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

Community Based Outpatient Clinic in Rochester, New York March 15, 2016

1. Summary of Why the Investigation Was Initiated

The investigation was initiated based on information received from a complainant who stated that a medical support assistant (MSA) supervisor at the Veterans Affairs (VA) Community Based Outpatient Clinic (CBOC) in Rochester, NY, asked a subordinate MSA to contact veterans and verify that they still wanted to keep their current appointment date. The MSA allegedly was told that if the veterans wanted to keep their current appointments, the MSA should alter the veterans' "desired date" to reflect the date of appointment, thus creating the illusion that CBOC Rochester was providing medical appointments on the exact date desired by patients.

2. Description of the Conduct of the Investigation

Interviews Conducted: We interviewed four current VA employees during the course of this investigation.

3. Summary of the Evidence Obtained From the Investigation

Interviews Conducted

- An MSA stated that he was given a veterans/patients list by his/her MSA supervisor and had been directed to call specific veterans/patients to advise them that the CBOC could schedule them within 30 days. He/she should then change that date to make it appear as their desired date, thus indicating a zero-day wait time for the appointment. The MSA stated that he/she had called/contacted every veteran on the sheet under his/her responsibility and every one had been satisfied with his/her initial appointment dates. The MSA stated that he/she is not overly concerned with numbers and doesn't necessarily care about supervisory orders, as he/she is more concerned with the veteran being satisfied than anything else.

- An MSA supervisor stated that he/she had given the MSA a document with approximately nine veterans to contact to inquire whether they wanted earlier appointments within a 30-day window. The MSA appeared to understand the task and soon after returned the sheet to the MSA supervisor with the handwritten word "Done" on it. The MSA supervisor thought the MSA may not have had the time to complete it in such a short time but didn't question him any further. The MSA did not ask for any additional clarification on the matter, so the MSA supervisor just assumed the MSA knew what he/she was supposed to do.

- An administrative employee said that he/she understood that some veterans had been called by MSAs to offer them an earlier appointment. When the veterans declined the

earlier appointment date, the MSAs then went ahead and canceled the original appointment, making a new one with the appointment date as the desired date. The employee still did not agree with the desired date and felt this was inappropriate and explained this to the MSA supervisor. The MSA supervisor agreed and informed the administrative employee that he/she had spoken with the MSA along with a manager at VAMC Canandaigua about this matter. The manager agreed with not changing the desired date.

- The VAMC Canandaigua manager corroborated the discussions between the administrative employee and the MSA Supervisor. The manager said there was never anything intentional to try to mislead anyone, including the MSAs. The manager stated that there had been previous issues with the MSA. The manager also voiced concerns that the MSA may not have contacted the veterans as he/she was directed to do so by the MSA supervisor. The manager believed the MSA could not have possibly called all of the veterans in such a short period of time.

- When re-interviewed, the MSA admitted that he/she did not call all of the veterans as directed by his manager and that responses to Office of Inspector General (OIG) questions regarding this matter were not truthful during the first interview. The MSA explained that his/her failure to contact the veterans was laziness on his/her part and was not the conduct he/she normally displayed. The MSA stated that there was confusion on his/her part when it came to the MSA supervisor's directions regarding desired dates and that he/she thought he/she may need more training.

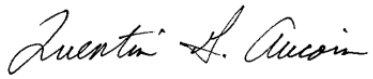
- After re-interviewing the MSA, the manager was apprised of the MSA's admissions. The manager advised that she had already had another MSA call the nine veterans in question who confirmed they had not spoken with the MSA. She also stated that all the veterans indicated they were happy with their originally scheduled appointments.

- The director of VAMC Canandaigua stated that the MSA had been given additional training on the matter.

4. Conclusion

The investigation revealed that an MSA was ordered by an MSA supervisor to contact nine veterans via telephone, but he/she failed to do so. It was determined that the MSA never called or contacted the veterans and lied about it to management and to OIG special agents. The manager suspected that the MSA did not call the veterans and had another employee do so. When the veterans were contacted, they were all satisfied with their original appointment dates and confirmed they had not been contacted by the MSA. During a second interview, the MSA admitted that he/she provided false information to management and VA OIG special agents. Changes to the desired dates made by the MSA were attributed to his misunderstanding of supervisory instructions.

The OIG referred the Report of Investigation to VA's Office of Accountability Review on June 3, 2015.



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