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

VA Medical Center in Gainesville, Florida
November 29, 2016

1. Summary of Why the Investigation Was Initiated

This investigation was prompted by a complaint submitted to the Department of Veterans Affairs (VA) Office of Inspector General (OIG) Hotline. The anonymous referral alleged that the former chief, Outpatient Anesthesia Service Pain Clinic, VA Medical Center (VAMC) in Gainesville, FL, had instructed scheduling staff and physicians to delay or spread out scheduling patients so the wait list would not be affected. It was further alleged that this action resulted in a delay for patients to be seen and that the former chief's monetary bonuses were tied to this metric.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** VA OIG interviewed two physicians and two administrative employees.

- **Records Reviewed:** VA OIG reviewed the former chief's personnel record.

3. Summary of the Evidence Obtained From the Investigation

Interviews Conducted

- Physician 1 stated that he worked with the former chief for approximately 1 year in 2011. He said that there were issues with scheduling established patients because of a staff shortage. He added that the clinic policy was to document the next appointment dates in the clinic notes. He believed that this recording ensured that the time lapse between appointments could be attributed to the fact that dates were set by the physician. As for the effect this had on patient care, he said patients would sometimes come in for appointments that were unnecessary—wasting the patients' time. He stated that he did not know that the former chief had received a bonus linked to patient scheduling. He also stated that he thought that the former chief had received performance pay, as did most physicians at the facility.

- Physician 2 stated that she worked with the former chief for approximately 1 year in 2011. She explained that because the specialty clinic was short-staffed, the screening of patients had to be done closely. She said she disapproved of the way the former chief would schedule patients because she felt that person did not schedule using an "appropriate standard." This was based on her experience at other clinics and not on any written standard or policy. She stated that she was unaware of any patients who were not receiving needed care because of scheduling issues. She knew of no issues concerning new patients and the wait list, nor did she know anything about the former chief receiving monetary awards because of patient scheduling.

- A medical support assistant (MSA) in the specialty clinic stated that he was not asked to manipulate the patient schedule and saw no evidence of such. He added that he scheduled new patients according to their desired appointment date. He stated that he worked with the physicians to schedule the next appointment date for existing patients. He said there were no scheduling procedures that he felt were noncompliant with VA directives or policy, or that were improper. He also said that before the Phoenix Electronic Wait List (EWL) issue in 2014,[1] the only paper list maintained at the clinic was a standby list for patients who desired an earlier appointment, if one opened up following a cancellation, and that the use of this list was stopped in April 2014. He added that he was never told to do something he felt was against VA policy or directives, the law, or ethics standards. He also stated that at no time was the scheduling of patients manipulated. He stated that no patients received delayed or poor care because of the scheduling process.

- A former MSA who worked in the specialty clinic during the same time as the former chief stated that he was not asked to manipulate the patient schedule and saw no evidence of such. He further stated that he scheduled new patients according to their desired appointment date. He worked with the physicians to schedule the next appointment date for existing patients. He said there were no scheduling procedures that he felt were against VA directives or policy or that were improper. He added that before the EWL issue in 2014, the only paper list maintained at the clinic was a standby list for patients who desired an earlier appointment if one opened up because of a cancellation. He stated that use of this list was stopped in 2014. He said he was never told to do something he felt was contrary to VA policy or directives, the law, or ethics standards. He also stated that at no time was the scheduling of patients manipulated or that any patient received delayed or poor care due to the scheduling process.

Records Reviewed

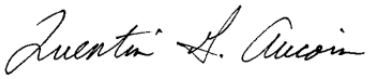
VA OIG reviewed the former chief's official personnel file. The record reflected that the former chief received performance pay in 2010, 2011, and 2012, based on her annual performance reports. In her performance reports ending on September 30, 2011, and September 30, 2012, she received "High Satisfactory" for three categories ("Clinical Competence," "Educational Competence," and "Personal Qualities"), as well as a "Satisfactory" assessment in "Administrative Competence." According to a senior VAMC leader, the performance plan for this former chief included a sub-element regarding scheduling in the "Administrative Competence" section.

4. Conclusion

The investigation did not find evidence showing that the former chief directed staff or physicians to manipulate patient schedules to minimize the waiting list. The investigation did not substantiate the allegation that the former chief received monetary awards for manipulating or directing the manipulation of patient wait times.

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

VA OIG referred the Report of Investigation to VA's Office of Accountability Review on July 11, 2016.



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