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

VA Medical Center in Dallas, Texas March 8, 2016

1. Summary of Why the Investigation Was Initiated

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.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** Based on the allegations and the specific departments identified, we interviewed 19 individuals with direct, supervisory scheduling and training responsibilities relevant to the allegations, a Police Service employee, and the facility Director. We also interviewed seven individuals whose names were provided by Congresswoman Johnson's office.

- **Records Reviewed:** VA OIG reviewed emails.

3. Summary of the Evidence Obtained From the Investigation

Interviews Conducted

- VA OIG interviewed the MAS Chief regarding the allegations of inaccurate wait times for appointments and destruction of records. The chief explained his knowledge of the New Enrollee Appointment Request (NEAR) Report and the Electronic Wait List (EWL). He stated he was unaware of any wait lists used for appointments, other than the EWL.

- During a follow-up interview, he stated he did not provide any guidance, via email, in writing, verbally, or otherwise, to schedulers regarding how to schedule patients or on the use of the "desired date" versus the "next available date" in VistA. Nor was he aware of any of his supervisors in MAS telling any other MAS employees to use next available date instead of desired date.

- He advised that when he reviewed the scheduling training material that a scheduling trainer for MAS employees was using (in the fall of 2013), he found the material contained inaccurate and/or misleading information related to scheduling practices and procedures. Specifically, he saw that at least one of the slides referenced using the next available date as the desired date. Based on his review, he told the trainer to stop using the presentations and to correct them to accurately reflect VA policy according to the Veterans Health Administration (VHA) Directive 2010-027, VHA Outpatient Scheduling Processes and Procedures, dated June 9, 2010. He also stated that he is taking corrective action to address proper training and reduce the amount of individuals with scheduling keys. The manager provided, via email, the two PowerPoint presentations that he said the trainer had used to train new MAS employees on how to schedule appointments.

- An Eligibility/Enrollment supervisor at VAMC Dallas explained that she does not use the NEAR report because she said everyone is assigned to a primary care provider. She uses other tools in the Veterans Health Information Systems and Technology Architecture (VistA) to track the dispositions of enrollment and eligibility. She does not use the EWL function in VistA because that is part of the clinical scheduling function and not part of Eligibility/ Enrollment. Lastly, she has no knowledge of any appointment wait list(s) except what was in VistA/CPRS.

- The OIG investigators interviewed six employees working in various clinics identified through Congresswoman Johnson's office. None of the interviews substantiated the allegations that were received. All six employees denied shredding documents or keeping a secret appointment list. Clinics used locked shred bins for shredding, which is completed through a contracted vendor. According to VAMC Dallas police, no altercation concerning destruction of binders had been reported to them.

- All seven employees identified by Congresswomen Johnson's office were interviewed and stated they had no knowledge of wrongdoing concerning patient appointment records, destruction of patient appointment records, or an incident between staff and management that pertained to scheduling appointments or maintaining secret appointment lists.

- Three scheduling clerks at OPC Forth Worth were unable to provide any information that substantiated allegations of wrongdoing concerning manipulation of patient appointment wait times or scheduling practices.

- The VANTHCS Director was unaware of the destruction of appointment records or of scheduling employees intentionally failing to follow the scheduling policy. He believed there may have been improper scheduling occurring due to lack of knowledge or training. He reported that over the next 4 weeks, employees with scheduling access would receive Talent Management System (TMS) training on scheduling and have the opportunity to talk with a subject matter expert.

- A scheduling trainer was interviewed regarding scheduling practices and manipulation of wait times. He stated that he believed his training accurately reflected VA's scheduling policy. He stated that the PowerPoint presentations that he created and used to conduct

scheduling training reflected both VA policy and VA performance goals. He further stated that the presentations should have focused only on how to properly schedule appointments, per VA policy, and not have mentioned VA's goal of trying to schedule a patient's appointment within 14 days.

Records Reviewed

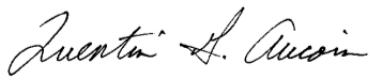
A review of the VAMC Dallas MAS Chief's emails did not identify that he received guidance from upper management or directed lower level supervisors to change and/or manipulate wait times of patient appointments.

4. Conclusion

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.



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