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

VA Medical Center in Memphis, Tennessee
March 10, 2016

1. Summary of Why the Investigation Was Initiated

An anonymous complainant contacted the Department of Veterans Affairs (VA) Office of Inspector General (OIG) Hotline alleging that two senior management employees at the VA Medical Center (VAMC) in Memphis, TN, were changing consultation times to hide the fact that patients were receiving delayed treatment for pulmonary function exams. The complainant also alleged that VAMC Memphis used "bogus scheduling" and "secret lists" to cover the fact that they missed required deadlines.

2. Description of the Conduct of the Investigation

Interviews Conducted: VA OIG interviewed eight VA employees.

3. Summary of the Evidence Obtained From the Investigation

Interviews Conducted

- A clinical associate (CA) at Memphis VAMC stated that when he started several years ago, there was confusion regarding what the veteran's "desired date" was. The schedulers had very little training in terms of how to properly schedule according to desired dates. The CA exchanged emails regarding this issue with a VAMC Memphis Patient Service assistant (PSA) who thought the first available date should be listed as the veteran's desired date. The CA estimated he entered information this way for a few months at the end of 2011 and possibly into 2012. Since then, he has entered in the veteran's desired date correctly. The CA advised that all clinics are entering in the date the veteran states as the desired date. After the story regarding wait lists at VAMC Phoenix[1*] became public, the CA reread the email exchange with the PSA and believes it was a result of different interpretations of the regulations, which were not clear, and not the result of any nefarious activity or an attempt to hide wait list times. The CA repeated he was unaware of any secret wait lists, attempts to manipulate or change data, or any scheduling issues affecting patient care.

- A supervisory nurse (SN) at VAMC Memphis stated she did not have access to software to submit, change, or alter any consults and she was not aware of any delays in service or secret list, and that there were no wait lists for pulmonary function tests and no delay in patient care. She supervised eight Surgical Liaisons in different clinics and she had been assured that there were no wait lists. She explained that scheduling is done in Veterans Health Information Systems and Technology Architecture (VistA). She was not aware of

[*] Any reference to Phoenix in this summary refers to wait time allegations that surfaced at VAMC Phoenix in early 2014.

any delay in scheduling pulmonary function tests because these tests are fee-based out.

- A Patient Service associate (PSA) at VAMC Memphis stated that he had worked at the VAMC for many years and does schedule appointments. He explained that scheduling information is directly input into the computer. He speaks regularly with other schedulers and is unaware of any paper wait lists, secret wait lists, or attempts to manipulate data or other information. The PSA noted the Memphis clinic "finds a way to get veterans treated."

- A senior manager at VAMC Memphis stated that he has not been involved in any way in changing any consults. He stated that the facility is completely transparent and that there are no paper wait lists. He never instructed anyone to change consults to show that patients have not been receiving delayed treatment for pulmonary function exams.

- A senior medical manager at VAMC Memphis stated that she is responsible for making sure that consults are error free, as well as reviewing all non-VA Care matters for clinical appropriateness and safety. She never directed anyone to change consults and that any physician could edit a consult. She was not aware of anyone changing consults to meet any type of metrics nor was she aware of any secret wait lists. She further stated that the access problems VA had were due to the hiring process being difficult and fee basing out services. She explained that about a year and a half prior to the investigation, there was a list in the Business Office regarding mammograms, which she was not aware of it at the time, but learned of later. She addressed the issue with the associate director and the chief of staff and the matter was resolved. They ensured there was no delay in veterans receiving mammograms. She stressed that she had no knowledge of any secret lists at the facility.

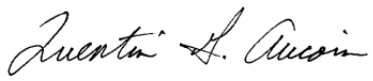
- The Veteran Integrated Support Network 9 Director and Deputy Network Director denied any knowledge of bogus scheduling or secret lists at the VAMC Memphis prior to being interviewed during this investigation.

- The director of VAMC Memphis stated that she had no knowledge of the secret wait lists, bogus scheduling, or changing consultation times for pulmonary function tests.

4. Conclusion

The investigation did not substantiate the allegations that VAMC Memphis changed consultation times to hide delays in treatment for pulmonary function exams and that the facility used bogus scheduling or had a secret list. The investigation found that the first available date was used as the desired date in 2011 and 2012, but the practice had stopped. In addition, approximately 18 months prior to the investigation, there was list of patients needing mammograms that was used outside the appropriate process by the Business Office. The inappropriate scheduling practices for mammograms were resolved before this investigation was initiated.

The OIG referred the Report of Investigation to VA's Office of Accountability Review on February 25, 2015.



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