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



VA Medical Center in Jackson, Mississippi February 23, 2017

### 1. Summary of Why the Investigation Was Initiated

The VA Office of Inspector General (OIG) initiated an investigation regarding a complaint made by a VA Medical Center (VAMC) Jackson, MS, physician, who alleged that hospital administrators created "ghost clinics" and/or "vesting clinics" in which veterans were assigned to nonexistent Primary Care Clinics to make it appear that these patients were receiving timely care. The physician's allegation was part of a *New York Times* article, which also referenced an internal VA investigation having determined that VAMC Jackson did not have enough Primary Care doctors, leading to an increased number of complex medical cases handled by nurse practitioners. After conducting two interviews, the OIG learned that this complaint had already been addressed by the Office of Special Counsel (OSC) and determined that no further work was necessary.

# 2. Description of the Conduct of the Investigation

• Interviews Conducted: VA OIG interviewed two VA employees.

• Records Reviewed: None

## 3. Summary of the Evidence Obtained From the Investigation

### **Interviews Conducted**

• The physician stated that she began working as a Primary Care physician at the VAMC in September 2008. She said that the VAMC created a vesting clinic to deal with the increased patient demand. [Note: The physician referenced vesting clinics and ghost clinics as the same thing.] She stated that during routine morning meetings, a service chief and his assistant provided Microsoft Excel spreadsheets containing a list of providers, the number of patients scheduled, and the number of patients seen. Under the providers' column, "VICE" was typed in the block next to a provider's name or in the block where the name should have gone. She explained that patients were assigned to VICE, which was a non-existent provider, causing patients to be shuffled to other providers when they arrived for their appointments. She said that this practice caused long wait times because of "double booking."

She also stated that this issue was reported to the Office of Special Counsel (OSC) and addressed in their final report, adding that the VAMC's responses to the allegations made by her and other whistleblowers had been deemed "insufficient." She indicated that she did not know who had created the vesting clinics concept. She stated that if a nurse practitioner was transferred or promoted out of a Primary Care Clinic, the VAMC

maintained the panel of patients and those patients kept their scheduled appointments and were seen by other providers.

• A VAMC senior leader stated that the physician's allegations were addressed in an OSC report. He further stated that vesting clinics was a concept that had started before his assuming his current position and ceased shortly after. He explained that the vesting clinic was created to triage new patients, who were then transferred to their permanent clinics after they were assessed. He stated that although the concept appeared to be an efficient means of processing new patients, it was not well received and thus discontinued. Concerning the VICE labels for the clinics, he stated that he was not familiar with the term and did not recall using or seeing the VICE acronym in his morning meeting reports. He stated that if a Primary Care provider transferred from a clinic, the VAMC did not disband the panel; they maintained the panel until a new provider was hired.

### **Records Reviewed**

None

### 4. Conclusion

Once VA OIG determined that this complaint had been addressed by OSC, we ceased investigative efforts. Our preliminary inquiry disclosed no evidence of wrongdoing regarding the allegation that ghost clinics or vesting clinics were used inappropriately.

VA OIG referred the Report of Investigation to VA's Office of Accountability Review on November 9, 2016.

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for Investigations

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