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

VA Medical Center in Durham, North Carolina
April 1, 2016

1. Summary of Why the Investigation Was Initiated

This investigation was initiated based on information received from a Department of Veterans Affairs (VA) Medical Center (VAMC), Durham, NC, employee, who alleged some employees engaged in inappropriate scheduling practices between 2009 and 2012. The employee had provided documentation to the VAMC Durham Director. As a result of the allegations, Veterans Health Administration (VHA) placed two VAMC Durham employees on administrative leave pending a VHA review of the allegations.

These are the issues addressed during the investigation:

- Whether schedulers were using the next available appointment date as the veterans' "desired dates."
- Whether schedulers were instructed to change appointment information.
- Whether an instructor, during a scheduling training class, instructed schedulers to use the "next available date" as the veteran's desired date. As part of the same allegation, an employee attempted to correct the instructor but was stifled by another staff member.
- Whether schedulers in the Primary Care Clinic of VAMC Durham and the Raleigh Community Based Outpatient Clinic (CBOC) were scheduling inappropriately.
- Whether a doctor acknowledged that reports contained "doctored numbers."
- Whether a doctor suggested using a method, referred to as the "special method," to add time to veteran patients' follow-up examinations.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** VA Office of Inspector General (OIG) interviewed the complainant and 58 current and former VAMC Durham employees.
- **Records Reviewed:** VA OIG reviewed, in addition to documents provided by the complainant, training records and materials, functional statements and performance appraisals for 2012 and 2013, documents relating to a congressional referral, appointment data for a specialty clinic, and documents provided by various witnesses.

3. Summary of the Evidence Obtained From the Investigation

Interviews Conducted

- The complainant stated that in 2009 she was instructed by a program specialist and former employee (now deceased) to use the next available date for the desired date. The complainant said she told her supervisor at that time, that it was wrong. Her supervisor wanted her to make the changes in the Veterans Health Information Systems and Technology Architecture (VistA) from the right way to the wrong way of scheduling. The complainant also stated that her current supervisors were still having schedulers use the wrong method. She was familiar with the special method of scheduling based on an email sent by a provider. A copy of that email was provided in the packet the complainant provided to VAMC Durham management. She mentioned two medical support assistants (MSAs) at VAMC Durham (MSA1 and MSA2) who had refused to use the next available date as the veteran's desired date and identified another MSA (MSA3) at VAMC Durham who knew the scheduling practices were ongoing.

  When re-interviewed, the complainant provided additional information about scheduling and stated that MSA1 and MSA2 would be able to provide information about "zeroing out" scheduling practices at CBOC Raleigh and the Primary Care Clinic at VAMC Durham. She had recently been told that the practice of inappropriate scheduling was still happening. She also stated that she overheard a conversation between MSA4 and MSA7 discussing the fact that their supervisor, a lead MSA, instructed them to continue the practice of zeroing out veterans' wait times.

- A supervisor stated that on May 8, 2014, the complainant gave her a packet of information pertaining to scheduling practices and requested to meet with the director. She was familiar with the special method of scheduling because of the information the complainant provided. She said she did not know of any paper waiting lists.

- MSA1 stated she interrupted an MSA training class on June 17, 2013, because the trainer was teaching the improper way of scheduling veterans in VistA. She said when she tried to find a copy of Dr. Schoenhard's memo,[1] a nursing supervisor discouraged her from pursuing the matter further. MSA1 further stated that her supervisor routinely gave a monthly list to MSAs/program support assistants (PSAs) and told them to go into VistA and change the desired date. She provided a packet of information pertaining to this matter that included an MSA Training Schedule dated June 17, 2013, with handwritten notes about those in attendance and a copy of an email series between MSA1 and another MSA (MSA4), wherein MSA1 expressed her concern about scheduling practices.

- MSA2 stated she was first trained in scheduling in about 2006 or 2007, when she was taught to use the next available date for the desired date. She was taught that practice by three individuals whom she identified. MSA2 also identified three VAMC Durham

[1] The Schoenhard memo, *Inappropriate Scheduling Practices*, was issued on April 26, 2010, by VA's Under Secretary for Health for Operations and Management. The purpose of the memo, as detailed in its first paragraph, was "to call for immediate action within every VISN to review current scheduling practices to identify and eliminate all inappropriate practices . . ."

employees who worked in Telephone Care with her as being aware of the practice of using the next available date as the desired date. She said that she notified her supervisor and tried to express their concerns, but the scheduling practices continued. She stated that she was also directed to make changes in VistA to make appointments look like they were made within 30 days of the appointment date when, in fact, they may have been made several months before the appointment date.

- MSA4 stated she was taught the correct way of scheduling appointments while at VAMC Durham. She further explained the training she provided other MSAs was to enter the actual desired date as defined by the veteran; however, she had learned that a lead MSA had been instructing attendees of her training to schedule inappropriately in order to reflect reduced wait times. She provided a packet of MSA training-related documents. Of note were training slides titled, "Day 1 MSA Certification Training," dated March 21, 2013; and a page titled, "Scheduling Tip-Desired Date." Both the slides and the document reflected appropriate scheduling practices.

- MSA5 acknowledged he was taught to enter the next available date as the desired date. He expressed his concerns about unethical scheduling practices to one of the trainers and another employee, both of whom were no longer at VAMC Durham at the time of the investigation. MSA5 stated that both told him to continue with the scheduling practice. According to MSA5, one of the former employees told him a provider ordered her to do it that way also.

- An employee who had been a lead MSA in Telephone Care at VAMC Durham acknowledged he instructed his subordinates to enter the next available date as the veteran's desired date in VistA prior to 2010. When he was employed in Telephone Care, he had concerns about how scheduling was done. He recalled periodically getting paper lists of scheduled appointments and being told to alter the appointments in the computer of those over 30 days. He said he reported his concerns to the service chief, who told him if he did not like the way they were doing it, perhaps he should find another place to work.

- MSA6 stated she was trained to schedule the next available date as the veteran's desired date when she worked in Telehealth. Her supervisor at the time routinely divided lists of veterans who had appointment wait times exceeding 30 days among the schedulers. She said the schedulers were told to go into VistA and change the wait times so as to reflect a wait time within 30 days.

- A clinician in Telehealth stated he never taught an improper way of scheduling. He also denied he was ever present for a class that was interrupted by MSA1 or any other person.

- MSA8 stated she scheduled the way she was taught by always entering the veteran's desired date without regard to what is available.

- A PSA for Home Telehealth, VAMC Durham, acknowledged she was taught prior to 2010 to change the desired date to make the numbers look good. She said she was taught that method by a former employee. She stated that during her training classes she taught

students to enter the veteran's desired date; she also acknowledged she told students that she could not control what the students did when they got back to their workplaces.

- The nurse manager identified by MSA1 denied ever being present at a class that was interrupted because the content was contrary to VA policy.

- A Health Systems specialist identified by the complainant stated her staff should be scheduling appropriately; however, there were some MSAs who had been employed by VA for a long time and they may have been using the old method periodically. She conducted an inquiry and responded to a congressional complaint filed by the complainant. She said there were no findings regarding a trainer teaching the wrong method in scheduling classes. She further stated there was great pressure from VAMC Durham leadership to ensure veterans were seen within 30 days. She vaguely remembered someone advising her some employees were scheduling inappropriately.

- MSA9 stated that a former nurse instructed MSAs to put the desired date in the system as the next available date and to schedule patients within 30 days of the desired date. He stated his supervisors periodically gave MSAs lists of approximately 30 to 40 patients who had appointments 60 to 90 days in the future and instructed them to change the desired date to the next available date, which reduced the wait times of the appointments. He and other MSAs knew this was wrong, but he never complained to anyone.

- A lead MSA confirmed that two individuals (a current and a former employee) instructed MSAs to exit out of VistA after finding the next available date and re-enter VistA, selecting the desired date. She stated the only reason anyone would change the desired date or put it in VistA incorrectly would be to make the numbers look better. She pulled a report about a week earlier and discovered three MSAs were putting the next available date in the system as the veteran's desired date. She sent an email to those MSAs and spoke with their direct supervisor about the issue.

- One of the individuals, identified by others as providing improper training, admitted that prior to 2010, she routinely taught others to use the next available date as the veteran's desired date. She also stated that by teaching those scheduling methods, veterans' wait times were made to appear shorter than they actually were. When she left the position in which she conducted training, MSA7 and a PSA for Home Telehealth took over the scheduling training. She did not have to train them when she left because they were already considered expert schedulers. However, they became experts during the time she had taught scheduling. She said she originally learned scheduling from the former nurse sometime prior to 2010. Any VA staff who used the old, wrong method were not doing it maliciously but were doing what they had been taught.

- MSA10 stated he had been properly trained to schedule veterans' appointments; he further stated he had never used the next available date as the veteran's desired date.

- MSA11 stated he had never been told to change wait times or "game the system" for statistical purposes.

- MSA12 stated he had no knowledge of supervisors guiding MSAs to alter records. He stated there was not an appointment backlog and most patients were scheduled within 14 days. He also stated he entered the desired date correctly.

- MSA13 stated she did not change the desired date based upon VAMC availability; she also stated there was not an appointment backlog. She said most veterans were scheduled around their desired date. She had no knowledge of supervisors guiding MSAs to alter records.

- MSA14 said she had never been told to change wait times or game the system for statistical purposes. Her supervisor, a lead MSA, stressed the importance of using the correct desired date.

- MSA15 stated the desired date was entered correctly and she had no knowledge of employees changing it. She could not recall anyone from MSA training class questioning the scheduling method being taught and she had never heard of anyone altering records in VistA.

- MSA16 stated he did not remember anything strange occurring during his MSA training class. He did not recall anyone questioning MSA training or walking out of training. He said the desired date was not changed based upon VAMC availability; he had no knowledge of supervisors guiding MSAs to alter records. He did not know of any "secret" wait list or special method and was not aware of wait times linked to performance appraisals or bonuses.

- The lead MSA identified by MSA14 stated she had nine MSAs in her clinic and was responsible for their training and evaluation. She confirmed she was instructed to change veterans' desired dates closer to the actual appointment date 3 or 4 years prior to the investigation. She thought those instructions came in an email but did not recall any additional details. She thought the email might have been sent by one of four supervisors at that time. She also said she did not instruct others to change desired appointment dates.

- MSA17 stated she was trained to schedule appointments at another VAMC. She was familiar with the old, improper way of scheduling, but stated the right way of scheduling was stressed at VAMC Durham.

- MSA18 stated she worked in a clinic in which most of her scheduling was based on the doctors' orders.

- MSA19 confirmed she had used the next available date as the veteran's desired date in order to keep appointments with 14 days. She said that she had not scheduled improperly since her last MSA training in either December 2013 or February 2014.

- MSA20 stated she had never been asked to change the desired date or appointment date. She added that veterans usually had to wait about 2 months for an appointment.

- A supervisory MSA stated she was never told nor pressured to use the next available date as the desired date to make a veteran's wait time appear as zero. Although she was taught that method several years ago, after 2010, she had not told any of her staff to use the old method of scheduling. She sent her employees to VAMC Durham's MSA scheduling training to learn the proper method of scheduling.

- MSA21 stated she had originally been taught to use the next available date as the veteran's desired date; however, during the last several years she had been taught to use only the desired date. She could not recall who the instructors were who taught the scheduling course.

- MSA22 said he did not know of any desired date being manipulated to next available date; however, his understanding was that, if mutually agreed upon by the provider and the veteran, the next available date would become the veteran's desired date. He said most patients receive appointments around their desired date. He had not heard of the use of the special method, a secret wait list, a paper wait list, or an electronic wait list. He noted that both Dermatology and Orthopedics had very long wait times for appointments.

- MSA23 remembered attending an MSA training class in the summer of 2013, during which someone interrupted the class to inform the instructor they were teaching the wrong procedures. She did not know the name of the instructor or the person who interrupted the class. There were approximately 20 students in this class, and there were many CBOC Raleigh and CBOC Greenville students attending this class.

- MSA24 said that when she worked in a specialty clinic, as late as December 2013, she was aware of a paper list of veterans to be scheduled. She stated the specialty clinic was still scheduling improperly as of December 2013. In addition, she said her direct supervisor, a lead MSA for the specialty clinic and the clinic's administrative officer, told her to schedule by using the next available date as the desired date, so there would be no wait time. She said the administrative officer wanted the wait times to be zeroed out so the specialty clinic could meet their goals. She went to a June 2013 scheduling class and MSA23 was also present. The instructors were teaching the proper way to schedule. However, when she returned, the lead MSA told her to revert to using the next available date as the veteran's desired date so there was no wait time.

- The lead MSA cited by MSA24 stated that he had always had a wait list. One of the providers brought a list of Plastics patients' backlog charts in January or February 2014. At that time, the backlog charts had been in existence for 1 or 2 years. The lead MSA stated that he suggested to the provider that he coordinate putting the entire backlog onto a spreadsheet to which all the residents, the administrative officer, and she [the provider] would have access. He told the administrative officer to assist in compiling the spreadsheet with two other doctors. According to the lead MSA, the charts were being maintained in a locked cabinet drawer. He said he was told by the provider to get rid of the charts and enter all the information from the charts into a spreadsheet and place it on SharePoint for the specialty clinic residents and lead MSA to access in order to schedule future appointments in VistA. Two other providers were aware of the charts. According to the lead MSA, in April 2014, new guidance forbidding paper wait lists was released

after the issues in Phoenix[2] surfaced. At that time, he recalled there were 23 patients who were past the 90-day wait time on the Microsoft Excel spreadsheet. He instructed employees to schedule those patients immediately as a result of the new guidance. He also said the Excel spreadsheet was still on SharePoint.

- An administrative officer said, "I might have misinterpreted. I might have talked in such a way that they understood that it should be both zeroes. I'm not denying that." He said the only time next available date would become the desired date is if patient and provider agreed to it. The administrative officer for the specialty clinic admitted she would just give the next available date to the veterans. She explained that by doing so, she would allow for a zero wait time to be reflected. She said she was told by the lead MSA that there should only be one wait time. If she had two wait times, the lead MSA would tell her and the other schedulers to correct it by using the next available date as the desired date. She attended scheduling training at VAMC Durham in May or June 2013 and stated that they were teaching the correct way of scheduling. MSAs, schedulers, technicians, and volunteers were used to discontinuing consults that were backlogged. She also stated each veteran should have been called prior to their consults being discontinued; however, when the technicians and the volunteers assisted in the process, she believed the veterans were not called. In addition, she stated veterans were not offered the chance to give a desired date because employees would just give them the next available date. She told the lead MSA about veterans not being called prior to their consults being discontinued, and he told her he would handle it. She had 500 to 600 backlogged consults herself and complained to the lead MSA that it was wrong and he did not give her any more. She stated that there was a spreadsheet on SharePoint, to which doctors and MSAs had access. The Excel spreadsheet was a list of veterans who needed appointments but had not yet been scheduled. She said there was no record of the lists given to employees; however, she was able to retrieve all discontinued consults from May 2013 through December 2013.

- MSA25, who worked in the specialty clinic, stated that during her MSA training class in January 2013, the instructors taught a method that was not compliant with the slides being shown. She and a few other students brought the discrepancy to the instructors' attention. The instructors acknowledged the discrepancy but told them to do the scheduling in the manner they were telling them. She also learned the same method by on-the-job training and being told verbally by the lead MSA, her supervisor. She was told in training and by the lead MSA that the veteran's desired date should always be the same as his/her actual appointment date.

- A provider explained the practice she described as the "special method" pertained to care providers, not schedulers. The suggestion was intended to cause physicians to make a conscientious effort to determine when they need to see a patient for a return visit; rather than habitually scheduling set time frames for follow-ups. The provider suggested that rather than using repetitive blocks of time, such as 1-, 3-, or 6-month follow-ups, physicians should determine if a 5- or 7-month follow-up would be clinically sound.

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

This practice would open up more time in the physician's schedule while having no negative effect on patient care. She reviewed the email message between herself and another employee and admitted she had used a poor choice of words but denied any specific knowledge of anyone manipulating wait times.

- An assistant service chief stated that the director ordered MSAs to have a formal training program in October 2012 and placed a suspense date of December 2012 for it to be implemented. A PSA for Home Telehealth and MSA4 were used to help implement the program. She said that an employee identified by MSA2 had not been present for any training since the formal MSA training began in 2013. She said she had never seen the Schoenhard memo before.

- MSA26, who was assigned to a CBOC, did not recall any disturbance during the MSA training he attended in June 2013. He acknowledged that prior to 2010 at another VAMC, he had been taught WAIT2 should always be zero.

- A supply technician, who was assigned to a CBOC, stated she underwent MSA training at VAMC Durham in the summer of 2013; however, she did not currently schedule any appointments. She did not recall any disturbance during her MSA training class.

- MSA27, who was assigned to a CBOC, stated he had performed scheduling duties since 2010 and attended an MSA training class during the summer of 2013. He did not recall any disturbance during his training class.

- MSA28, who was assigned to a CBOC, said she attended the MSA training at VAMC Durham in August 2013 and denied any disturbance during the class.

- A lead MSA for a CBOC stated she attended MSA training at VAMC Durham in June 2013. She denied that there was any disturbance during the class.

- MSA29, who was assigned to a CBOC, stated she attended MSA training at VAMC Durham in June 2013. She denied that there was any disturbance during the class. She also said that the individual identified by MSA1 as the trainer was not at the training.

- An administrative officer for a specialty clinic denied she ever changed or altered any veteran's desired date. She explained that whatever date the veterans provided was to be their desired date and that WAIT2 would be the wait time from their desired date. She stated she had given the complainant a decreased rating on the scheduling portion of one of her performance appraisals because an audit indicated she potentially "zeroed out" patients' wait times. She noted that the complainant was upset about the rating.

- After interviewing employees who were identified as attending the training during which MSA1 stated that she interrupted the trainer for teaching the wrong method for scheduling, MSA1 was re-interviewed and shown, for the first time, a photograph of the individual she had previously identified as the trainer. MSA1 was unable to identify the individual in the photograph and said she was uncertain about the date of the training. However, when shown a photograph of the training attendees, she confirmed it was the

class she attended, and the class to which she had referred to in prior testimony. MSA1 subsequently contacted the OIG special agent and stated she had been mistaken about the date of the appointment scheduling class she previously described. She said she had found another document that reminded her that the class was actually in 2012 rather than 2013. MSA1 subsequently sent an email stating that the class was held on May 16, 2012.

- A registered nurse stated she suspected Non-VA Care records were being destroyed because she could not locate them after being told they had been sent via fax from case managers at other hospitals. She could not provide any specific instances of anyone destroying records and suspected the administrative officers of the day (AOD) were not diligent in retrieving and following up on the records that came to VAMC Durham during non-business hours.

- A provider explained that he did not know who coined the term "special method," and added that he had learned that another coworker had used that term. He explained that what has been referred to as the special method was a suggestion of a way to increase availability in physicians' services without compromising any clinical care of veterans. He denied that he ever had any issue with the rehabilitation specialist and that he never threatened the rehabilitation specialist's employment should that individual continue the unethical scheduling. He also denied he ever directed anyone to use any unethical scheduling practices. The provider subsequently sent an email that contained a file titled, "Follow up to interrogatory." He stated that "on continued reflection and asking for validation from others, I just can't come up with anything that supports the allegation you shared with me."

- When presented with the allegations pursued during the investigation, the Senior Leader 1 stated he did not have any prior knowledge of any of the allegations.

- Senior Leader 2 was presented with the allegations examined during this investigation. She started at VAMC Durham in June 2012 and noted during her initial evaluations of VAMC Durham programs that scheduling was an area that needed improvement. She directed the development of a robust scheduling training and set a deadline of November 2012 for its implementation. When she first learned of the complainant's allegations, she reported them to the Senior Leader 1 and they further made notifications to the VA Central Office. She also stated that she was previously interviewed by personnel in VA's Office of Accountability Review.

Records Reviewed

- A file provided by the director's office that was submitted by an MSA at VAMC Durham contained these items of particular interest:

    - An email dated April 14, 2009, from a program specialist in Ambulatory Care Service, and which contained instructions to "VHADUR [VHA Durham] Schedulers" on how to schedule appointments and referenced a Veterans Integrated Service Networks (VISN) goal of seeing patients within 30 days of the veterans' desired

appointment dates.

- An email from a provider, wherein she acknowledged she did "realize that there is some cooking involved," in response to a suggestion from another employee that the Primary Care Clinics' availability statistics were "doctored numbers." In that same email exchange, the provider stated, "When vets agree to a next available PCP [Primary Care Provider] appointment (Is there any other choice?), we've been told to put this in as the desired date making the wait time zero."

- The director's office also provided a copy of a VHA Issue Brief titled, *Reported Concerns Regarding Scheduling Practices*, with fax cover sheets indicating it was successfully sent to Senior Leader 3, and a Report of Contact with the complainant, in which the complainant reportedly acknowledged she was trained in her most recent MSA training to correctly schedule veterans' appointments, but she indicated she suspected some MSAs at CBOC Raleigh and the Primary Care Clinic of VAMC Durham were not properly scheduling veterans' appointments.

- The director's office provided a packet of Scheduling Training documents that contained training slides dated May 8, 2014, and pertained to scheduling veterans' appointments in VistA. A slide on page 16, titled "Electronic Wait List" (EWL), indicated the EWL was the only official wait list and would be used only if the appointment could not be scheduled within 90 days of the veteran's desired date. Another document titled, *Scheduling Tip-Desired Date*, described the difference between Next Available Appointments and Not Next Available Appointments and what is and what is not a desired date. The last bullet on the documents shows, "The desired date is not the date agreed to by the patient for lack of an earlier appointment but rather an authentically patient-requested desired date."

- The director's office provided copies of Functional Statements–Medical Support Assistant, GS-0679-05, Ambulatory Care Service Line, and a template of VA Form 0750, *Performance Appraisal Program for MSAs*, dated August 7, 2012, and February 19, 2013. Both sets of documents listed Appointment Scheduling as a critical element under the "Performance Elements/Standards" section.

- The director's office provided copies of performance appraisals for the complainant and two MSAs for fiscal years (FYs) 2008, 2009, 2010, and 2011 showed Performance Elements/Standards of a "30-day rule for appointments in open access" for October 2008 through September 2010 and a "14-day rule for appointments in open access" for October 2010 through June 2012. The records did not indicate that these three individuals received awards for meeting these goals.

- The director's office provided a series of emails pertaining to the response to complainant's congressional complaint to the office of then-U.S. Senator Kay Hagan.

- The director's office also provided another series of emails pertaining to complainant's disagreement with the response to her congressional complaint.

- The manager, Talent Management System, provided a list that contained names of individuals who attended MSA training during the class held from June 17, 2013, through June 20, 2013. MSA1's name was on the list and other names on the list appeared to match the names MSA1 wrote on the class schedule, dated June 17, 2013, she provided.

- The lead MSA provided documents relating to scheduling practices to show that she had been identifying scheduling mistakes and correcting those mistakes. A review of the documents confirmed that the lead MSA had been identifying and correcting mistakes as she found them.

- The lead MSA for a specialty clinic provided documents relating to appointments scheduled in the specialty clinic on May 20, 2014. Of the 196 appointments scheduled during that time frame, all reflected a WAIT2 of "0." The lead MSA also provided 81 pages of appointments that had been discontinued in the specialty clinic from May 1 through December 26, 2013.

- VA OIG contacted a random sample of veterans who had scheduled appointments at VAMC Durham a specialty clinic. Below is a synopsis of the conversations with the veterans, or their spouses, if the veterans were unavailable.

  - Seven veterans (or their spouses) reported positive experiences with VAMC Durham. All advised they had no issues with either the care they received or scheduling/wait time.
  - One veteran stated he had specialty surgery and after he was cleared, he was told he would have to wait a year to be seen, which caused him concern. He was told he would be sent a letter with his appointment date, which he was. However, he received another letter stating his appointment had been canceled and he had to call and make another appointment.
  - Another veteran advised his care at the VAMC Durham specialty clinic was satisfactory; however, he did report he was not happy with the 2-month wait time to see his Primary Care physician.
  - The last veteran stated that when he made an appointment at the specialty clinic, he was not asked when he wanted to be seen, he was just told when the next available appointment date was to be; however, he did not find this to be an issue or an inconvenience.

- A review of information contained in the Executive Career Field (ECF) Performance Measures received from the director's office identified the following:

  - In the FY 2011 ECF Word document, page 3, Performance Objective (PO) 3 and PO4 have directions for each Network [VISN] to monitor for veterans with wait times in excess of 14 days from the veterans' desired dates.

- In the FY 2012 ECF document, element 1, paragraph 1.4, discusses implementing the Patient Aligned Care Teams (PACT); and element 5, paragraphs 5.2b and 5.4g, both place emphasis on a 14-day threshold for wait times in Mental Health.
- In the FY 2013 ECF document, element 5, paragraphs 5.2b and 5.4g, references are made to 14-day wait times.

- Emails provided by an administrative officer for a specialty clinic included some that were pertinent and predated the initiation of this investigation, in which she specifically denied ever instructing anyone to change wait times or to schedule veterans' appointments in any unethical or illegal manner.

- Documentation provided also showed that an administrative officer for a specialty clinic counseled the complainant on scheduling inappropriately.

Patient Harm

During the investigation, it was reported in the press that a veteran had died because there was an 8-month delay in scheduling a colonoscopy. This matter was the subject of an inspection by the VA OIG's Office of Healthcare Inspections.[3]

4. Conclusion

The investigation did not substantiate all of the allegations as presented by the complainant. Investigation determined that the first available date was used as the veteran's desired date prior to the issuance of the Schoenhard memo. Subsequent to the memo, this practice was greatly diminished and a training program was developed and used to ensure scheduling was completed appropriately.

[3] A report, issued on November 6, 2014, *Healthcare Inspection – Alleged Delay in Gastroenterology Care, Durham VA Medical Center, Durham, North Carolina*, Report No. 14-03298-20.

The OIG referred the Report of Investigation to VA's Office of Accountability Review on August 9, 2015.

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