Wait Time Report | Cardiology Clinic

This investigation was initiated based upon information provided by Veterans Integrated Service Network (VISN) 15 management regarding scheduling practices in the Cardiology Clinic of the Veterans Affairs Medical Center (VAMC) in Kansas City, MO. A VAMC Kansas City internal review of the scheduling practices in the Cardiology Clinic revealed that a Cardiology scheduling clerk's practices were erratic and potentially unreliable. Some Cardiology

providers used a "yellow sheet" to indicate dates for return appointments for their patients. In May 2014, approximately 1,032 of these yellow sheets were found in a drawer and file cabinet that had apparently not been processed by the clerk.

The report's conclusion was that the investigation substantiated that the clerk maintained paper records relating to the scheduling of patients in the Cardiology Clinic that she did not process. An immediate review of the paper records by VAMC Kansas City scheduling supervisors and clinical staff was completed over the course of 2 days in May 2014 and identified that 37 of the 1,032 sheets represented delayed appointments, and all 37 were immediately scheduled. A clinical review by VAMC Kansas City officials found no specific harm to patients as a result of the scheduling delays. The OIG referred the Report of Investigation to VA's Office of Accountability Review on September 2, 2014. At http://www.va.gov/oig/pubs/ims/wait-times-14-02890-202.pdf the entire report is available for review. [Source: OIG Admin summary | Stephen M. Jones | March 25, 2016 ++]

New York

VAMC Brooklyn NY ► OIG Wait Time Report

This investigation was initiated based upon information provided by an employee at the Department of Veterans Affairs (VA) Medical Center (VAMC) in Brooklyn, NY, who contacted VA Office of Inspector General (OIG) on June 12, 2014. The complainant alleged that the Radiology Department at VAMC Brooklyn was manipulating patient scheduling and misrepresenting wait times for medical scans

The report's conclusion was that the investigation did not substantiate the allegation. The Radiology Department at VAMC Brooklyn currently follows the 2008 policy recommended by the former VA National Radiology director regarding "no-show" appointments. The policy directs that a supervisor, or his/her representative, check the appointment list at the end of each day to identify any no-shows. Provided there is no inclement weather, and excluding Department of Defense patients, MSAs were directed to cancel the order for testing of any no-show and notify the physician's office that the order was canceled; the physician must then re-order the test. The OIG referred the Report of Investigation to VA's Office of Accountability Review on August 22, 2014. The entire report is available for review at http://www.va.gov/oig/pubs/ims/wait-times-14-02890-190.pdf. [Source: OIG Admin summary | Quentin G. Aucoin | March 15 2016 ++]

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VA CBOC Rochester NY ► OIG Wait Time Report

The investigation was initiated based on information received from a complainant who stated that a medical support assistant (MSA) supervisor at the Veterans Affairs (VA) Community Based Outpatient Clinic (CBOC) in Rochester, NY, asked a subordinate MSA to contact veterans and verify that they still wanted to keep their current appointment date. The MSA allegedly was told that if the veterans wanted to keep their current appointments, the MSA should alter the veterans' "desired date" to reflect the date of appointment, thus creating the illusion that CBOC Rochester was providing medical appointments on the exact date desired
by patients.

The report's conclusion was the investigation revealed that an MSA was ordered by an MSA supervisor to contact nine veterans via telephone, but he/she failed to do so. It was determined that the MSA never called or contacted the veterans and lied about it to management and to OIG special agents. The manager suspected that the MSA did not call the veterans and had another employee do so. When the veterans were contacted, they were all satisfied with their

original appointment dates and confirmed they had not been contacted by the MSA. During a second interview, the MSA admitted that he/she provided false information to management and VA OIG special agents. Changes to the desired dates made by the MSA were attributed to his misunderstanding of supervisory instructions. The OIG referred the Report of Investigation to VA's Office of Accountability Review on June 3, 2015. The entire report is available for review at http://www.va.gov/oig/pubs/ims/wait-times-14-03542-178.pdf. [Source: OIG Admin Summary | Quentin G. Aucoin | March 15 2016 ++]

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VA CBOC Rochester NY ► OIG Wait Time Report

The investigation was initiated based on information provided by a confidential complainant (CC). The CC alleged that a former medical support assistant (MSA) supervisor (MSA Supervisor 1) at the Department of Veterans Affairs (VA) Community Based Outpatient Clinic (CBOC), in Rochester, NY, instructed CBOC Rochester Primary Care Clinic MSAs to make veterans' desired dates for appointments at the CBOC to be the same date as the scheduled appointment date or first available date. The CC stated this has resulted in the appearance of a zero-day wait time for veterans seeking Primary Care appointments at the CBOC and created the perception that there was adequate staffing at the CBOC when that was not the case.

The report's conclusion was the investigation revealed that several schedulers at the CBOC were routinely using the first available appointment date as the desired date. This was likely due to erroneous information provided by MSA supervisors who stated that they trained staff to use the first available date as the desired date because they misunderstood the correct procedure. This issue was being corrected by management through the issuance of additional guidance and oversight and other corrective actions.

The VA employees interviewed advised that management never provided instruction intended to limit cooperation with OIG auditors or investigators for any inquiry into the CBOC patient wait time issue. They were advised just to be honest if they had to answer any questions. No one was aware of any computerized, hard copy, or separate patient waiting lists. In addition, the employees interviewed were never directed to destroy or shred any documents pertaining to patient waiting lists or wait times other than what was destroyed during the normal course of business. They were never informed that there was any monetary gain for anyone relating specifically to patient wait times. In addition, they were not aware of any managerial changes that occurred recently because of disciplinary actions relative to the wait times. Many of the employees voiced their opinion that there was no malicious intent by any employee to defraud or mislead anyone regarding wait times.

They commented that the zero-day wait time created a misconception that the schedulers were handling their workload in an appropriate manner. The OIG referred the Report of Investigation to VA's Office of Accountability Review on August 22, 2014. The entire report is available for review at http://www.va.gov/oig/pubs/ims/wait-times-14-03542-183.pdf. [Source: OIG Admin Summary | Quentin G. Aucoin | March 15 2016 ++]

Oregon

VAMC Portland OR Update 01 ► OIG Wait Time Report

On May 22, 2014, the Department of Veterans Affairs (VA) Office of Inspector General (OIG) received information that schedulers at the VA Medical Center (VAMC) in Portland, OR, used fictitious patients, known as "ZZ Test Patients" (ZZTP), to occupy appointment times in the computerized scheduling system for the Neurosurgery Clinic.

The report's conclusion noted that their review did not substantiate that inappropriate scheduling was ongoing at the time of this complaint. VA OIG review found that VAMC Portland did use ZZTP to reserve appointments for the

Neurosurgery Clinic until December 2013, when the facility self-reported the problem and took corrective action. The facility determined that Neurosurgery Clinic MSAs used ZZTP appointments to ensure patients who needed to be seen in the clinic could access appointments as non-Neurosurgery MSAs were scheduling appointments for patients who should not be seen in the clinic. ZZTP appointments in the system did not negatively affect quality of care for patients. The facility changed the scheduling processes for the Neurosurgery Clinic between December 2013 and April 2014, prior to this complaint to VA OIG, which has resulted in the proper use of ZZTP appointments at VAMC Portland. This change has enhanced patient access to the Neurosurgery Clinic. The entire report is available at http://www.va.gov/oig/pubs/ims/wait-times-14-02890-167.pdf . [Source: OIG Admin summary | Quentin G. Aucoin | March 7, 2016 ++]

Pennsylvania

VA CBOC Horsham PA ► OIG Wait Time Report

The investigation was initiated pursuant to information provided to the Department of Veterans Affairs (VA) Office of Inspector General (OIG) on May 16, 2014, by the associate director (AD) of the VA Medical Center (VAMC) in Philadelphia, PA. The AD had been informed during a Veterans Health Administration (VHA) Stand Down Audit Team exit briefing, that medical support assistants (MSA) at the VA Community Based Outpatient Clinic (CBOC) in Horsham, PA, allegedly reported being instructed through "upper level Health Administration Management" to identify the next available date as the "desired date." They were reportedly given lists of veterans with scheduled appointments and were being instructed to change the desired date to the next available date. They reported being issued a letter and being asked to sign it, to indicate that they did not change or manipulate the desired dates, which they refused to sign.

The report's conclusion was the investigation revealed that VHA policies relating to the creation of desired date were not followed. There also appeared to be misunderstandings relating to the correction of the desired date contained on an "error report" and management failed to adequately follow up with support staff to ensure that any corrections made were properly done. No one could produce the letter requesting that MSAs certify they did not change or manipulate desired dates. The OIG referred the Report of Investigation to VA's Office of Accountability Review on October 31, 2014. The entire report is available at http://www.va.gov/oig/pubs/ims/wait-times-14-02890-166.pdf. [Source: OIG Admin summary | Quentin G. Aucoin | March 8, 2016 ++]

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VAMC Philadelphia PA Update 01 ► OIG Wait Time Report

This investigation was initiated pursuant to information provided on May 30, 2014, by an employee (complainant) at the Veterans Affairs Medical Center (VAMC) in Philadelphia, PA, who had information relative to allegations of wrongdoing in the Audiology and Vascular Departments and the Eye Clinic of the VAMC. The complainant claimed that a former manager in Audiology was allegedly keeping a password-protected Microsoft Excel spreadsheet on his Department of Veterans Affairs (VA) computer that identified and was used to track patients who required consults for non-VA care at the Pennsylvania Ear Institute (PEI), Elkins Park, PA. The complainant also alleged appointments were not appropriately being made for veterans in the Vascular Department, and possibly other departments, during a period a Health Administration Services (HAS) clerk went on leave and was out for an extended period. Lastly, a manager in the Eye Clinic was allegedly "cooking the books" in that clinic by manipulating consults. During the investigation, another issue surfaced that consults in Physical Medicine and Rehabilitation (PMR) were being canceled and rebooked within Veterans Information Systems and Technology Architecture (VistA) for unknown reasons.

The report's conclusion was the investigation revealed that a spreadsheet was used by the former manager in Audiology approximately 4 to 5 years ago, when such use was permitted. He said he used the spreadsheet to track patients referred to PEI for hearing aid evaluations. Such patients would not have appeared on any wait list after being referred. According to the complainant, VAMC management took appropriate corrective actions regarding this issue following discovery and contacted all of the veterans (approximately 900) on the spreadsheet. The investigation also failed to show wrongdoing relating to the scheduling responsibilities of the clerk who went out on leave because coverage was provided during her absence.

With respect to allegations relating to the Eye Clinic, the alleged manipulation had to do with the inability of VistA to properly interface with a particular piece of diagnostic equipment. Any "manipulation" was claimed to have been done so the vascular ultrasound machine could interface with VistA and generate a patient list for the work to be done on a particular date. The investigation revealed that the vascular ultrasound machine does not interface with all parts of VistA and reads only consults. Appointments scheduled for veterans in VistA were not affected in any way by the manner in which consults were handled.

During the investigation, an issue surfaced that consults were being canceled and rebooked within VistA for PMR with the complainant providing no explanation as to why this was being done. The investigation revealed no wrongdoing in PMR and that the complainant, who is not involved in scheduling, was unfamiliar with the process for deleting old consults that were left open in VistA after a patient had been seen.

The OIG referred the Report of Investigation to VA's Office of Accountability Review on January 28, 2015. The entire report is available at http://www.va.gov/oig/pubs/ims/wait-times-14-02890-179.pdf. [Source: OIG Admin summary | Quentin G. Aucoin | March 8, 2016 ++]

Puerto Rica

VAMC San Juan PR ► OIG Wait Time Report

The investigation was initiated based upon a Department of Veterans Affairs (VA) Office of Inspector General (OIG) Hotline complaint alleging multiple issues that involved mismanagement by the director, VA Medical Center (VAMC) in San Juan, PR. These issues included "gaming" wait lists in Primary Care and specialty clinics by Health Administration Service (HAS) staff under the direction of the chief of staff (COS), and the associate director (AD).

The report's conclusion was the investigation found that VAMC San Juan HAS schedulers in Primary Care and a specialty clinic used the clinics' next available date as the veterans' desired date and changed appointments that fell outside of the 14-day desired date policy to be within 14 days. Schedulers stated that there was no senior management direction to manipulate wait times; however, pressure from first-level supervisors to meet the 14-day goal was clearly evident. The manipulation of wait times appeared to be an unintended consequence of this pressure combined with limited availability of appointments within 14 days of the desired dates. The investigation did not identify any inappropriate destruction of records by VAMC San Juan staff related to scheduling outpatient appointments. A review of the director's and the AD's personnel files did not identify any bonuses or appraisal ratings solely tied to patient access levels at the facility. The employee who taught the staff in 2009 was retired at the time of the investigation and the current manager confirmed that HAS staff were being trained the proper way to schedule appointments. As for the statement made by HAS Clerk 2 about the list provided to a supervisor of veterans he/she could not schedule, the investigation was unable to corroborate this claim.

The OIG referred the Report of Investigation to VA's Office of Accountability Review on September 29, 2014. The entire report is available at http://www.va.gov/oig/pubs/ims/wait-times-14-02890-219.pdf. [Source: OIG Admin summary | Quentin G. Aucoin | March 21, 2016 ++]

Tennessee

VA CBOC Chattanooga TN ► OIG Wait Time Report

An anonymous source alleged that two Department of Veterans Affairs (VA) employees at the Community Based Outpatient Clinic (CBOC), Chattanooga, TN, which is part of the Tennessee Valley Healthcare System (TVHS), took home personnel records on veterans/employees in order to conceal the records from a Veterans Health Administration (VHA) inspection team arriving at the facility in May 2014. The report's conclusion was that the VA Office of Inspector General (OIG) investigative efforts did not substantiate the allegations that the identified VA employees took home any personnel or other VA records. The OIG referred the Report of Investigation to VA's Office of Accountability Review on June 4, 2015. The entire report is available at http://www.va.gov/oig/pubs/ims/wait-times-14-02890-194.pdf. [Source: OIG Admin summary | Quentin G. Aucoin | March 8, 2016 ++]

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VA CBOC Chattanooga TN Update 01 ► OIG Wait Time Report

This investigation was initiated following receipt of a report from the Veterans Health Administration (VHA) National Stand Down Team (NSDT) and containing allegations from three medical support assistants (MSAs). The MSAs alleged that Chattanooga, TN, Community Based Outpatient Clinic (CBOC) employees were being directed by the Business Office to change patient "desired dates" to the actual appointment dates patients were seen, even when the providers clearly wanted the patients to be seen sooner. The NSDT report also relays the MSAs allegation that employees were being placed on a "bad boy" list if they did not comply with this direction.

The report's conclusion was the investigation did not substantiate that a bad boy list existed or that MSAs were written up for entering the correct desired date. No evidence of any effects on patient care was identified during this investigation, and no wait time manipulation intended to "game the system" was discovered. A need for standardized scheduler training was identified. This need was also independently identified by the director of TVHCS, who initiated a standardized training program for all of TVHCS. As of August 27, 2014, all CBOC Chattanooga schedulers had attended this training. Although the investigation could not rule out the possibility that schedule manipulation occurred in the past, the evidence showed that once formalized scheduler training began at the CBOC in June 2014, any indications that schedule manipulation may have been taking place no longer existed. The OIG referred the Report of Investigation to VA's Office of Accountability Review on June 4, 2015. The entire report is available at http://www.va.gov/oig/pubs/ims/wait-times-14-02890-195.pdf. [Source: OIG Admin summary | Quentin G. Aucoin | March 8, 2016 ++]

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VAMC Memphis TN ► OIG Wait Time Report

An anonymous complainant contacted the Department of Veterans Affairs (VA) Office of Inspector General (OIG) Hotline alleging that two senior management employees at the VA Medical Center (VAMC) in Memphis, TN, were changing consultation times to hide the fact that patients were receiving delayed treatment for pulmonary function exams. The complainant also alleged that VAMC Memphis used "bogus scheduling" and "secret lists" to cover the

fact that they missed required deadlines.

The report's conclusion was the investigation did not substantiate the allegations that VAMC Memphis changed consultation times to hide delays in treatment for pulmonary function exams and that the facility used bogus scheduling or had a secret list. The investigation found that the first available date was used as the desired date in 2011 and 2012, but the practice had stopped. In addition, approximately 18 months prior to the investigation, there was list of patients needing mammograms that was used outside the appropriate process by the Business Office. The inappropriate scheduling practices for mammograms were resolved before this investigation was initiated. The OIG referred the Report of Investigation to VA's Office of Accountability Review on February 25, 2015. The entire report is available at http://www.va.gov/oig/pubs/ims/wait-times-14-02890-201.pdf. [Source: OIG Admin summary | Quentin G. Aucoin | March 8, 2016 ++]

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VAMC Murfreesboro TN ► OIG Wait Time Report

The director, VA Tennessee Valley Health System (TVHS), notified the Department of Veterans Affairs (VA) Office of Inspector General (OIG) that four schedulers at the Central Scheduling Unit (CSU) at the Alvin C. York VA Medical Center (VAMC) had expressed concern that they either had or were presently inappropriately scheduling appointments based on supervisor instruction. The schedulers were not identified by name. The medical support assistants (MSAs) self-reported manipulating the patient "desired date" for appointments in the Veterans Health Information Systems and Technology Architecture (VistA) to reflect the date for which appointments were actually set.

The report's conclusion was the investigation found that scheduling was not done properly, which may have skewed wait times for the CSU. However, no evidence was found during this investigation indicating that the improper scheduling was an effort to intentionally manipulate wait times to "game the system." Upon learning that the appointments were not being properly scheduled, management implemented a corrective training program to ensure compliance with Veterans Health Administration scheduling policies. The OIG referred the Report of Investigation to VA's Office of Accountability Review on June 4, 2015. At http://www.va.gov/oig/pubs/ims/wait-times-14-02890-196.pdf the entire report is available for review. [Source: OIG Admin summary | Quentin G. Aucoin | March 8, 2016 ++]

Texas

VA HCS Amarillo TX ► OIG Wait Time Report

This case was initiated based on information provided to the Department of Veterans Affairs (VA) Office of Inspector General (OIG) by Congressman Mac Thornberry expressing concerns over recent allegations about negligent employee performance at the Amarillo, TX, VA Health Care System. The allegations investigated by VA OIG were:

- The **Endoscopy Clinic Amarillo** has such a huge backlog that they placed patients on a paper list. When a slot opened up, they were taken from the paper list and put on the electronic list (many have been on this list for more than 150 days). It was reported that the Endoscopy Department has been changing documentation and has shredded and is shredding the paper lists and some documentation.
- The **Outpatient Clinic (OPC) Lubbock** has been shredding papers and changing documentation as to the requested date patients asked to be seen. They are doing this at the request of their managers. It was reported that they do have a paper list that veterans are placed on. Once a slot opened up, they were then put on the "real" list and it appears that they were only on a waiting list for 25 to 35 days when, in fact, they have been

waiting for more than 150 days. Staff reported they were never trained in patient scheduling. They do not use the electronic scheduling system because no one ever trained them. They report a severe shortage of registered nurses and providers, which has caused huge backlogs in veterans' care. Lack of training and lack of access to documentation was reported. There were reports that employees were told by their managers to change the desired dates of veterans to a date that would reflect shorter patient wait time.

The report's conclusion was he Endoscopy Clinic Amarillo was using paper records to ensure continuity of care and to track the tissues samples. Emails showed that management was aware of these paper records and they were destroyed in accordance with VA directives. The OIG did not substantiate any allegations of wrongdoing concerning manipulation of patient wait times or scheduling, or the destruction of any patient paper lists at the Endoscopy Clinic Amarillo. At the OPC Lubbock, only one employee reported that the clinic's practice had been to use the next available date as the desired date, which he believed to be due to the instructions of a former supervisor. He reported this practice was discontinued after all the recent media coverage regarding patient wait time manipulation at VA. Interviews with other OPC Lubbock employees did not provide support for the allegations of manipulation of patient wait times or the destruction of patient paper lists. The OIG referred the Report of Investigation to VA's Office of Accountability Review on August 9, 2015. The entire report is available for review at http://www.va.gov/oig/pubs/ims/wait-times-14-02890-152.pdf. [Source: OIG Admin summary | Quentin G. Aucoin | March 8, 2016 ++]

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VA HCS Central & South Austin/San Antonio TX ► OIG Wait Time Report

This investigation was initiated based on information provided by a medical support assistant (MSA). The complainant alleged to the Department of Veterans Affairs (VA) Office of Inspector General (OIG) that Veterans Health Administration (VHA) facilities in San Antonio and Austin, TX, did not follow proper appointment scheduling protocols. In particular, the complainant alleged that scheduling staff were improperly directed to make patients' "desired dates" for appointments to be the same date as the first available date, and to avoid utilizing the electronic waiting list (EWL). Throughout the investigation, additional allegations required VA OIG special agents to expand the scope and methodology of the initial investigation. At the conclusion of the investigation, schedulers and supervisors from the VA Hospital San Antonio and a specialty clinic, VA Federal Clinic (VAFC) North Central, Frank Tejeda VA Outpatient Clinic (OPC), OPC Austin, Consolidated Outpatient Appointment Center (COPAC) Kerrville, and the VA Medical Center (VAMC) Temple were interviewed.

The report's conclusion was that the Investigation revealed that MAS and non-MAS schedulers were using the first available date as the patients' desired date when making appointments for VA medical care. Review of patient appointment data for facilities in San Antonio, Kerrville, and Austin revealed that the improper scheduling was systemic, and was not limited to a particular clinic or supervisor. The investigation did not reveal any VA employee receiving a bonus or award specifically related to patient wait times. The investigation did not reveal any clinic that was instructed not to use the EWL when it was necessary to use one. Numerous employees opined that there was no malicious intent by any employee to defraud or mislead anyone regarding wait times. Many individuals indicated problems with scheduling ranged from improper training, lack of supervision, to non-centralized scheduling. The OIG referred the Report of Investigation to VA's Office of Accountability Review on May 6, 2015. The entire report is available for review at http://www.va.gov/oig/pubs/ims/wait-times-14-02890-170.pdf. [Source: OIG Admin summary | Quentin G. Aucoin | March 8, 2016 ++]

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VAMC Dallas TX ► OIG Wait Time Report

The Department of Veterans Affairs (VA) Office of Inspector General (OIG) received allegations from multiple sources regarding employee misconduct at the VA Medical Center (VAMC) in Dallas, TX, including Congresswoman Eddie Bernice Johnson's office. The complainants alleged that VA employees engaged in conduct that resulted in

inaccurate wait times for patient appointments and possible destruction of records to conceal such activities. The anonymous allegations received through Congresswoman Johnson's office stated nurses at the medical center were ordered to destroy documents prior to a face-to-face access audit requested by the VA Secretary. The individuals who contacted Congresswomen Johnson's office did not identify themselves but suggested the Specialty Women's Clinic (specifically Clinic 7), Outpatient Clinic (OPC) Fort Worth, Home-Based Care, Dermatology, Podiatry, and the Dental Clinic, as areas where the alleged practice was taking place. Additionally, one of the complainants claimed she refused an order to destroy several black binders, which resulted in some type of altercation.

The report's conclusion was that the investigation did not substantiate that VA patient records were being destroyed, or that specific employees were intentionally manipulating patient wait times in order to meet the VA's since-rescinded goal of having patients seen within 14 days of their desired date. Additionally, VAMC Dallas police had no record of an altercation concerning destruction of binders. The investigation determined that a training specialist with OPC Fort Worth, which is overseen by VAMC Dallas, used presentations as training material to teach scheduling processes and procedures, which, in 2013, were determined by the manager in MAS not to be in compliance with VA scheduling directives; this may have led some schedulers to schedule patient appointments incorrectly, by using next available date or by using the appointment date as the patients desired date. The employee was directed by management to stop using the presentations and to correct them to accurately reflect VA policy according to VHA Directive 2010-027, VHA Outpatient Scheduling Processes and Procedures, dated June 9, 2010. The manager also was taking corrective action to address proper training and reduce the amount of individuals with scheduling keys. The OIG referred the Report of Investigation to VA's Office of Accountability Review on November 20, 2014. The entire report is available for review at http://www.va.gov/oig/pubs/ims/wait-times-14-02890-138.pdf. [Source: OIG Admin summary | Quentin G. Aucoin | March 8, 2016 ++]

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VA HCS El Paso TX Update 01 ► OIG Wait Time Report

This investigation started with information received from the Federal Bureau of Investigation (FBI), El Paso, advising that Congressman Beto O'Rourke wanted the FBI to look into the possibility of the manipulation of patient wait times at the Veterans Affairs Health Care System (VAHCS) El Paso. FBI/El Paso requested that the Department of Veterans Affairs (VA) Office of Inspector General (OIG) partner with them in the inquiry and interview a random sampling of appointment schedulers from various clinics within the facility

The report's conclusion was that the investigation identified policy violations in that schedulers were incorrectly capturing veterans' desired dates when scheduling appointments. Most of the clerks interviewed negotiated with veterans for a date based on provider availability, rather than first asking a veteran for the date he/she desired to be seen—in violation of Veterans Health Administration Scheduling Directive 2010-027. The OIG referred the Report of Investigation to VA's Office of Accountability Review on June 28, 2015. The entire report is available for review at http://www.va.gov/oig/pubs/ims/wait-times-14-02890-137.pdf [Source: OIG Admin summary | Quentin G. Aucoin | March 8, 2016 ++]

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VA OPC Fort Worth TX ► OIG Wait Time Report

On June 6, 2014, the Department of Veterans Affairs (VA) Office of Inspector General (OIG), South Central Field Office, in Dallas, TX, received a referral from the OIG Hotline in response to the Veterans Health Administration (VHA) Stand Down Team's face-to-face audit of Veterans Integrated Service Network (VISN) 17 Outpatient Clinic (OPC) Fort Worth. The referral reported a concern that staff at OPC Fort Worth were previously instructed to use the "next available date" as the "desired date," but that it has been corrected. According to the National Stand Down Team, the new instruction included the use of "find next available appointment" to find next availability. The National

Stand Down Team advised that during their review, one clerk reported being threatened with reprimand for noncompliance due to not using this function.

The report's conclusion was that the investigation identified several employees who stated that they were using the next available date as the patient's desired date while scheduling appointments of veterans, which would be in conflict of VHA Directive 2010-027, VHA Outpatient Scheduling Processes and Procedures. MAS supervisors had identified improper use of next available through audits. No evidence was obtained to suggest these employees intentionally manipulated patient wait times in order to give the appearance of meeting the VA's since-rescinded goal of having patients seen within 14 days of their desired date. The OIG referred the Report of Investigation to VA's Office of Accountability Review on September 27, 2015. The entire report is available for review at http://www.va.gov/oig/pubs/ims/wait-times-14-02890-156.pdf [Source: OIG Admin summary | Quentin G. Aucoin | March 8, 2016 ++]

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VA OPC Harlingen TX ► OIG Wait Time Report

This investigation was initiated by an anonymous complaint to the Department of Veterans Affairs (VA) Office of Inspector General (OIG) Hotline, which alleged that a VA Texas Valley Coastal Bend (TVCB) Health Care System management official threatened the employment of an employee at the VA Outpatient Clinic (OPC) in Harlingen for not falsifying VA patient scheduling numbers. In addition, we proactively investigated the issue of whether VA patient appointment wait times were being manipulated throughout the VA TVCB Health Care System.

The report's conclusion was that the investigation did not corroborate the allegation that the TVCB Health Care System management official threatened the employment of an OPC Harlingen employee for refusing to falsify VA patient scheduling numbers. In addition, there was no evidence that the TVCB Health Care System management official directly instructed staff to manipulate the information in VistA to keep scheduling numbers within standards. There was evidence that the employees felt pressure from the TVCB Health Care System management official, which led to the manipulating of VistA in order to keep scheduling numbers within standard. We also found evidence indicating that there had been inappropriate training years ago, which carried through into present-day work activities with regard to scheduling. The OIG referred the Report of Investigation to VA's Office of Accountability Review on June 28, 2015. The entire report is available for review at http://www.va.gov/oig/pubs/ims/wait-times-14-02890-165.pdf. [Source: OIG Admin summary | Quentin G. Aucoin | March 8, 2016 ++]

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VAMC Houston TX Update 02 ► OIG Wait Time Report

A confidential complainant (CC) reported to the Department of Veterans Affairs (VA) Office of Inspector General (OIG) Hotline that an employee at the VA Medical Center (VAMC) Houston had information regarding veterans who have been awaiting appointments since 2006. The CC also requested that investigators speak with program support personnel concerning "GI consults fraud."

The report's conclusion was that the investigation substantiated that schedulers in the Primary Care Service Line, Mental Health Care Line, and Dental Service of VAMC Houston "zeroed out" patient wait times by basing the patients' desired dates on clinic availability. Interviews of schedulers in all three services disclosed that clerks had been trained to schedule by using the patients' actual appointment date as their desired date. The allegations pertaining to the NEAR list and improper discontinuation of gastroenterology consults were not substantiated.
VA OIG Administrative Summary 14-02890-163 7 Administrative Summary of Investigation by VA OIG in Response to Allegations Regarding Patient Wait Times at the VAMC in Houston, TX The OIG referred the Report of Investigation to VA's Office of Accountability Review on April 16, 2015. The entire report is available for review at http://www.va.gov/oig/pubs/ims/wait-times-14-02890-163.pdf [Source: OIG Admin summary | Quentin G. Aucoin | March 8, 2016 ++]

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VAMC San Antonio TX Update 01 ► OIG Wait Time Report

This investigation began after the Department of Veterans Affairs (VA) Office of Inspector General (OIG) received information from the South Texas VA Healthcare System (STVHCS), San Antonio, TX, that a member of the support staff (SS1) at the Frank Tejeda VA Outpatient Clinic in San Antonio provided a list of 161 patient names, the last four digits of each patient's Social Security number, and telephone numbers to ABC affiliate, News 4 WOAI (News 4), in San Antonio. A second employee (SS2) at the same clinic was later identified as an individual suspected of releasing patient information to the media. The report's conclusion was that the allegations were not substantiated. The investigation did not reveal direct or circumstantial evidence indicating that either SS1 or SS2 was involved in the release of patient information to the media. The OIG referred the Report of Investigation to VA's Office of Accountability Review on January 30, 2015. The entire report is available for review at http://www.va.gov/oig/pubs/ims/wait-times-14-02890-162.pdf [Source: OIG Admin summary | Quentin G. Aucoin | March 8, 2016 ++]

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VAMC San Antonio TX Update 02 ► OIG Wait Time Report

On May 22, 2014, a confidential complainant (CC), who was previously employed by the South Texas Veterans Health Care System (STVHCS) in San Antonio, TX, contacted the Department of Veterans Affairs (VA) Office of Inspector General (OIG) Hotline and alleged that employees assigned to the STVHCS Home-Based Primary Care (HBPC) Program were not allowed to use the Electronic Wait List (EWL). The report's conclusion was that employee interviews, reviews of managers' performance appraisals, and a review of official email correspondence did not produce evidence to substantiate the allegation. The OIG referred the Report of Investigation to VA's Office of Accountability Review on April 17, 2015. The entire report is available for review at http://www.va.gov/oig/pubs/ims/wait-times-14-02890-164.pdf. [Source: OIG Admin summary | Quentin G. Aucoin | March 8, 2016 ++]

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VAMC San Antonio TX Update 03 ► OIG Wait Time Report

On June 9, 2014, a confidential complainant (CC) employed by the Audie L. Murphy VA Hospital in San Antonio, Texas, contacted the Department of Veterans Affairs (VA) Office of Inspector General (OIG) Hotline and alleged that clerks and technicians assigned to the sleep clinic were made to schedule appointments incorrectly in order to make the "desired date report" reflect a shorter wait time.

The report's conclusion was that the investigation substantiated that from 2011 through 2013, schedulers in the Sleep Medicine section of the Audie L. Murphy VA Hospital in San Antonio, TX, zeroed out patient wait times by basing the patients' desired dates on clinic availability. Several employees stated that they had been trained to schedule patients by using the next available appointment date as the patient's desired date. In addition, the supervisory technician admitted that she resolved scheduling errors by canceling and rescheduling the appointments in question with a different desired date than what the patients had originally selected. The supervisory technician also admitted that she may have instructed other employees to resolve scheduling errors in this manner. The OIG referred the Report of Investigation to VA's Office of Accountability Review on April 17, 2015. The entire report is available for review at http://www.va.gov/oig/pubs/ims/wait-times-14-02890-169.pdf. [Source: OIG Admin summary | Quentin G. Aucoin | March 8, 2016 ++]

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VAMC Temple TX ► OIG Wait Time Report

This investigation was initiated in response to a complaint to the Department of Veterans (VA) Office of Inspector General (OIG) Hotline by a former VA Medical Center Temple employee who was working at another facility in the Central Texas Veterans Health Care System (CTVHCS). The employee stated that he had witnessed manipulation of radiology consults by the chief of Imaging Service for the CTVHCS. According to the complainant, this involved the Imaging Service Chief asking or ordering CTVHCS physicians to move the desired dates of requested imaging procedures out beyond 30 days, so that the procedures could be shown to have been completed within 30 days of the desired dates listed on the original orders. This was allegedly done by sending out memos to physicians indicating that there were backlogs in the Radiology Department, and by asking that the physicians cooperate by ordering radiological studies within time frames in excess of 30 days, when clinically appropriate.

The complainant did not allege that the Imaging Service Chief ever falsified data; rather, the complainant indicated that the Imaging Service Chief regularly reported on these backlogs via widely distributed email messages. The complainant further indicated that the Imaging Service Chief documented the cancellation (or discontinuation) of imaging consults in the Computerized Patient Record System (CPRS) and suggested that since all of this activity was done through the CPRS, the activity could therefore be tracked. The complainant specifically alleged that one veteran patient was directly affected by delays in radiology procedures. The complainant alleged that he submitted an urgent order requesting that an ultrasound be completed within 1 week. Instead, it took 2 or 3 weeks for the ultrasound to be completed.

On May 30, 2014, during the VA OIG investigation, the U.S. Office of Special Counsel (OSC) sent a letter to the VA Acting Secretary, outlining the following related allegations received from an anonymous complainant: Radiology appointments at the Temple medical center were scheduled and canceled improperly, specifically:

- The Radiology Chief regularly canceled and rescheduled appointments that would have otherwise shown an extended wait time.
- The Radiology Chief directed radiologists to cancel and reschedule appointments in a similar fashion when he was unavailable.

The investigation did reveal that the OSC complaint in fact pertained to discontinuation of imaging consults. Imaging consults were not sent to schedulers until after the screening process referenced in the OSC complaint had already been completed

The report's conclusion was that the allegation was not substantiated. Veterans Health Administration (VHA) Directive 2010-027, VHA Outpatient Scheduling Processes and Procedures, defines "Desired Date" as follows: "The desired appointment date is the date on which the patient or provider wants the patient to be seen" (emphasis added). There is no evidence to suggest that the Imaging Service Chief ever canceled imaging consults without appropriate clinical review and there is no evidence to suggest that subordinate radiologists ever canceled imaging consults without appropriate clinical review. The conduct disclosed by the investigation (suggesting desired dates for imaging studies based upon the urgency of the procedure and the patient's clinical history, determining the desired dates of procedures following the clinical review of imaging consults, or requesting that the desired dates of imaging studies be modified based upon clinical review) does not constitute a Federal crime, nor does it appear to violate the referenced scheduling directive. In addition, a VA Medical Center staff radiologist in Houston reviewed the medical records of the patient identified by the OIG Hotline complainant and determined that, given the patient's clinical history, all imaging procedures were performed within a reasonable period of time. The OIG referred the Memorandum for Record to VA's Office of Accountability Review on November 16, 2015 The entire report is available for review at http://www.va.gov/oig/pubs/ims/wait-times-14-02890-148.pdf. [Source: OIG Admin summary | Quentin G. Aucoin | March 8, 2016 ++]

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VAMC Temple TX Update 01 ► OIG Wait Time Report | PSAS

On August 18, 2014, the Department of Veterans Affairs (VA) Office of Inspector General (OIG), South Central Field Office in Dallas, TX, was advised by a special agent in the Federal Bureau of Investigation in Waco, TX, that his office had received an allegation from a complainant regarding the Prosthetics and Sensory Aids Service (PSAS) at

the VA Medical Center (VAMC) in Temple, TX. Based on this information, on September 23, 2014, VA OIG special agents interviewed the complainant. The complainant:

- Stated that until recently, the PSAS Chief had purchasing agents overseeing the management of all PSAS consultations (consults), which would include artificial limbs.
- Opined that purchasing agents are not qualified to manage consults for artificial limbs.
- Alleged that the purchasing agents were mistakenly closing artificial limbs consults, which require an appointment, due to the pressure that they were under to abide by durable medical equipment (DME) consult performance measurements.
- Alleged that the PSAS Assistant Chief determined that the purchasing agents did not need to send a letter to the veteran before closing the consult. Due to the pressure to meet consult performance measurements, it became a standard practice to close consults without first sending a letter to the veteran.
- Stated that once the consult was closed, there is no longer a record that showed patients did not receive the intended care. However, the consult is good for 1 year, which means that the patient can come in any time during that year. He opined that if a veteran were not aware of the consult, the veteran would never learn of the consult due to the cessation of notification letters.
- Said that referring physicians also do not have time to follow up on the consults they originate. Furthermore, referring physicians are supposed to inform the veteran of the consult, but many do not and assume that PSAS will send a letter.

  Sstated that closing consults without sending a letter is a violation of the PSAS Business Practice Guidelines (BPG) for Prosthetics Consult Management and that it was being done to meet consult management performance measurements so that PSAS consult management reports would look better.

In support of his allegation, the complainant provided a Microsoft Excel file, which contained data related to 677 Orthotics & Prosthetics Laboratory closed consults for May and June 2014. He stated that the 677 consults were closed without the veterans being informed in writing. PSAS staff reportedly reviewed 435 of the 677 closed consults. The spreadsheet is divided by tabs for May 2014 (389 patient records) and June 2014 (288 patient records). According to the complainant, the spreadsheet is further divided into groups of consults for items that were fitted (meaning the veteran came in on his/her own); consults for items that were still outstanding (meaning the veteran has not yet come in); and consults that were not reviewed. Of the 389 patient records for May 2014, PSAS staff reportedly identified 35 consults for items that were fitted; 112 consults for items that were still outstanding; and 242 consults that they did not review. Of the 288 patient records for June 2014, PSAS staff reportedly identified 65 consults for items that were fitted and 223 consults for items that were still outstanding.

The complainant further stated that as of September 17, 2014, PSAS was managing consults in accordance with the PSAS BPG for Prosthetics Consult Management. He told the VA OIG investigators that he was satisfied with the new procedures and believed that PSAS will properly manage Orthotics & Prosthetics Laboratory consults because qualified personnel will review every consult to determine if any consult should be handled by the Orthotics & Prosthetics Laboratory. Furthermore, PSAS will send a letter before closing consults.

The report's conclusion was that the allegation was not substantiated. The investigation did not reveal the intentional inappropriate closing of consults. The investigation did not reveal that consults were closed for the purpose of manipulating consult management performance measurements. The investigation revealed that, from approximately April to September 2014, PSAS consults were closed with no letters mailed to veterans. Two PSAS employees stated that the PSAS Chief gave the instruction not to send letters; however, the chief said that if letters were not sent, it was the result of employee error. Neither the PSAS BPG for Prosthetics Consult Management or VHA Directive 1173, Prosthetics and Sensory Aids Service, requires that a letter be mailed. The VA OIG Office of Healthcare Inspections did not find any refusals to provide items when the patient showed up or evidence that patients suffered harm and/or death as a result of consults that were closed. The OIG referred the Memorandum for Record to VA's Office of Accountability Review on November 16, 2015. At http://www.va.gov/oig/pubs/ims/wait-times-14-02890-150.pdf the entire report is available for review. [Source: OIG Admin summary | Quentin G. Aucoin | March 8, 2016 ++]

Washington

VAMC American Lake WA ► OIG Wait Time Report

The investigation was initiated based on information received through the Department of Veterans Affairs (VA) Office of Inspector General (OIG) Hotline from a former VA employee who alleged that a manager for the Non-VA Care Program (NVACP) at the VA Medical Center (VAMC) American Lake instructed schedulers to fabricate veteran contact dates, in order to artificially lower the number of outstanding fee-based referrals in the VA Puget Sound Healthcare System (VAPSHS) area of operation. The complainant also alleged that the NVACP manager had mistreated the complainant, and that she was borderline abusive to other employees.

The report's conclusion was that the investigation determined that the NVACP manager did instruct schedulers to re-create NVACP veteran contact dates in an internal Microsoft Access scheduling database system in order to capture contacts and attempted contacts that had occurred, but that had not been properly recorded in the database system. We did not substantiate the allegation that the NVACP manager abused schedulers. The OIG referred the Report of Investigation to VA's Office of Accountability Review on September 4, 2015. The entire report is available for review at http://www.va.gov/oig/pubs/ims/wait-times-14-02890-229.pdf. [Source: OIG Admin summary | Quentin G. Aucoin | March 25, 2016 ++]

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VAMC Spokane WA Update 01 ► OIG Wait Time Report

This investigation was initiated based upon information received by the Department of Veterans Affairs (VA) Office of Inspector General (OIG) Hotline from a former VA employee who alleged that the VA Medical Center (VAMC) Spokane, WA, used unauthorized methods to manually track Behavioral Health Services (BHS) patient appointments.

The report's conclusion was that the investigation determined that VAMC Spokane BHS scheduling employees used manually printed appointments slips while transitioning patients between medical providers, and that the facility was not in full compliance with the VHA policy for scheduling. BHS employees advised that they maintained manual paper appointment slips due to BHS provider turnover and limitations within the VA scheduling system used in 2013–2014. The VAMC Spokane BHS scheduling supervisor advised VA OIG that because of VistA's technical limitations, VAMC Spokane scheduling employees were unable to electronically schedule appointments when there was no provider to which to assign the future patient appointment within VistA. The supervisor stated that her understanding of the VA scheduling policy indicated that the EWL should be used for new patients awaiting appointments. The patients involved in this situation were primarily existing patients.

As a result of this situation, the supervisor felt the best solution for this particular situation was to have BHS schedulers place paper appointment slips into a folder system for future patient appointments in anticipation of new BHS clinicians being assigned to the department. Once the new BHS clinicians arrived at VAMC Spokane, schedulers used the appointment slips previously placed in the folder to schedule patient appointments in VistA. This situation regarding future appointment scheduling for patients assigned to providers who had retired was resolved with BHS's deployment of the VA PCMM in late 2014. The OIG referred the Report of Investigation to VA's Office of Accountability Review on September 24, 2015. The entire report is available for review at http://www.va.gov/oig/pubs/ims/wait-times-14-03145-176.pdf. [Source: OIG Admin summary | Stephen M. Jones | March 25, 2016 ++]

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CBOC Chehalis WA ► OIG Wait Time Report

The Department of Veterans Affairs (VA) Puget Sound Health Care System Director notified the VA Office of Inspector General (OIG) regarding an allegation that a manager pressured a medical scheduling assistant (MSA) to change patients' desired dates for medical appointments. The director advised that he had met with an MSA from the Community Based Outpatient Clinic (CBOC) Chehalis who brought this allegation to his attention. The MSA advised that a former manager at CBOC Chehalis had pressured the MSA to change patient desired dates on several occasions. The complainant assumed that the former CBOC manager got direction to do so from another person in the General Medicine Service. The last time the MSA had been asked to change a patient's desired dates was in approximately January 2014. CBOC Chehalis is managed by a private VA contractor. Unless otherwise identified, the individuals who were interviewed are employees of the contract company.

The report's conclusion was that the investigation revealed that CBOC Chehalis MSAs made changes to patients' desired date information in VistA on less than 10 occasions during the last 3 years. It was also reported that some of the initial patient desired date data had been inputed incorrectly, which resulted in the former CBOC manager receiving instructions to fix the data input errors. The OIG referred the Report of Investigation to VA's Office of Accountability Review on August 10, 2015. At http://www.va.gov/oig/pubs/ims/wait-times-14-02890-175.pdf the entire report is available for review. [Source: OIG Admin summary | Stephen M. Jones | March 25, 2016 ++]

West Virginia

VAMC Huntington WV Update 01 ► OIG Wait Time Report

On May 19, 2014, a former Veterans Affairs Medical Center (VAMC) Huntington, WV, contract psychiatrist was interviewed by Fox News and alleged in a national television interview that veterans committed suicide because they were not given timely follow-up appointments. The complainant reported to Fox News that she would request that veterans be given a follow-up appointment within 10–12 days and noticed that her patients weren't returning. She further reported to Fox News that she discovered her patients were being scheduled several months later for follow-up appointments and at least two of her patients committed suicide while waiting for follow-up appointments.

The report's conclusion was the review did not substantiate the allegation. VAMC Huntington did not experience the delays in providing psychiatric care to veterans, as reported by the complainant. The review further determined that none of the complainant's patients committed suicide while waiting for follow-up appointments. The complainant alleged that she would request that veterans be given a follow-up appointment within 10-12 days and noticed that her patients weren't returning. Based on a review of this documentation, there is no indication that this occurred. The progress notes entered by the complainant, in which the appointment wait time was greater than expected, appear to have been for follow-up appointments from 30 days to as long as 5 months. Appointments that had requested follow-up times for the patient to return sooner, such as 2 weeks, appear to have been scheduled properly with no wait time issues. The OIG referred the Report of Investigation to VA's Office of Accountability Review on June 2, 2015. The entire report is available at http://www.va.gov/oig/pubs/ims/wait-times-14-02890-177.pdf. [Source: OIG Admin summary | Quentin G. Aucoin | March 9, 2016 ++]