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

VA Medical Center in San Antonio, Texas March 8, 2016

1. Summary of Why the Investigation Was Initiated

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).

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** Interviews included the following individuals; the CC, an associate chief of nursing, an associate chief of staff, a nurse manager, a support assistant, and a director.

- **Records Reviewed:** VA OIG reviewed performance plans, performance appraisals, and emails.

3. Summary of the Evidence Obtained From the Investigation

Interviews Conducted

- VA OIG interviewed the CC at his/her place of residence. During the course of the interview, the CC provided additional information and answered questions regarding the allegation stated above. The CC further related that in February 2013, the HBPC Program had a significant backlog and an employee therefore decided to start using the EWL on his/her own, without obtaining prior approval. In November or December 2013, an associate chief of Nursing and an associate chief of staff told the employee to "get rid of" the EWL. The employee continued to use the EWL, but stopped adding new patients to it. The CC indicated that the employee then began to use an Excel spreadsheet in lieu of the EWL, although, according to the CC, the spreadsheet was not a secret within HBPC, since it was discussed and displayed at weekly meetings every Tuesday morning. In addition, the actual dates reflecting the true patient wait times could be easily tracked in the Computerized Patient Record System (CPRS) because CPRS shows the original dates on which physicians requested an HBPC consultation, as well as the dates of the "pre-admission notes," reflecting when a nurse visit actually took place. The CC did not provide any documentation to support his/her allegations.

- A nurse manager stated that there was never a time during which patients awaiting consults were tracked only by use of a spreadsheet; however, staffing spreadsheets were sometimes used to track the program's workload geographically. She was not aware of any cases in which patients listed on spreadsheets were not also listed on the EWL, if

those patients were required to wait longer than 30 days for an initial assessment. She added that patients were never placed on a "secret" wait list, nor was she ever instructed by anyone that she could not use the EWL. The manager stated that she was not aware of anyone having received these instructions, nor has she personally instructed any of her employees not to use the EWL.

- A support assistant indicated that "upper management" had encouraged HBPC providers to see patients as soon as possible in order to get them off of the EWL. However, no patients were ever removed from the EWL without a consult taking place, nor were spreadsheets ever used in lieu of the EWL.

- An associate chief of staff stated that during the time she was responsible for supervising the HBPC Program (since October 2011), the EWL has been appropriately used on an as-needed basis. She recalled receiving an email from an employee in 2013, in which the employee notified her that due to an increased number of consults, use of the EWL may be required. The associate chief stated that she instructed the employee to begin using the EWL in accordance with the HBPC Handbook. Use of the EWL was discontinued once the HBPC Program was able to fill all of its vacant positions because the EWL was no longer needed to address backlogs. She stated that use of the EWL in the HBPC Program was never prohibited, and she never instructed anyone to use "off-the-books" spreadsheets in lieu of the EWL. She stated that, to her knowledge, none of these improper practices ever took place in the HBPC Program nor were similar allegations ever brought to her attention.

- An associate chief of Nursing stated that she had never prohibited use of the EWL, and that she had always encouraged proper use of the EWL according to program guidelines. She indicated that the associate chief of staff had also encouraged use of the EWL and had never instructed that use of the EWL should be discontinued. The associate chief stated that she never instructed the CC to discontinue use of the EWL and that, to this day, the EWL continues to be used by the HBPC Program on an as-needed basis.

- VA OIG interviewed the STVHCS Director. She denied instructing anyone to manipulate patient appointment data and stated that she had never told anyone that use of the EWL was not permitted. The director indicated that she had never been aware of any secret or off-the-books patient wait lists nor was she aware of any instances in which patient appointments were canceled in order to report better patient access.

Records Reviewed

- VA OIG reviewed performance plans and appraisals for the associate chief of Nursing and the associate chief of staff. The review disclosed that the performance plans did not include any measures or performance objectives pertaining to the use or non-use of the EWL for either employee.

- Emails accounts of an employee and the associate chief of staff were reviewed. No instances were found in which the employees corresponded in regard to the EWL and the review did not disclose anything that would tend to substantiate the allegation.

4. Conclusion

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.

QUENTIN G. AUCOIN
Assistant Inspector General
for Investigations

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