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

VA Medical Center in Orlando and VA Outpatient Clinic in Daytona Beach, Florida
February 26, 2016

1. Summary of Why the Investigation Was Initiated

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.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** The OIG interviewed a sampling of employees assigned to both the VAMC Orlando and OPC Daytona Beach to determine the veracity of the allegations. Agents also interviewed the director of VAMC Orlando to determine his knowledge of the April 26, 2010, Veterans Health Administration (VHA) memo, *Inappropriate Scheduling Practices*; VHA Directive 2010-027; and certifications of compliance.
- **Records Reviewed:** The OIG reviewed VA policies and records for excessive wait times, including the records of three patients to determine if delayed care caused harm/death.

3. Summary of the Evidence Obtained From the Investigation

Interviews Conducted

- A former employee of the OPC Daytona Beach stated that consults were being canceled without the doctor's knowledge. She added that there were coding issues occurring in patient's charts. The former employee provided a list of four employees who she believed would have information regarding these allegations.

- Physician 1, OPC Daytona Beach, who was identified by the complainant, expressed numerous concerns about staffing levels within OPC Daytona Beach. He stated patients were not receiving follow-up care due to low levels of staffing, which resulted in a lack of appointments/access. He stated he had encountered resistance from the fee basis section when he referred patients out for fee basis treatment for procedures that could have been performed at the VA, but not in a timely manner. In a subsequent interview, Physician 1 reiterated his original complaints. Physician 1 stated that physical therapy was another area of concern; he felt patients were not being seen in a timely manner. He

stated that unless patients were post-operative, they were not seen within the 30-day time period.

  - Two of the individuals identified by the complainant were OPC Daytona Beach Health Administrative Service (HAS) clerks who stated that it was common practice for schedulers to ask patients when they would like to be seen. The scheduler then scrolled through the system to find an available appointment. The scheduler would then exit the system, which caused the system to lose the ability to calculate the time between the original "desired date" and the actual appointment date, and use the actual date as the desired date. One of the HAS clerks stated the clerks typed in the notes section when the patient requested to be seen.

- Physician 2, OPC Daytona Beach, who was identified by the complainant, stated that there were three patients that he wanted to bring to the attention of the VA OIG, two of whom had died and the other, Physician 2 thought, had a delay in care.

- The director of VAMC Orlando indicated that he was familiar with the memo, Inappropriate Scheduling Practices; VHA Directive 2010-027; and the certifications. He also provided copies of the requested certifications. He stated that he recalled being advised that the Mental Health Clinic recently disclosed to the HAS staff that Mental Health was keeping a list of patients who providers felt may benefit from a new psychotherapy treatment. The director indicated that the list was not being kept in an effort to manipulate wait times, but to allow mental health providers to keep a list of patients who they believed could benefit from this treatment, when it became available. He stated that out of an abundance of caution, he decided to have these patients put on the Electronic Wait List (EWL).

- A program analyst at VAMC Orlando stated he had never instructed anyone to remove a patient from the EWL. He stated he had never given guidance to any employee at OPC Daytona Beach, or anywhere else, on what to do with patients on the EWL. His role was to create the database, with the information in the computer, and to send that information out for the HAS clerks to review.

- A manager in HAS, Orlando, FL, stated she had never directed any employee to remove a patient from the EWL. When shown an email that another employee provided relating to the removal of patients from the EWL, the manager clarified that there was miscommunication on how notes should be documented within the scheduling system. She also provided detailed background information on the EWL, and information on when/how it was supposed to be used. She explained the role of analysts in creating reports to send out to other VAMC locations that fall under VAMC Orlando, so they could update their EWL and patient appointment database.

Records Reviewed

On June 25, 2014, OIG health care staff reviewed the records of patients identified by Physician 2 at the OPC Daytona Beach and did not identify any harm to the patients.

4. Conclusion

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 OIG referred the Report of Investigation to VA's Office of Accountability Review on September 8, 2014.

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