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

VA Medical Center in West Haven, Connecticut
April 6, 2016

1. Summary of Why the Investigation Was Initiated

This investigation was initiated by a news report, which ran in Connecticut on television station WTNH, alleging that a veteran was denied certain VA care following a breast cancer diagnosis and ultimately resulting in the veteran's developing ovarian cancer. The veteran claimed her appointments were scheduled and then canceled for unknown reasons and, consequently, she ended up with a cancer that could have been prevented. Another segment of the same news report featured an interview with a former Department of Veterans Affairs Medical Center (VAMC) employee whose identity was kept anonymous and who described the VA scheduling process as dysfunctional. For example, a scheduler would be handed a stack of patient files and told to cancel more than a third of their associated appointments without knowing the details of each case.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** The Department of Veterans Affairs (VA) Office of Inspector General (OIG) identified and interviewed the anonymous former VAMC employee from the news report.

- **Records Reviewed:** VA OIG reviewed medical records associated with the veteran's VAMC appointments from 2008 through 2014.

3. Summary of the Evidence Obtained From the Investigation

Interviews Conducted

- The former VA employee who appeared in the WTNH news story was subsequently identified. When interviewed, the former employee advised that she had not worked at VAMC West Haven. Instead, the former employee worked at a different VAMC between 1992 and 2000 and had no information regarding current scheduling practices. The former employee, who was also a veteran receiving care through VA, stated that VA was now more customer service-oriented than when she was an employee.

Records Reviewed

- A review of the veteran's appointment history at the VAMC from January 2008 through September 2014 disclosed there were no appointments canceled relating to care for her cancer condition. The veteran had a total of 294 appointments in that time frame of

which 19 were canceled by the VAMC. Of the 19 cancellations, three were for Plastic Surgery; three for Podiatry; four were dental appointments; three were for Cardiology; three for Primary Care; two for Gastroenterology; and one was an Ear, Nose, and Throat appointment. VA OIG Office of Healthcare Inspections reviewed the 19 cancellations and found no connection between the cancellations and the veteran's eventual diagnosis of metastatic cancer.

4. Conclusion

The investigation did not substantiate the claims made in the WTNH news story. The anonymous former VAMC employee interviewed in the news story was determined to have been an employee at a different facility from 1992 to 2000 and had no information concerning current VA scheduling practices.

A review of the veteran's records failed to show a connection between any cancellations of appointments and the spread of her cancer.

The OIG referred the Report of Investigation to VA's Office of Accountability Review on October 16, 2014.

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