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

VA Medical Center in Washington, District of Columbia
November 29, 2016

1. Summary of Why the Investigation Was Initiated

This investigation was initiated by an unannounced site visit that a Department of Veterans Affairs (VA) Office of Inspector General (OIG) investigator conducted at the VA Medical Center (VAMC) located in Washington, DC, on May 4, 2014. This allegation addressed that VA employees might be shredding documents related to excessive patient wait times.

During the site visit, the VA OIG investigator found no evidence of document shredding; however, the investigator discovered Lead Medical Support Assistant (LMSA) 1 working on a Microsoft Excel spreadsheet that contained information generated from a new enrollee appointment request (NEAR) list. This NEAR list contained the names of veterans who had requested Primary Care appointments at the facility. A former VAMC senior leader had provided similar Microsoft Excel spreadsheets to several VAMC Washington employees. These employees were tasked with determining whether the veterans found on the NEAR list and who had requested Primary Care appointments actually received Primary Care treatment at VAMC Washington.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** We interviewed schedulers, supervisors, management officials, administrative employees, and medical care providers.

- **Records Reviewed:** We reviewed VA emails, training materials, internal messages, and clinical information associated with three veterans' deaths.

3. Summary of the Evidence Obtained From the Investigation

Issue 1: Investigation of the NEAR List and Manipulation of Patient Wait-Time Data

Interviews Conducted

- LMSA1 stated that a (now) former VAMC senior leader had instructed several of his subordinates to review a list of approximately 2,300 veteran patients to determine the status of their requests for Primary Care appointments. He stated that he and his coworkers were to determine if veteran patients on the list had received VA treatment. If not, the team members were to determine what reason was noted in the Veterans Health Information Systems and Technology Architecture (VistA) records. He stated that he was working on a Sunday because he and his coworkers were authorized overtime to

work on this project. He stated that he had no knowledge as to why he was tasked with this project or why the records of these specific veteran patients needed review. He stated that he was unaware of anyone shredding documents. He also stated that he had the ability to schedule patients in VistA, but he had not scheduled an appointment related to this project, and that he had no knowledge of the NEAR list.

During a follow-up interview, LMSA1 stated that in the spreadsheet he was working on, the "1010EZ" [VA Form 10-10EZ, "Application For Health Benefits"] column indicated the date that the veteran electronically applied to receive an appointment date with a Primary Care provider. LMSA1 also stated that where it indicated "N/A" in the "Scheduled Appointment Date" column, VistA and the Computerized Patient Record System (CPRS) had no records of any scheduled appointments. He stated that he did not know why veterans did not receive a follow-up appointment. He further stated that he did not know if anyone "dropped the ball" about contacting the veterans for follow-up appointments and that he only did what was asked of him concerning these tasks. He also stated that he did not know of any instances of employees manipulating "desired dates" to make overall wait times appear shorter.

- LMSA2 stated that the former VAMC senior leader had tasked him with reviewing a spreadsheet that contained information aggregated from the NEAR list. He stated that he never had an opportunity to work on the spreadsheet. He added that he had no knowledge or information about any schemes or rumors concerning employees who were manipulating wait time data.

- LMSA3 stated that she was familiar with scheduling practices and described them as "very difficult." She added that, historically, a culture existed among all VAMC Washington schedulers in which schedulers made the desired date the same as the appointment date. She stated that this practice was passed down from scheduler to scheduler through hands-on training, and that she personally learned it in approximately 2009. She also stated that this was most likely done in order to meet the "14-day rule." She stated that she suspected management was aware of the practice; however, she could not say for sure that management officials actually knew it was occurring. She stated that sometime in 2010 or 2011, management officials eventually told them to stop this practice, but she could not recall who specifically gave this order. She stated that an administrative employee also told the schedulers that the practice of making the desired date the same as the appointment date was not proper, and the administrative employee provided training on how to properly schedule. She stated that the former VAMC senior leader tasked her with reviewing the NEAR list for veterans who did not receive an appointment, and reporting her findings to him as soon as possible. She stated that this was the first time she heard about the NEAR list.

- A supervisory Medical Support Assistant (MSA) stated in May 2014 that the former VAMC senior leader tasked her with determining if VAMC Washington contacted the veterans on her assigned list and if these veterans had received an appointment. She stated that she was told at that time that this assignment was part of the NEAR list review. She added that this was the first time she heard about the NEAR list. She stated that for each veteran appearing on the NEAR list she was provided, she checked CPRS

and VistA for any notes or comments. She stated that she had no knowledge or information about any schemes or rumors concerning employees who were manipulating wait-time data. She stated that she reviewed her subordinates' work and had not seen any practice in which her subordinates had maliciously altered a veteran's scheduled appointment date.

- A service director stated that she managed the NEAR list until approximately 2011. She stated that, at that time, service chief 1 told her that the NEAR list was going to be managed from a central location out of Atlanta and would no longer be under her management. She added that when she was in charge of the NEAR list, her team would contact the veterans to schedule an appointment as soon as the team received their information. In response to a statement that the results of the recent NEAR list review seemed to indicate that there were veterans who had not received follow-up contact from VA, she stated that when it was under her supervision, the NEAR list was managed properly. She further stated that she had no knowledge of any schemes involving VAMC Washington employees who were manipulating wait-time data.

  During a follow-up interview, the service director stated that she first heard about the NEAR list in approximately 2007. She added that, at that time, she and her division were tasked with providing oversight regarding the list. She further stated that her staff would run reports of the NEAR list and call the patients to schedule appointments. She stated that she asked for weekly reports on the NEAR list, adding that, in approximately 2011, she attended a "morning report," also known as the director's meeting, during which she was directed to discontinue monitoring the NEAR list because it was going to be centrally monitored from a VA facility out of Atlanta, GA. She stated that she was told this by either service chief 1 or service chief 2. She also stated that she met with a former VAMC senior leader about the NEAR list after her first interview with VA OIG. She stated that during the meeting, the former VAMC senior leader said that "they" needed to clean up the NEAR list. She also stated that the former VAMC senior leader did not ask questions about why the NEAR list went unmonitored for several years (2011 to 2014). The service director denied that she was part of any previous meeting in which she, service chief 1, VAMC executive 1, and VAMC executive 2 were participants.

- Service chief 1 stated, when interviewed in 2014, that he had been placed in charge of the NEAR list; however, he was detailed to a new position following his request for a transfer. He stated that monitoring the NEAR list was typically a responsibility of a different office, but the former VAMC senior leader had recently assigned that responsibility to his (service chief 1) office. He stated that prior to being placed in charge of this list; he had not heard of or managed the NEAR list. He stated that when he was shown the NEAR list, he was shocked to see that more than 2,000 veterans had not received an initial appointment with a Primary Care physician. He stated that it was clear to him that the NEAR list had not been managed for some time.

  When re-interviewed, he stated that he first heard of the NEAR list from VAMC executive 1 about a week prior to his aforementioned interview with the OIG in May 2014. He stated that VAMC executive 1 had told him that the NEAR list had "not been run in a couple of years." He added that during this same conversation, VAMC

executive 1 stated that the service director told him (VAMC executive 1) that he (service chief 1) had told the service director to stop monitoring the NEAR list. He stated that he had previously participated in a meeting with the VAMC executive 1, VAMC executive 2, and the service director. He stated that in this meeting, the service director explained that she could not remember who gave her the order to stop monitoring the NEAR list. He stated that he did not tell the service director to stop monitoring the NEAR list. He reiterated that the first time he ever heard of the NEAR list was when VAMC executive 1 told him about it in approximately May 2014.

- A former VAMC senior leader stated that he was made aware of the NEAR list when he received an assignment from VA Capitol Health Care Network, Veterans Integrated Service Network (VISN 5). He stated in May 2014 that he was tasked to review VAMC Washington's NEAR list to determine how many veterans on the list had not received an appointment. He stated that until he received this assignment from VISN 5, the responsibility to monitor the NEAR list was the duty of the service director. He also added that the service director told him she had been responsible for monitoring the NEAR list until she was told to no longer do so in 2011 by an unnamed individual from VA Central Office. He stated that when he first ran a NEAR List report, it revealed that the list had not been managed since approximately 2006. He stated that approximately 2,200 veterans had not been contacted for an initial appointment by VAMC Washington. He stated that he was given permission to authorize overtime to employees who would assist him in filtering through the NEAR list to identify those veterans who did not receive an appointment. He stated that he reported these findings to VAMC executive 2 and VAMC executive 3. He also stated that a former service chief and VAMC executive 3 had argued about whose responsibility it was to monitor the NEAR list.

  The former VAMC senior leader stated that he was placed in charge of a plan to reconcile which patients had not received contact from VAMC Washington after it was requested. He also stated that action on the initial NEAR list from May 2014 had been completed around the end of July 2014. He explained that for each patient, VAMC Washington attempted three phone calls and also sent a notification postcard. He stated that once 30 days had passed from the last attempt at communication and no response had been received from the veterans, the request was removed from VistA.

- A VISN senior leader stated that a former VISN executive leader had directed her to investigate the current state of NEAR lists that fell under VISN 5. She stated that service chief 2 told her that the report had not been run in "a while." She added that, based on the numbers reported to her, she believed that there were approximately 2,000 veterans on VAMC Washington's NEAR list who had requested appointments but had not received follow-up contact from the facility. She also stated that the former VAMC senior leader indicated to her that approximately three veterans on the NEAR list who had not received follow-up contact were now deceased.[1] She stated that someone from VAMC Washington should have monitored the NEAR List; she did not believe that the

[1] VA OIG's Office of Healthcare Inspections reviewed the available records pertaining to these deaths. Their review is discussed in the Records Reviewed section

NEAR List was ever supposed to be monitored from a central location, as claimed by the service director, because she had heard no indication of such.

- A confidential source (CS) stated that the NEAR list contained the data of veterans who enrolled online for VA medical care. CS stated that at the end of the online enrollment application, the veterans were asked if they would like to schedule an appointment. CS also stated these appointment requests were compiled into the NEAR list and that this list had to be monitored by the service director to ensure that a VA employee contacted the veterans. CS added that approximately 1 month before this interview (conducted in June 2014), the service director told them that she (the service director) should have been managing the NEAR list. CS further said that the service director also mentioned something about not having monitored the NEAR list for approximately 3 years. CS additionally stated that they discovered that the NEAR list report contained approximately 2,200 veterans who had not received follow-up contact by VAMC Washington. Moreover, CS said that VAMC executive 2 was notified of the 2,200 veterans who had not received follow-up from VAMC Washington. CS explained that during a "Quadrat" (senior level VAMC Washington employees) meeting, it was expressed that the NEAR list responsibility was going to be henceforth monitored by a different office. Finally, CS stated that he/she had no knowledge of any schemes involving VAMC Washington employees who were manipulating wait-time data.

- VAMC executive 1 described the NEAR list as the process during which veterans can apply for enrollment at a VA facility and request an appointment; if they ask to be seen, the request is sent to "Atlanta." When asked why the NEAR list was not monitored for several years, he stated, "I can't give you a definitive answer." And, "I think the process just slipped . . . I don't know why we didn't see them." He added that he believed that VAMC Washington did, in fact, treat many of these patients. He further stated that if the veteran did request to have an appointment, that it was "our" responsibility to fulfill this request as soon as possible. He stated that once the NEAR list issue was discovered, there was an aggressive plan put into action to correct the problem. He added that the service director and her group were in charge of routinely monitoring the NEAR list, but at some point they stopped monitoring the list; he added that he was unsure of what the service director was doing to actually monitor the list. He further said that he was told by the service director that an outside VA facility was going to take over monitoring the NEAR list, but he did not further investigate the details. He added that he was unsure when the service director told him this. He noted that he had not seen any evidence that corroborated the service director's claim that she was told the NEAR list was going to be monitored from a VA facility in Atlanta. Moreover, he stated that he did not know who was responsible for the NEAR list being unmonitored for several years. Finally, he said that his primary goal was to reduce and reconcile the backlog, and that he took the service director's word that she was told that the list was going to be monitored from a separate facility. At the time of this interview (April 2015), VAMC executive 1 made it clear that the NEAR list was being monitored on a daily basis.

- The executive assistant stated that he doubted that it would have been a duty of the service director to actually monitor the NEAR list. The executive assistant also stated that he was told by administrative employee 2 that a different office was responsible for

monitoring the list and was accountable for the list going unmonitored. He added that he did not know who was supposed to monitor the NEAR list.

- VAMC executive 2 described the NEAR list as an electronic process to enable a new VAMC enrollee to request an appointment. He stated that the information can come from VA's Health Eligibility Center or from a veteran walk-in; he added that he did not know all the "ins and outs" of the NEAR list. When asked why these veterans were not contacted by VAMC Washington for an initial appointment, he answered, "I don't know." He indicated that unless something arose to a level requiring that he be notified, he would not know certain things that are happening at VAMC Washington. He stated that he did not know why the NEAR list was not run for several years; he did not even know what the NEAR list was until it became a problem. He stated that once he found out about the problem with the NEAR list, he corrected it. He further stated that he did not know how many veterans were unreachable on the original list. He added that, in 2014, the service director was in charge of the NEAR list. He stated that he was unsure who "dropped the ball" by not monitoring the list. He did not recall anyone telling him that the NEAR list was supposed to be monitored from another facility in Atlanta.

- Service chief 2 stated that she did not know why the NEAR list went unmonitored for several years. She stated that it was her understanding that the service director was in charge of the NEAR list up until the time of her retirement.[2] She stated that she never told the service director to stop monitoring the NEAR list because it was going to be monitored from a location out of Atlanta, GA. She stated that she had no knowledge of any schemes involving VAMC Washington employees who were manipulating wait-time data.

- A former VISN executive leader stated that he first became familiar with the NEAR list when he found out about the allegations coming from VAMC Phoenix.[3] He stated that a VISN senior leader developed a "daily report" for the NEAR lists within his VISN, which was used to monitor the NEAR lists in real time. He stated that VAMC Washington's NEAR list had been mismanaged and the information that it represented was inaccurate. He further stated that his immediate reaction—when he discovered that there were problems—was to ensure that patients were receiving care and that the NEAR list reflected accurate information. He stated that he could not recall which employees specifically were responsible for the list. He added that he had no knowledge or information concerning the manipulation of wait-time data or malicious scheduling practices at VAMC Washington.

- VAMC executive 3 stated that the NEAR list went unmonitored because the service director was told that she no longer needed to monitor the list. He also stated that he heard this information in a meeting from the service director, who could not remember the individual who told her to stop monitoring the list. He stated that "thousands" of veterans did not receive initial contact from VAMC Washington to schedule an

[2] The service director retired during the course of the investigation.
[3] Any reference to Phoenix in this summary refers to wait time allegations that surfaced at VAMC Phoenix in early 2014.

appointment. He further stated that addressing the backlog of patients who were not contacted was a priority. He stated that he had no knowledge or information concerning VAMC Washington employees deliberately hiding or manipulating wait time, desired date, or NEAR list data.

- VA OIG special agents interviewed six VAMC Washington service line chiefs. None of these interviewees indicated that they were directed by upper management to manipulate wait time data.

- An MSA, when asked whether desired dates were scheduled on the same date as the actual appointment to ensure the "numbers looked good for VA," responded "probably." He did not provide any specific information.

- Nine additional employees interviewed stated that they did not have any knowledge of or information concerning activity associated with intentional manipulation or hiding wait time data. The interviews disclosed that there were multiple methods of scheduling training and practices at VAMC Washington and that interpretation of scheduling policies, specifically desired date interpretation and negotiation of the desired date with veterans, varied among employees. Several employees indicated that clerical errors existed due to antiquated and confusing scheduling software.

Records Reviewed

- VA OIG reviewed email provided by a quality management coordinator, at VA OIG's request, concerning the three veterans on the May 2014 NEAR list who had died before being contacted for an appointment. Review disclosed that two of the veterans had no record of a Primary Care team assignment and no record of a Primary Care provider assignment. The third veteran was seen at another VA facility for examinations due to Compensation and Pension (C&P) claims. The records further indicated that this third veteran was receiving medical care outside VA and: (1) had medications on file prescribed by the Annapolis Navy Medical Clinic; (2) was seen at a Department of Defense Military treatment facility in 2011, and (3) was seen at the National Naval Medical Center, Bethesda, MD, in 2006.

- VA's Office of Healthcare Inspections (OHI) reviewed the limited medical information available in VA's systems and the death certificates for the three veterans. OHI's review found no evidence that VA's failure to contact these veterans for appointments contributed to their deaths. Regarding the veteran who was seen for a C&P exam, OHI's review determined that the veteran had requested a rating decision for an increase due to heart disease and several other issues. Regarding the heart disease, the veteran was already under the care of a private cardiologist. The other issues were non-urgent diagnosis. There was nothing in the information obtained that indicated the veteran's death was connected with his being on the NEAR list.

- VA OIG reviewed an email containing an action item order from the VISN senior leader. In this electronic message, which was dated May 1, 2014, the VISN senior leader directed the former service chief to run the NEAR list dates from

January 1, 2000, through April 30, 2014. The order then showed that once the list had been run, the former service chief should review all patients on the list to see which had not received an initial appointment and to remove those who had had appointments.

- VA OIG reviewed a scheduling training guide, which consisted of definitions of various wait lists, various scheduling policies, and instruction on how to properly schedule patients using the scheduling package within VistA.

- VA OIG reviewed emails belonging to the former VAMC senior leader, the service director, VAMC executive 1, service chief 1, administrative employee 2, and VAMC executive 2. The review disclosed that while there was ample discussion of wait times, the NEAR list, and electronic wait lists, there were no emails found that were indicative of the deliberate manipulation of wait-time or NEAR list data.

- VA OIG reviewed internal VistA messages belonging to the service director, service chief 1, VAMC executive 1, service chief 2, administrative employee 2, and VAMC executive 2. The review did not reveal any evidence indicative of the deliberate manipulation of wait-time or NEAR list data.

Issue 2: Non-standard scheduling practices at VAMC Washington

VA OIG special agents interviewed VAMC Washington employees who were associated with scheduling within the facility, who had scheduling as part of their official duties, or who provided oversight to other employees who had scheduling duties. These interviews revealed that scheduling training and practices, along with general knowledge of scheduling policy, were not standardized throughout VAMC Washington. These interviews further revealed that training was provided by official training, Talent Management System (TMS) training, and/or other informal training, such as learning "on the fly."

- Administrative employee 1, stated that "TMS . . . scheduling training is too much for a new person to our VA system." She also stated that "Schedulers are confused on how to schedule because of the rules with desired dates."

- Lead MSA3 stated that the scheduling practices were challenging.

- Program Support Assistant (PSA) 1 stated that training was not in line with Veterans Health Administration policy.

- PSA2 stated that there was "no formal training."

- Service chief 4 stated that desired date policies "are a little bit confusing" and "not well written."

During the aforementioned interview of a former VISN executive leader, he stated that various scheduling practices were occurring throughout VISN 5 and that ensuring standardization efforts were a continuous process.

Issue 3: Pen and Paper Wait List Use by a Specialty Service

Service chief 4 stated that within VistA, there is a specialty scheduling package known as the "wait list." He stated that neither he nor his subordinates had access to this program. He stated that because they did not have access, they resorted to "pen and paper wait lists" to keep track of veteran patient schedules. He also stated that by using the pen and paper wait list, there was no effective way to monitor exactly how long a veteran patient had been waiting to be seen by a provider. At the time of this interview (June 2014), he stated that he had initiated action to get his schedulers access to the "wait list" scheduling package within VistA.

- During the aforementioned interview of VAMC executive 1, VA OIG agents told him that a specialty service was maintaining a paper wait list because service chief 4 and his schedulers did not have access or the training to use the electronic scheduling package. VAMC executive 1 stated that he was unaware of these circumstances.

- VAMC executive 2 stated that he "was aware of this lame excuse." He stated that he had counseled the specialty service that the paper wait list was inappropriate. He added that once he found out about the use of a paper wait list, he took immediate action and had the specialty service's employees properly trained.

- The former VISN executive leader, he stated that he did not recall anything about the specialty service having to use paper wait lists to monitor patient appointments.

4. Conclusion

VA OIG found that the NEAR list had not been actively managed for approximately 8 years (2006–2014), which resulted in 2,228 veterans not receiving their requested initial contact from VAMC Washington. We were told that the service director was responsible for monitoring the NEAR list. The service director stated that she was told to stop monitoring the NEAR list; however, investigation could not confirm her statement. The service director retired during the course of the investigation. When VAMC Washington senior staff discovered that these veterans had not been contacted, the facility developed a plan to identify all of the veterans who were on the list but did not have any appointment history.

The investigation determined that three of the veteran patients on the NEAR list who had never been contacted by VAMC Washington had died. The information revealed that one of the veterans had been seen for C&P examinations (which are not diagnostic examinations) at VAMC Baltimore, MD, and had received treatment from various non-VA medical facilities. OHI's review of this veteran's limited medical information contained in the C&P file did not disclose any indication that the veteran's death was connected to his being on the mismanaged NEAR list . Based on a review of the death certificates and the limited information available in VA's system, OHI found no evidence that VA's failure to contact these veterans for appointments contributed to their deaths.

VA OIG found that scheduling training and practices, along with general knowledge of scheduling policy, were not standardized throughout VAMC Washington.

VA OIG found that a specialty service was using a paper wait list. When VAMC management discovered the use of this wait list, its use was stopped and the specialty service employees instructed on proper use of the scheduling system.

VA OIG referred the Report of Investigation to VA's Office of Accountability Review on June 8, 2016.

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