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

VA Medical Center in Huntington, West Virginia
March 9, 2016

1. Summary of Why the Investigation Was Initiated

On May 19, 2014, a former Veterans Affairs Medical Center (VAMC) Huntington, WV, contract psychiatrist was interviewed by Fox News and alleged in a national television interview that veterans committed suicide because they were not given timely follow-up appointments. The complainant reported to Fox News that she would request that veterans be given a follow-up appointment within 10–12 days and noticed that her patients weren't returning. She further reported to Fox News that she discovered her patients were being scheduled several months later for follow-up appointments and at least two of her patients committed suicide while waiting for follow-up appointments.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** Department of Veterans Affairs (VA) Office of Inspector General (OIG) personnel interviewed the complainant.
- **Records Reviewed:** Patient records; records supporting the VAMC Huntington's Issue Brief, (581) V9-05-19-14; and other data relating to follow-up appointments for complainant's patients.

3. Summary of the Evidence Obtained From the Investigation

Interviews Conducted

- In May 2014, VA OIG personnel interviewed the complainant by phone because she was working in another state at the time of the interview. The complainant stated that she was hired by Staff Care, Inc. for locum tenens[*] work at the West Virginia Community Based VA Outpatient Clinic (CBOC) in Charleston, from approximately January 2008 through the spring of 2008. She further stated that she never contacted VA OIG with allegations of wrongdoing by her employers during or after her tenure with VA. She acknowledged that the two veterans she mentioned during her Fox News interview, who allegedly committed suicide, had actually died prior to her employment at CBOC Charleston. When asked, she could not recall the name of any supervisors or colleagues. She stated that she had records available, which consisted of VA emails and memos, to support her allegations. When asked to provide the records, she explained that the records were in a storage unit in Florida and that she was currently living in another state. However, she said that she would try to retrieve the records from storage in the near future. Despite

[*] Merriam-Webster defines *locum tenans* as "a medical practitioner who temporarily takes the place of another." (http://www.merriam-webster.com/medical/locum%20tenens, accessed March 4, 2016)

numerous contacts with the complainant and her husband, whom she requested the VA OIG contact because of her busy schedule, and the eventual issuance of a VA OIG subpoena for these claimed records, the complainant did not produce any records. In response to the subpoena, the complainant submitted a VA OIG "Affidavit of Compliance with Subpoena," which contained this handwritten statement: "No Records available."

Records Reviewed

- VAMC Huntington provided VA OIG with an update to VHA Issue Brief (581) V9-05-19-14, which was dated May 21, 2014. The following is a summary of this update:

  The Decision Support System clinical coordinator pulled a complete list of patients seen by the complainant during her employment at CBOC Charleston. From January 16 through July 22, 2008, the complainant attended to 732 patient appointments. A total of two deaths occurred within her patient population, both due to significant medical issues and did not involve suicide. A review of the 732 patient appointments was conducted and included a comparison between the recorded "desired date" for the appointment and the actual scheduled appointment date. Here are the findings:

  - No delay (zero days) from desired date to the scheduled appointment–649 patients
  - Delay of 1 to 5 days from the desired date–47 patients
  - Delay of 6 to 9 days from the desired date–18 patients
  - Delay of 10 to 15 days from the desired date–8 patients
  - Delay of 16 to 20 days from the desired date–6 patients
  - Delay of 21 to 26 days from the desired date–3 patients
  - Delay of 39 days–1 patient

- VA OIG received records from VAMC Huntington, which were used by the facility to write and submit VHA Issue Brief (581) V9-05-19-14. This review focused on when follow-up appointments were scheduled with the complainant. The review found the following:

  - There were 25 follow-up appointments with the complainant that VAMC Huntington acknowledged were scheduled "Greater than Expected."
  - There were eight instances in which a follow-up appointment with the complainant was not scheduled.
  - There were 32 instances in which the VAMC indicated that the follow-up appointment with the complainant was within the complainant's requested date but was actually beyond the standard requested date. The later appointment date was scheduled because it was the date that the complainant requested to follow up with the patient. The follow-up appointment date exceeded the requested date by 2 days to 2 weeks.

- There were 78 follow-up appointments that were scheduled within the requested date but were canceled by the clinic without explanation. (In the VAMC's Data Summary sheet, it was noted that 76 of the 82 appointments canceled by the Mental Health Clinic were scheduled for July 23, 2008, or farther, after the complainant had left employment at the VAMC. The total of 82 appointments included all appointments that were canceled with and without explanation. It is unclear if the reason these appointments were canceled was because the complainant had left employment and there were no other Mental Health Clinic physicians available for the time scheduled.)
- There were eight instances in which there were no notes or documentation from the complainant.
- There were four instances in which there was no "Return to Clinic" ordered.
- The information reviewed is consistent with VAMC Huntington's Issue Brief (581) V9-05-19-14. The only observation of note is regarding the 78 follow-up appointments that were canceled by the clinic without explanation. It was previously explained by VAMC Huntington senior management that the complainant was never available, which is the main reason she no longer does contract work for VA.

- Documentation regarding the 78 follow-up appointments that were scheduled with the complainant within the requested date but were canceled by the clinic without explanation was requested. The chief of Quality Management advised that it appears the appointments were canceled by the clinic due to the absence of the complainant. She further advised that the appointments were then scheduled with other providers, but the providers were not always another psychiatrist and the appointments may have been with a nurse practitioner. She further advised that she would have the VAMC Huntington Business Office review each of the 78 patient records and provide a reason and the documentation for each of the canceled appointments.

- The additional documentation from VAMC Huntington regarding the follow-up appointments that were scheduled with the complainant within the requested date but were canceled by the clinic without explanation was reviewed. The review found that there were a total of 92 appointments canceled, not 78 as previously reported. The reasons for the clinic cancellations reflect the comments entered into the system by a clerk when the appointments were canceled. The records reflect that the 92 canceled appointments were for these reasons:

  - Clinic profile changed because complainant's clinic moved (from the main Medical Center to CBOC Charleston): three appointments
  - Complainant canceled due to planned or unplanned leave: seven appointments
  - No provider available, patients instructed to contact the Mental Health Clinic (the clinic's phone extension was provided for 29 of the 38 appointments): 38 appointments
  - Per clinic cancellation (no other reason specified): 44 appointments (Note: A subsequent review conducted by VAMC Huntington determined that 23 of the

92 patient appointments were incorrectly listed as "cancelled by clinic." These 23 appointments were corrected by VAMC Huntington to "cancelled by patient," based on a review of the progress notes.)

Only eight of the 92 appointments had a return to clinic date longer than requested by the provider. These eight appointments, for unique veterans, were reviewed in detail and showed the following:

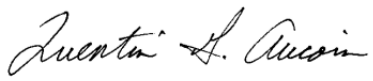
- "Visit 4/16/2008 – Progress note return to clinic in four months, scheduled for 9/16/2008. Wait time greater than expected.
- Visit 4/23/2008 – Progress note return to clinic in three to four months, scheduled for 9/26/2008. Wait time greater than expected.
- Visit 4/23/2008 – Progress note return to clinic in 30 days, scheduled for 06/25/2008. Complainant took leave causing the clinic to cancel the appointment and reschedule. Wait time greater than expected.
- Visit 5/1/2008 – Progress note return to clinic in 90 days, scheduled for 9/12/2008. Wait time greater than expected.
- Visit 5/1/2008 – Progress note return to clinic in five months, scheduled for 11/3/2008. The clinic canceled the appointment because there was no provider. Wait time greater than expected.
- Visit 6/3/2008 – Progress note return to clinic in three to four months, scheduled for 11/3/2008. The clinic canceled the appointment because there was no provider. Wait time greater than expected.
- Visit 6/5/2008 – Progress note return to clinic in eight weeks, scheduled for 8/21/2008. The clinic canceled the appointment because there was no provider. Wait time greater than expected.
- Visit 6/5/2008 – Progress note return to clinic in eight weeks, scheduled for 8/26/2008. The clinic canceled the appointment because there was no provider. Wait time greater than expected."

4. Conclusion

The review did not substantiate the allegation. VAMC Huntington did not experience the delays in providing psychiatric care to veterans, as reported by the complainant. The review further determined that none of the complainant's patients committed suicide while waiting for follow-up appointments.

The complainant alleged that she would request that veterans be given a follow-up appointment within 10-12 days and noticed that her patients weren't returning. Based on a review of this documentation, there is no indication that this occurred. The progress notes entered by the complainant, in which the appointment wait time was greater than expected, appear to have been for follow-up appointments from 30 days to as long as 5 months. Appointments that had requested follow-up times for the patient to return sooner, such as 2 weeks, appear to have been scheduled properly with no wait time issues.

The OIG referred the Report of Investigation to VA's Office of Accountability Review on June 2, 2015.



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