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

VA Medical Center in Charleston, South Carolina
December 20, 2016

1. Summary of Why the Investigation Was Initiated

This investigation started following the receipt of a letter from a complainant alleging that Department of Veterans Affairs (VA) Medical Center (VAMC) Charleston management was manipulating the wait times for outpatient medical appointments. The complainant alleged that three managers had dumped overdue appointments onto a Fee-Basis consult list. The complainant further alleged that she and other registered nurses (RNs) assigned to VAMC Charleston Fee Basis were required to "flip" consults from pending to active status before the consult took place and, as a result of this practice, veteran care was delayed. The complainant claimed that this was done to give the appearance that VAMC Charleston had fewer pending consults. Moreover, the complainant alleged that one manager had retaliated against her because of her complaining about this practice.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** VA Office of Inspector General (OIG) interviewed the complainant, as well as four current VAMC employees and one former manager.

- **Records Reviewed:** VA OIG reviewed documentation provided by the complainant. We also reviewed the medical records of three veterans alleged to have suffered harm from delayed care, as well as the medical records of four veterans whose delayed consults potentially created clinical concerns.

3. Summary of the Evidence Obtained From the Investigation

Interviews Conducted

- The complainant stated that, in 2012, a former manager and a service chief ordered her and two other VA employees to manipulate the consult list by changing the status of veterans' appointments from pending to active. This action would give the appearance that the veterans were scheduled for an appointment when they were not. The complainant stated that she and two other employees complained about this situation and warned the former manager and service chief that this would cause veterans' consults to be overlooked. The complainant further stated that she and the other two employees were told verbally and via email to manipulate the list. The complainant added that she had documentation to prove her allegation and would provide all documentation to include emails that support her claims.[1]

[1] Although the complainant provided documentation, none of it supported the allegations concerning manipulation of the EWL. The complainant subsequently stated that VAMC Charleston management had been careful to ensure that none of the directives relating to the manipulation of the EWL were written down or recorded.

- The service chief stated that he did not tell subordinates to manipulate the Fee-Basis non-VA medical care list by changing the status of veterans' consults from pending to active to give the appearance that veterans were scheduled for appointments. He described a morning meeting during which a senior leader asked him to have his Fee-Basis staff switch pending Fee-Basis consults to active, to document which consults were being accepted by Fee-Basis. He recalled that the complainant and VA employee 1 did complain at this time, but it was mostly about the 2012 "National Consult Clean Up," which resulted in VAMC Charleston Fee-Basis receiving a large increase in consults. As well, after a few weeks, he discovered that the new policy did have the potential to have consults "fall through the cracks" and might not have been accurately tracked. So, this practice was discontinued. He estimated that roughly 100 consults were recorded as accepted, prior to being worked, before the practice was stopped. He stated that all 100 consults were re-examined and worked as active consults to ensure no consults were dropped.

- A manager stated that she had not ordered anyone to manipulate the Fee-Basis list or to change the status of veterans' consults from pending to active, which would give the appearance that the veterans' consults were scheduled when they were not.

- VA employee 1 stated that she, the complainant, and VA employee 2, changed "hundreds" of consults from pending to active without properly working the consults, back in November 2012 and at the direction of a former manager and a service chief. VA employee 1 stated that this practice continued today (at the time of the interview) with the knowledge of a senior leader and a manager. She further stated that she had written proof this directive was given by the former manager and the service chief. She said it was her understanding that a senior leader instructed the former manager and the service chief to change the consults. She stated that she and the other RNs expressed their concerns to the former manager and the service chief about "flipping" the consults. She added that this was fraudulent because it made VAMC Charleston look like they were doing better than they were, and it "put Charleston VAMC in a favorable light." She stated that she and the complainant also warned the former manager and the service chief that by flipping consults without actually working them and having no tracking mechanism could lead to delays in patient care. As well, she believed the flipping of consults continued at this time (May 2015) by consults being sent to Health Net. She explained that Health Net was a contractor used by VAMC Charleston to act as a "clearinghouse" for non-VA care. She further explained that it was hard to find vendors who would accept VA patients because VA did not pay enough or not on time. She described one veteran, whose name she could not remember, as a cancer patient who died because of this new directive. VA employee 1 agreed to provide additional information at a later date, including the written proof she alleged to have and more information about the cancer patient.[2]

- VA employee 2 stated that she never "flipped" consults from pending to active status, adding that she had no direct knowledge of this allegation.

[2] VA employee 1 has not provided additional information about the cancer patient or the alleged written proof to support her allegation. VA employee 1 has now indicated that VAMC Charleston management has been careful to ensure none of the directives were written down or recorded.

- The complainant and VA employee 1 were interviewed together regarding statements they had made during previous interviews, namely, that they had written confirmation on being ordered by VAMC Charleston management to flip consults to improve the facility's image to the detriment of veterans. Both interviewees acknowledged that no additional information or documents were in their possession, and that none of the previously provided emails included an order to flip consults without first working the consult. The complainant stated that VA management was "coy and only provided the direction verbally." The complainant stated that before the service chief took over as head of the Fee-Basis Service, all the meetings were recorded, but the service chief ended the practice. Neither the complainant nor the VA employee 1 was able to identify the suspect consults. The complainant stated that once a consult was switched from pending to active, it was impossible to go back in time and determine when that consult was switched. The complainant added that the majority of consults they had manipulated came from the Surgery Clinic. VA employee 1 had previously provided medical records showing that three veterans had their care delayed by this "flipping scheme." VA employee 1 also provided medical records she claimed showed the flipping is ongoing. When questioned specifically about the records she believed proved that flipping was ongoing, VA employee 1 stated that any records indicating the manager or any other employee, other than a Fee-Basis RN, switched the consult, was proof to her that the process was ongoing. VA employee 1 further stated that if consult changes were not made by her or the complainant, delayed veteran care would occur. This was because the consult would be moved from a queue that indicated work was required to a queue with hundreds of other consults and neither she, nor the complainant, would know that the consult needed attention.

- The service chief stated that he was confident none of the consults were overlooked because of the 2012 directive as these consults had been flipped just before the nationwide consult cleanup; after this event, all consults were reviewed "from A-Z." He was given the names of the three veterans alleged to have suffered delayed care and said he would review his files and provide all documentation related to these veterans' consults.

- The former manager stated that she did not direct anyone to manipulate the consult Fee-Basis list. She explained that the surgery clinic had "dumped" about 600 Optometry consults on to VAMC Charleston Fee-Basis Service in 2012, and that this incident had caused problems. She stated that she and the service chief met weekly with the senior leader and kept him informed of all consults referred to Fee-Basis. The former manager did not recall a morning meeting during which the senior leader had decided that all consults referred to Fee-Basis would be switched from pending to active—in order to determine which consults were accepted by Fee-Basis. She stated that all three Fee-Basis nurses had problems changing the way they had always worked consults. The large dump of consults created problems in Fee-Basis as well as a need for the RNs to work older consults first. The RNs refused to change and this created problems.

Records Reviewed

- The complainant provided a three-ring binder filled with documentation. A review did not find any documentation that indicated VA management directed RNs to manipulate Fee-Basis consults.

- The complainant provided additional documents for review. A review of those documents, which included VA Fee-Basis documents and VA emails, failed to find written proof that VA management directed RNs to flip consults. The documents did contain numerous medical records with handwritten notes indicating delayed care for three veterans. The documents did not contain any information about the identity of the unknown veteran cancer patient discussed in the interview with VA employee 1. Further our investigators were unable to identify one patient who had cancer and died in an unspecified year, of an unspecified cancer, when we did not have the veteran's name. As a result, the identity of this patient remains unknown.

- VAMC Charleston's quality manager conducted a review of the medical records for the three veterans identified in the documents we examined. Her review did not disclose any clinical indications that patients were negatively affected; she gave her findings to the OIG. The OIG Office of Healthcare Inspections (OHI) also reviewed the medical files of the three veterans alleged to have suffered harm from delayed care, as well as the review conducted by the quality manager. OHI determined that the quality manager's review was accurate. OHI noted that one veteran waited 289 days from the day the consult was requested to the day of the appointment; however, no patient harm was found despite the lengthy wait time.

- The quality manager then reviewed all consults worked by VAMC Charleston Fee-Basis from December 18, 2012, through January 18, 2013. Her analysis disclosed that, during this period, some 855 consults were reviewed and 77 consults were found to exceed 90 days. A detailed review of the 77 consults identified four additional veterans for whom delay might have created clinical concerns. These concerns were then reviewed by the chief of staff who found no negative clinical outcomes related to the delay in, or the discontinuation of, the consult. OHI also reviewed the medical files of the four veterans and found no quality-of-care issues.

4. Conclusion

The investigation found that, for a short period of time in 2012, VAMC Charleston management did ask employees of the non-VA-Care Fee-Basis Division to record consults accepted by the Division as active. This adjustment was carried out so that consults could be eliminated from the other VAMC Charleston Divisions' electronic wait lists. The investigation further determined that once VAMC Charleston management learned that this practice could lead to consults "falling through the cracks," management ended it and completed a comprehensive review of all Fee-Basis consults. The complainants also alleged that these practices continued beyond 2012; however, they were unable to provide documentation to support their allegation of improper consult management post 2012. Reviews of the identified patients' files found no specific patient harm was caused by this scheduling practice.

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.