ADMINISTRATIVE SUMMARY OF INVESTIGATION BY THE VA OFFICE OF INSPECTOR GENERAL IN RESPONSE TO ALLEGATIONS REGARDING PATIENT WAIT TIMES

Dental Service, VA Medical Center in Minneapolis, Minnesota
February 29, 2016

1. Summary of Why the Investigation Was Initiated

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.

2. Description of the Conduct of the Investigation

Interviews: In addition to the complainant, we interviewed five Dental Service employees and the CDS.

3. Summary of the Evidence Obtained From the Investigation

Interviews

- The complainant articulated a variety of complaints about the CDS at VAMC Minneapolis, but could not provide any specific examples or evidence to corroborate his allegation that data associated with patient wait times had been manipulated.

- A provider did not provide any information to corroborate the complainant's allegation. She did acknowledge that the clinic was very busy and that a "walk-in clinic" had been added to the weekly schedule to accommodate emergent dental care and appropriate triage.

- A supervisor noted that the Dental Clinic was very busy and explained that the clinic initiated a "return to clinic" procedure wherein a dentist reviews the patient's circumstance and determines when he or she is to be seen again. The DAS stated that the schedulers also confer with a dentist when a patient calls about possible emergent care and that the scheduler then schedules the appointment under provider guidance.

- A Dental Services employee related that she occasionally schedules appointments at the Dental Clinic. When provided the details of the allegations during the interview, she was unable to corroborate the allegations.

- A medical support assistant (MSA) related that the biggest difference between her experiences in other clinics and the Dental Clinic was the eligibility restraints associated with dental care. The MSA acknowledged that the 14-day access list had been an ongoing topic of discussion as a result of the heavy volume at the clinic. The MSA

explained that the practice of provider consultation was the process adopted to address this issue (specifically, when an appointment was outside the required 14 days, it had to be reviewed by a medical provider). The MSA stated that she was not aware of anyone modifying desired dates to hide these occurrences.

- Another Dental Services employee complained that the Dental Clinic was understaffed. She also complained that patients were being scheduled to the next available provider rather than continuously scheduled to see the same provider. The employee did not provide information to corroborate the complainant's allegation.

- We read the allegations to the CDS and he denied them. He asserted that in truth the clinic has always been "in the red" on the access list. The CDS stated that he has used these data to increase the capacity of the clinic, and opined that the access list was very helpful in illuminating staffing needs. The CDS stated that no one in the VAMC Minneapolis Director's office ever pressured him to "clean up" or otherwise modify these data. The CDS related that their actual response was "what can we do to help."

4. Conclusion

These 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.

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For more information about this summary, please contact the Office of Inspector General at (202) 461-4720.