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
May 4, 2017

1. Summary of Why the Investigation Was Initiated

The Department of Veterans Affairs (VA) Office of Inspector General (OIG) initiated an investigation in 2014 based on information provided by a confidential complainant alleging that, from 2012 to 2014, thousands of consults were removed from the Veterans Health Information Systems and Technology Architecture (VistA) scheduling program at VA Medical Center (VAMC) Washington, DC. The complainant alleged that former senior leader 1 consulted with administrative official 1 to assist each specialty clinic in an operation called "Consult Clean-Up." The complainant further alleged that this operation was intended to delete or cancel consults within VistA that were 5 years and older to make it appear that there were fewer consults on the books.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** VA OIG interviewed 17 current and former VA employees, including the complainant.

- **Records Reviewed:** VA OIG reviewed consult data, documentation provided by administrative official 1, and patient medical files.

3. Summary of the Evidence Obtained From the Investigation

Initial Complaint and Investigation

Interviews Conducted

- The confidential complainant stated that, at the direction of former senior leader 1, thousands of consults were canceled/discontinued en masse. The complainant added that the high number of consults became a real concern to VAMC Washington's leadership. The complainant stated that there was no follow-up with patients to determine if care was given or received. The complainant alleged that former senior leader 1 consulted with administrative official 1 to assist each specialty clinic in an operation called Consult Clean-Up. The complainant also alleged that this operation was intended to delete or cancel consults within VistA that were 5 years and older to make it appear that there were fewer consults on the books. The complainant stated that former senior leader 1 met with the clinical service line chiefs and advised them to manage the high number of consults by following up or closing them because they were "hanging out there." The complainant further stated that soon after administrative official 1 was hired at VAMC Washington, she, too, began working very closely with the service line chiefs. The complainant alleged that administrative official 1 was very "tech orientated" and knew how to navigate within VistA to cancel/discontinue appointments. The complainant

stated that the outstanding consult numbers began to drop soon after this action was taken by administrative official 1. The complainant also stated that administrative official 1 worked on weekends to get the consult numbers down, adding that the number of consults could have been "a few hundred, but the number 12,000 sticks in (their) mind for some reason." The complainant reported that he or she did not witness administrative official 1 canceling/discontinuing consults within VistA nor did he or she hear former senior leader 1 order administrative official 1 to take this administrative action.

- Administrative official 1 stated that she was responsible for reporting on all clinical operations that directly affected the facility's effectiveness. She explained that her duties also included managing the consult data for VAMC Washington and then reporting her findings to former senior leader 1. She stated that all the VAMC Washington clinics entered their consult data daily into VistA; she then used these same data to create a user-friendly Microsoft Excel spreadsheet that reflected all of the consult data in VistA. She further stated that these data were put into subcategories (e.g., High Risk, High Interest, Canceled, Scheduled), so that the facility's Executive Team had a clearer picture of the consult data. She said her task was to give an accurate snapshot of all of the consults at any given time, adding that she reported her findings daily to former senior leader 1. She also said that these findings were discussed every morning during the Executive Team's "Morning Minutes" meeting. She stated that her reports were used to help the Executive Team determine which clinical services needed more support in managing their consults. She also stated that she had never discontinued or canceled a consult within VistA on her own or at the request of former senior leader 1 or any member of the Executive Team. She further stated that before she started working there, in November 2012, a Consult Clean-Up was performed by a former administrative official. She stated that in 2012, this Consult Clean-Up discontinued/canceled hundreds and maybe thousands of consults within Vista. She noted that the statement "Cancelled per Chief of Staff" was left in the remarks section of all the consults affected. She said she was unsure about the rationale behind the Consult Clean-Up, which was ordered by former senior leader 1. She further stated that these consults could still be accessed and viewed in VistA.

- The former information security officer (ISO) stated that, in 2012, former senior leader 1 asked him to perform what was described to him as a Consult Clean-Up. He explained that the Consult Clean-Up stemmed from the large number of consults VAMC Washington had during this time. He stated that former senior leader 1 characterized the consults as being "unwieldy." He said former senior leader 1 had specifically told him to identify all consults in VistA that were 5 years and older. Once these consults had been identified, he was instructed by former senior leader1 to cancel/discontinue them and write the following in the notes section: "Discontinued by order of the Chief of Staff. If you feel that the consult is absolutely necessary, please resubmit." He stated that he did not question former senior leader 1 further and that he considered this work assignment legitimate. He described how he had canceled/discontinued about 10,000 consults in 3 hours, adding that before canceling/discontinuing the consults, he had not checked VistA or the Computerized Patient Record System (CPRS) to determine if any clinical notes were present, or sought the opinion of a clinical professional. He stated that he made no attempt to contact the veterans who were affected by the canceled/discontinued

consults. He further stated that if the deleted consult was truly needed, then the provider could resubmit the consult request in VistA. He stated that in the late 1990s and mid-2000s, he had also been asked by former senior leader 1 to perform Consult Clean-Ups. He said that, just as in 2012, he had canceled/discontinued thousands of consults at the prompting of former senior leader 1 to whom he would then report the final disposition of those consults. He stated that he did not receive any financial reward nor was he recognized in his performance appraisal for these actions.

- Service chief 1 reported that, at one time, VAMC Washington had about 20,000 consults. He stated that VAMC Washington had struggled to get them down to their current level of around 3,000. He explained that the Executive Team at VAMC Washington had always provided support to service lines to reduce the number of consults and that the facility's priority had been to close consults legitimately by seeing the patient. He recalled ongoing discussions on how to properly close consults and when it is appropriate to do so. He reckoned that consults should not be closed without going through the proper measures, which includes contacting the concerned veterans. He said the facility had a consult committee that actively monitored the number of consults at VAMC Washington. He stated that he had not heard of any directive given by former senior leader 1 to discontinue/cancel consults. He further stated that senior leader 2 had always inquired about what was needed to help reduce the number of consults at VAMC Washington. He also stated that senior leader 2 had suggested hiring more staff and even providing more clinics.

- Senior leader 3 stated that she was responsible for the daily clinical operation of the hospital, all clinical service departments, and all performance measures for network directors. She added that she was familiar with how consults were generated at VAMC Washington; however, she stated that consults and the consult historical data were managed by former senior leader 1. She explained that, typically, a consult can be requested by a doctor, a nurse practitioner, or a resident physician. Once a consult is requested in VistA, the consult is routed electronically to the appropriate specialty clinic. Upon receipt of the consult at the specialty clinic, a scheduler reviews the consult and then schedules the resulting appointment within the appropriate time frame set by policy. She stated that no consult should go unattended for any extended period of time, adding that all consults should be reviewed and scheduled within 14 days of their initial request. She further stated that she was unaware of any consults having been deleted, canceled, or discontinued. As well, she was unaware of any order given by former senior leader 1 to delete, cancel, or discontinue consults in large numbers. She noted that there was a process to administratively delete, cancel, or discontinue a consult. That process involves the careful review of each consult by a doctor, nurse practitioner, or resident physician to determine whether the requested consult is needed. She stated that no administrative personnel should delete, cancel, or discontinue a consult without first having a clinical professional review it.

- Service chief 2 stated that, when a consult is discontinued, it is returned to the initiating provider, and that would be a red flag. She added that consults might get discontinued if they are old, if the patient had already been seen by a provider, or if they were duplicate

consults. She said a clerk could possibly discontinue/cancel a consult. However, the initiating provider would be notified and could initiate the action once again if needed.

- Senior leader 4 stated that she was responsible for overseeing the mental health services provided to veterans both inside VAMC Washington and in the surrounding community. She said consults should average about 3,200 at VAMC Washington. She also stated that many employees at VAMC Washington had the ability to manage consults and that she was looking to standardize the way consults were managed throughout all services at VAMC Washington. She further stated that consults could stay in any "state" forever if they are not resolved or managed properly. She pointed out that consults need to be monitored daily to ensure all care is properly given to veterans. She stated that she was unaware of any order given by former senior leader 1 to delete, cancel, or discontinue consults in large numbers. She said consults were discussed daily at the Executive Team's Morning Minutes meeting and that, in 2014, an outside group was hired by the facility to assist in managing all consults within all services at VAMC Washington.[1]

- Senior leader 1 stated that he had never heard of anyone manipulating consults at VAMC Washington. He explained that senior leader 2 and former senior leader 1 had always provided the necessary support for the hospital to meet its objectives and goals. He stated that he had never told anyone to discontinue or cancel consults. He also stated that he never received an order from anyone to discontinue or cancel consults. He added that clinicians should determine whether a consult is needed and that if a consult is closed, it should automatically go back to the initiating provider.[2]

- We interviewed service chief 3, service chief 4, and service chief 5 regarding the allegation that consults were deleted/canceled en masse. All of these service chiefs stated that the deletion and cancellation of consults without prior medical review was not common at VAMC Washington. The service line chiefs also stated that they were not familiar with any order given by former senior leader 1 to perform a Consult Clean-Up.

- Service chief 6 and administrative official 2 stated that before being deleted/canceled within VistA, consults were reviewed by a medical professional. Administrative personnel within their clinic were authorized to administratively close a consult once a clinician had reviewed the consult. Service chief 6 and administrative official 2 also stated that they were not aware of any order given by former senior leader 1 to perform a Consult Clean-Up.

Records Reviewed

- VA OIG reviewed documentation provided by administrative official1 and supporting her statement that a Consult Clean-Up was performed in 2012. Review of the documentation revealed that the former ISO discontinued numerous appointments within VistA and

[1] During the course of the investigation, VA OIG could not find any information that such a company was consulted or hired by VAMC Washington.
[2] Our investigation confirmed that when a consult is canceled/discontinued, the consult is automatically routed back to the initiating physician within VistA for review.

added the notation "Discontinued by order of the Chief of Staff's Office. If you feel that the consult is absolutely necessary, please resubmit."

- VA OIG reviewed consult data that showed all the consults that had been canceled/ discontinued by the former ISO. Review of the data determined that the former ISO canceled/discontinued a total of 63,924 consults during his tenure at VAMC Washington. He canceled/discontinued 28,096 consults within a 2-day period (August 31, through September 1, 2011).
    - On August 31, 2011, he deleted 9,525 consults in approximately 17 minutes.
    - On September 1, 2011, he deleted 18,571 consults in approximately 3 hours and 31 minutes.
    - He also canceled/discontinued 360 consults on October 24, 2012 and 23 consults on October 26, 2012.
    - A closer examination of these activity dates revealed that the majority of the consults canceled/discontinued by the former ISO were older than 5 years. However, some consults that were not 5 years or older were also canceled/discontinued during the massive purge.

Office of Healthcare Inspections Review

An employee of the VA's Office of Compliance and Business Integrity (CBI) provided OIG with a Microsoft Excel spreadsheet containing consults that were discontinued/canceled by the former ISO from 2008 through 2012. The CBI employee also provided a reference identifying key parameters of the data collected, such as the visit priority flag, urgency, and request date/consult activity date for each consult. The CBI employee said it was his belief that the high number of discontinued/canceled consults listed in the data would be consistent with "batch closings."

The VA OIG Office of Healthcare Inspections (OHI) conducted a review of a subset of the former ISO's canceled/discontinued consults to determine the extent to which patients had received services and, if not, the extent to which patients were harmed. The OHI reviewed 215 consults at VAMC Washington. They met all of the following criteria:

- Pertained to a high-interest consult or a consult that was otherwise included in the Veterans Health Administration's (VHA) gastrointestinal (GI) lookback,[3] and
- Were less than 1 year old at the time of discontinuation.

OHI identified 26 consults (12.1 percent) for which VAMC Washington did not provide care or did not document that care was refused or no longer applicable. Among these 26 consults:

[3] For more information on VHA'S GI lookback, please refer to VA OIG report, *Healthcare Inspection: Evaluation of the Veterans Health Administration's National Consult Delay Review and Associated Fact Sheet*, Report No. 14-04705-62, December 15, 2014.

- The request was an average of 254 days old at the time of discontinuation (range 91–364 days).
- Nine were for cardiology-related studies/imaging, nine were for cardiology, five were for hepatology, and three were for gastroenterology.

OHI concluded that for this "minority of consults (12.1%), the patients' care warranted closer review since the patient had not received the requested service and there was no documentation in the record that the patient had declined the care or that the service was no longer indicated. Based on [VA OIG Criminal Investigations Division's] analysis of the sheer volume of consults that the facility administratively discontinued in an effort to "clean up" the consult data, it is clear that the consult dashboard was not historically a meaningful tool to identify patients awaiting services. The fact that these consulted services were not rendered or documented as declined or no longer applicable was likely caused by scheduling issues and documentation lapses within the various clinics."

OHI further determined that "for the remaining 189 consults (87.9 percent), we found that the care was rendered (n=152, 70.7 percent), declined by the patient (n=29, 13.5 percent), or was no longer applicable (n=8, 3.7 percent)." The OHI report concluded that "for the majority of consults (87.9%), the act of administratively discontinuing consults served to "clean up" the Washington, DC VAMC's consult data by removing consults that should no longer remain open because the service was already rendered, declined by the patient, or was no longer applicable."

OHI provided additional information on the eight patients (3.7 percent) for whom care was "no longer applicable." Specifically, the report stated that "For the remaining 8 (3.7 percent) consults, we found that care was not medically necessary (n=4), care was no longer applicable in that the patient moved (n=1), the patient obtained service at another hospital (n=1), the patient died (n=1), or the patient could not complete the procedure (n=1; patient was too large to fit in the MRI scanner). Of note, when the patient died, his consult was not delayed at that time."

VAMC Washington was asked to conduct additional review on the 26 consults at issue; this was done by senior leader 1 who concluded that, although the consults were administratively closed by the former ISO, the veterans' care was not affected. Senior leader 1 reported that for 17 of the 26 consults he reviewed, the identified veterans continued to receive care at VAMC Washington; for the remaining 9 consults, the corresponding veterans were deceased and a complete chart review was performed.

OHI reviewed senior leader 1's conclusions regarding the 26 consults. OHI "concluded that, based on the patients' medical history and the nature of the services and/or indications for the requested care, these patients were not adversely impacted."

Interviews of Current and Former VAMC Washington Executive Staff

- Senior leader 2 stated that, in 2012, VHA directed a Consult Clean-Up action nationwide to every VAMC facility. He explained that VHA presented to VAMC Washington a list of 10,000 to 15,000 outstanding consults that needed to be addressed and that VHA

wanted VAMC Washington to get close to "zero consults." He stated that he instructed the medical staff to determine which consults needed immediate treatment so that these veterans could receive treatment at VAMC Washington or fee-based services. He also stated that an emphasis was placed on higher priority consults for care such as Oncology, Gastrointestinal, and Cardiology. For the remaining open consults, a significant amount of time and instructions was given to determine: (1) if the requested services were rendered, and (2) if not, was the requested service still needed. Once this action was complete, the persons reviewing the consults could administratively close them. He reportedly did not remember whether VHA gave specific instructions on the proper methodology to close consults. However, he did recall discussing how to best close many consults so that it would not appear as if the facility was "gaming" the system. He stated that it was preferred that the consults should be closed by the provider. However, he stated that, at times, administrative staff had been authorized to close consults once a provider had clinically reviewed them.

Senior leader 2 stated that former senior leader 1 was directly responsible for the clinical administration of consults. He explained that former senior leader 1 reported on this process during Morning Minutes meetings with VAMC Executive Team members. He stated that since his appointment to VAMC Washington in September 2011, he had not heard of any issues regarding the manipulation of consults. He further stated that he was concerned about the large number of outstanding consults, adding that he always echoed a message to his staff that each and every consult should be closed properly following strict adherence to the rules. He explained that it was his belief that each consult was to be reviewed by clinical chiefs to ensure they were properly closed. He stated that he was not aware that the former ISO was managing consults until he was settled into his position at VAMC Washington. The discovery came during discussions in Morning Minutes meetings. He stated that until this interview (January 2016), he was not aware of the large number of consult closings by the former ISO. He also stated that when he became aware that the former ISO was closing consults, he had tried to find out why the former ISO had been taking these actions. He reportedly had learned of the former ISO's actions when the issue of the New Enrollee Appointment Request (NEAR) list surfaced.[4] He stated that he previously spoke with former senior leader 1 to ensure that the clinical chiefs were reviewing all consults before they were closed.

He recalled that when he questioned former senior leader 1 about the former ISO's involvement with the deletion/cancellation of consults, he was told that the former ISO was the most "knowledgeable person, worked well within the group, and they have been doing this for years."

- Former senior leader 1 said that, when dealing with consults, the facility followed the rules given to them by VA Central Office. He stated that, on occasion, VAMC Washington's Consult Committee, chaired by senior leader 4, had issued specific rules.

[4] Another OIG investigation determined that VAMC Washington's NEAR List had not been actively managed for approximately 8 years. The NEAR List contained the names of veterans who had requested primary care appointments at the facility. As a result of the NEAR List not being managed, approximately 2,228 veterans did not receive their requested initial contact from VAMC Washington. https://www.va.gov/oig/pubs/admin-reports/VAOIG-14-02890-400.pdf

He explained that the facility looked at consults pending for more than 7, 30, and 90 days and that if a consult went beyond 90 days, it was an indication that the veteran did not show up for a scheduled appointment, which then required the facility to create another appointment.

He further stated that there was specific guidance on when a consult could be discontinued because of a patient not showing up for a scheduled appointment. He stated that although he did not know the specifics, the rules covered how many times a patient could "no[t] show" before a consult could be discontinued. He also stated that, normally, when a consult was discontinued, the provider requesting the consult would be notified. He stated, "In the distant past consults were 2, 3, 4, and 5 years old and indeed a consult that's 5 years old or so, is no longer a relevant consult. However if they chose to do so, the provider would still have an opportunity to re-establish the consult." According to him, a 5-year-old consult that was discontinued should be submitted back to the initiating provider. He stated "that our intention, when I would ask [the former ISO] what he would do, he would say that is what he is doing. I'm not sure that, that's exactly what he did, but that's what he was supposed to do." He added that he was not sure whether he ever told the former ISO to administratively close consults. He stated that because he knew the former ISO was a nurse, he felt that this was an advantage as the former ISO would know what is correct and what is not.

Former senior leader 1 stated that he had never been aware that the former ISO was "batch closing" a large number of consults. He said the last time they spoke regarding the closing of consults, the former ISO disclosed that he had started from the letter A and stopped at F. He was not sure what methodology was used by the former ISO to discontinue consults, but he stated that the former ISO had not been assigned this task in years. When informed that the former ISO had closed approximately 7,000 consults within a short period of time, he stated, "Without knowing what those consults are, I can't, I can't respond to, I have no idea of what he was doing and that would not be though, that would not be what I would be asking him to do." He further stated that he had never received, nor did he ever ask for, any report from the former ISO that showed how many consults were closed. He also stated that he specifically had told the former ISO to contact the initiating provider for every consult that he closed.

When asked about the former ISO's statement that he was tasked to close consults because they were "unwieldy," senior leader 1 responded, "not unwieldy, they were ancient and we just have to re-establish." He further stated that if a consult is 5 years old, it should be renewed by the provider who initiated it.

Former senior leader 1 stated that when he solicited assistance from the former ISO, his intent had been to refresh old consults. He stated, "Frequently many of the five-year old consults had been answered many times. If they had been answered many times then they should be shut down." He reiterated that each closed consult should go back to the initiating provider, who could reestablish it should he or she see the need. He said it was well known that the former ISO would help him, and the facility, manage consults from time to time. He could not recall how many times the former ISO's services were used.

- Former senior leader 2 stated that former senior leader 1 was responsible for overseeing the clinical services at VAMC Washington. He said he was very familiar with the term Consult Clean-Up, but did not know if the term was specific to his tenure at VAMC Washington or at another VA facility. He stated that he was not as involved with consults while at VAMC Washington as he was at the other facility. He added, "the idea of working down any kind of consult back log at VAMC Washington while I was there, I am certain was going on and it is something that I was at least generally aware of." He stated that he did not know what methodology was used to manage consults at VAMC Washington and that he did not remember having any specific conversations about the management of consults while he was at VAMC Washington. He also stated that he did not know who had the responsibility of managing consults at VAMC Washington. He said although he could not recall any specifics, he believed consult management was discussed during Morning Minutes meetings with VAMC Executive Team members.

  Former senior leader 2 stated that he did not recall any conversation he may have had regarding consults, consult numbers, and how they were being managed. However, he recalled that the former ISO was involved with consult management. He also stated that former senior leader 1 "used" the former ISO as his "go to" person for Consult Clean-Up and working down backlogs. He said he believed that the former ISO's background in nursing was the reason former senior leader 1 would assign him the management of consults. He stated that he never spoke to former senior leader 1 about the "use" of the former ISO for managing consults, and he never had a conversation with the former ISO about the matter. He recalled that the former ISO was probably used multiple times to help manage consults. He stated that, since he did not have direct knowledge of what the former ISO was tasked to do, he would not comment on whether it was appropriate for an ISO to manage consults. When told that the former ISO had closed a high volume of consults in a 2-day period, he replied, "Yeah, that's pretty, that would be pretty concerning." He did not recall any Veterans Integrated Service Network (VISN)-mandated initiatives directed to VAMC Washington regarding the management of consults while he worked at that VAMC.

- Former senior leader 3 stated that, from 2007 through 2010, he was employed at VAMC Washington. He said he could remember several times that the guidance on how to manage consults had changed. He also stated that, at times, the VISN had forwarded instructions and guidance on how to manage consults. He recalled that, while he was at VAMC Washington, the facility was handling about 600,000 appointments a year. He stated that during his tenure at VAMC Washington, he could not provide an estimate for the average numbers of consults per year. He explained that if there were consults "sitting out" for some time and physicians felt it was appropriate to close the consults, then they would be closed. He said each consult would still require a proper clinical review before being closed and added that he did not know the meaning of the term "batch closing." He further stated that if consults were 2 years or older and had been clinically reviewed for closure, then they could be closed. He stated that before receiving specific guidance on how to close consults, he had believed that it would be appropriate to close a consult that was over a year old once it had been clinically reviewed. He said he had heard of non-clinicians—who work closely with clinicians and are familiar with consults—closing consults for various reasons, including that the patient had already

been seen or the consult was a duplicate. He stated that in these cases, it was important to emphasize to facility personnel that clinicians are the preferred persons to close out consults.

Former senior leader 3 stated that he did not know anything about former senior leader 1 using the former ISO to do any specific task at the facility. When told that former senior leader 1 routinely used the former ISO to discontinue/cancel consults, he remarked, "possibly as a nurse, clinician, [the former ISO] was qualified to review. You don't typically think of information security officers as clinicians, but as a nurse, [the former ISO] may have been qualified to review some consults. Perhaps [former senior leader1] asked [the former ISO] that if consults met a certain criteria, then it was ok to discontinue/cancel them, but I was not aware that was going on." During the interview, former senior leader 3 was told that the former ISO closed approximately 28,096 consults in a 2-day period and 63,924 consults during his tenure at VAMC Washington. He stated that in the short periods of time during which the former ISO discontinued/canceled this amount of consults, it would be impossible to conduct a clinical review of each consult—which is the standard practice. He further stated that the consult management system was used for many things and not just for managing consults. He stated that the system was often used to track and address the non-clinical needs of a veteran, adding that there could be thousands of non-clinical consults at any given time.

Review of the Electronic Messages of Select VAMC Washington Personnel

During the course of the investigation, VA OIG obtained complete access to the electronic messages of these VA officials: (1) senior leader 1, (2) administrative official 1, (3) former senior leader 1, (4) the former ISO, and (5) a former administrative employee.[5]

Review of the electronic messages revealed that while there were ample discussions about Consult Clean-Up, no electronic messages were found that showed a deliberate attempt to discontinue/delete consults. The electronic messages specifically discussed the national Consult Clean-Up initiative directed by each VISN in September 2012. On December 15, 2014, OHI issued a report on this initiative.[6]

4. Conclusion

VA OIG found that:

- A significant number of consults were canceled/discontinued in August/September 2011 by the former ISO.
- The former ISO was tasked by former senior leader 1 on numerous occasions to administratively manage older consults that were within VistA.

[5] The investigation did not disclose any evidence linking the former administrative employee to the canceling/discontinuing of consults by the former ISO. The former administrative employee was not interviewed because no evidence was found implicating her in anything; at the time of our investigation, she no longer resided in the continental United States.
[6] *Evaluation of the Veterans Health Administration National Consult Delay Review and Associated Fact Sheet* Report Number 14-04705-62

- During his tenure at VAMC Washington, the former ISO canceled/discontinued a total of 63,924 consults.
- During a massive purge that occurred on August 31 and September 1, 2011, most of the consults canceled/discontinued by the former ISO were older than 5 years. However, some consults that were not 5 years or older were also canceled/discontinued.
- The former ISO did not review VistA or CPRS for any clinical notes before canceling/discontinuing these consults, did not seek the opinion of a clinical professional, and did not make any attempt to contact any veteran who would be affected by the canceling/discontinuing of these consults

In the sample reviewed, we did not find any evidence that veterans' care was affected by the former ISO's actions.

VA OIG referred the Report of Investigation to VA's Office of Accountability Review on November 22, 2016.

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