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

VA Medical Center in Miami, Florida
February 26, 2016

1. Summary of Why the Investigation Was Initiated

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.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** We interviewed one MAS employee, three MAS supervisors, and the VAMC Director.
- **Records Reviewed:** We reviewed records to include a sample of the discontinued consults, VA emails, Clinic Appointment Availability Reports (CAAR), and the VAMC Director's performance ratings.

3. Summary of the Evidence Obtained From the Investigation

Interviews Conducted

- Through a series of interviews with one MAS employee and three MAS supervisors, it was revealed that VAMC Miami Gastrointestinal (GI) Clinic MAS clerks appeared to have discontinued provider consults and scheduled appointments for veterans that they could not contact within 15 days, thereby removing them from the facility's "Access" and Veterans Health Information Systems and Technology Architecture (VistA) "Active" lists. (HVAC staff provided the "double list" allegation.) The individuals interviewed identified a manager who they said directed MAS clerks to discontinue the provider consults. The employees said that some MAS staff questioned the manager's direction to discontinue consult guidance, and the manager responded by explaining that he came from another VA facility, and that they discontinued consults at that facility. The employees stated that the manager was told by the MAS Chief that it was inappropriate to have clerical staff discontinue providers' consults and he subsequently sent an email to MAS supervisors on April 14, 2014, telling them "do not discontinue/cancel any consults from this date forward."

- An MAS employee was contacted to obtain copies of the correspondences that she had with her supervisor and the director, related to the MAS staff discontinuing provider consults at VAMC Miami. She stated that over a 2-week period, she had heated discussions with the manager concerning discontinuing provider consults. She said that she briefed the director about the issue in April 2014.

  The MAS employee subsequently sent an email to the investigator clarifying that her

initial assessment of VAMC Miami's discontinuation of consults was incorrect and that the guidance to discontinue consults was correct and in accordance with VA policy.

The director was asked about his recollection of the MAS employees' assessments of MAS discontinuing provider consults. During a second interview, the director confirmed for the first time that a MAS employee had told him about the supervisor's authorization of MAS staff to discontinue provider consults and that it was not appropriate. He explained that, based upon the MAS employee's assessment of MAS, the medical center took action to ensure consult cancellations were conducted properly. The director provided information showing that 295 MAS employees have scheduling privileges but the number did not include providers (nurses, doctors, and therapists) who also have scheduling privileges.

Records Reviewed

- The VA OIG Office of Healthcare Inspections (OHI) reviewed a sample of the discontinued consults and determined that they were completed properly and in accordance with VA policies.

- Email reviews of MAS management and the director identified no management directed efforts to "game" access. In fact, emails revealed that the director told his staff to fully support and cooperate with the VA OIG investigation.

- A review of the CAAR reports for VAMC Miami identified that MAS clerks engaged in using the clinic's "next available date" as the veteran's "desired date."

- A review of the director's performance ratings did not identify any bonuses or appraisal ratings solely tied to facility access levels.

4. Conclusion

The investigation found that 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 OIG referred the Report of Investigation to VA's Office of Accountability Review on October 28, 2014.

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