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

VA Medical Center in Montgomery, Alabama
May 24, 2017

1. Summary of Why the Investigation Was Initiated

This investigation was initiated in 2014 pursuant to a referral from the VA OIG Office of Healthcare Inspections (OHI). OHI advised the VA OIG Office of Investigations that during an inspection of the Central Alabama Veterans Health Care System (CAVHCS) by the Atlanta OHI team, OHI identified a situation in which CAVHCS employees may have intentionally deleted patient names from an Electronic Waiting List (EWL) to give the appearance the list was shorter than it actually was. OHI also advised that an employee of the Community Based Outpatient Clinic (CBOC) in Dothan, AL, had stated there was also a long paper wait list that was being used within the Mental Health Clinic.

The U.S. Attorney for the Middle District of Alabama advised VA OIG that the U.S. Attorney's Office was initiating its own independent investigation into the alleged deletion of names from the EWL and the use of paper wait lists. The Federal Bureau of Investigation was tasked as the lead investigative agency with VA OIG providing assistance upon request. The U.S. Attorney took this action after receiving a complaint from Martha Roby, U.S. Representative, Alabama, 2nd Congressional District.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** VA OIG interviewed 16 VA employees, including senior staff and scheduling clerks, and one former VA employee.

- **Records Reviewed:** VA OIG reviewed the Administrative Investigation Board (AIB) Report of Investigation dated May 15, 2014.

3. Summary of the Evidence Obtained From the Investigation

Interviews Conducted

- OHI staff conducted five interviews with the CBOC employee about the use of an alleged long paper wait list at Mental Health. These interviews did not produce any findings regarding the use of paper wait lists, and it was determined that the CBOC employee was not a reliable source of information. Based on the results of the previous five interviews conducted by OHI staff, OIG special agents determined it would not be productive to interview this person a sixth time.

- CAVHCS senior managers 1,2,3,4, and 5 were interviewed about their knowledge or

involvement with the alleged altering or deletion of patients' scheduled appointments, destruction of documentation, or deaths that may have occurred while veterans were waiting for treatment. He/she reported having no knowledge or involvement with any of these issues. He/she stated that they were not aware of instances involving the use of paper wait lists, adverse medical outcomes relating to veterans health care, destruction of records, or change in policy dealing with scheduling.

- Administrative employee 1 was interviewed regarding the allegation that she instructed medical support assistants to use paper wait lists to maintain veterans' appointments. Administrative employee 1 said she was familiar with the patient-scheduling process; however, she stated that she had very little involvement with patient scheduling other than communicating with the CAVHCS business office regarding canceled patient appointments. She denied instructing any employees to use paper lists.

- A nurse manager was interviewed regarding the allegation that she instructed a program support assistant (PSA) to delete patients' names from the EWL. The nurse manager explained that CAVHCS participated in an initiative led by the VA Central Office (VACO) in Washington, DC, referred to as the Accelerated Care Initiative (ACI). This initiative required CAVHCS staff to go through the available wait lists and to make contact with each veteran to determine if appointments were still necessary. The nurse manager reported that if the veterans indicated they no longer needed the appointment, their names would be deleted from the list. She said she would receive a copy of the list from a CAVHCS senior official and that either the CAVHCS senior official or the CAVHCS senior manager 4 would instruct her and other staff to review the list and contact the patient to see if the veteran needed an appointment.

- The CAVHCS senior official was interviewed about her knowledge or involvement with the intentional deletion of patients' names from the EWL. She stated that she became intimately involved with CAVHCS scheduling shortly after the issues discovered at VAMC Phoenix[1] became headline news. She explained that VACO officials held a conference call with VA executives to formulate a strategy that would address access-to-care issues in the entire VA system. She stated that VACO management tasked the facilities with reducing veteran wait times throughout the entire network. Specifically, each facility was asked to contact the veterans on the EWL to determine if they needed an appointment or wanted to reschedule. She explained that if the patient no longer needed an appointment, the VA representative would remove the veteran's name from the list. She stated that she was not involved nor did she have access to the VA scheduling system. She added that she had no information that would indicate CAVHCS senior manager 1 or CAVHCS senior manager 2 was aware of improper scheduling practices in the facilities under their leadership.

- A PSA was interviewed about her knowledge or involvement with the alleged altering or deletion of patients' scheduled appointments, destruction of documentation, and deaths that may have occurred while veterans were waiting for treatment. She explained that

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

before her assignment as a PSA, she held the position of medical support assistant (MSA) and had been responsible for scheduling veteran appointments. She was provided for her review a copy of a report, which indicated she had deleted more than 90 appointments from the EWL, within a 2-day period. Purportedly, the deletion codes showed "Removed/Scheduled," but with no indication that the appointments had been rescheduled. The PSA initially denied deleting the names from the EWL; however, she later acknowledged her familiarity with the information and admitted that she deleted the names and disposed of the documents. She said she put the list in the "shred box." She further stated that the list had been sent to her via email by a nurse manager instructing her to delete the names from the EWL. She said administrative employee 3 had helped with the deletions of names; however, she could not provide the names of any other employees who had received the same instruction.

- Administrative employee 2 was interviewed about information reported to VA OIG claiming that she had helped several CAVHCS employees delete patients from the EWL. She acknowledged her involvement with the project and confirmed her assistance with the deletion of patient names from the EWL. She stated that sometime during September 2014, she was given the opportunity to earn some extra money by assisting the CAVHCS staff on a project that involved contacting veterans on the EWL. Her task was to ask them if they wanted an appointment, and to either reschedule their appointment at another facility or delete their name from the EWL. She explained that she deleted a veteran's name from the list only if he or she informed her that the appointment was no longer required or if it was determined the veteran had received treatment and no longer needed the appointment. She added that a nurse manager supervised the project.

- Administrative employee 3 was interviewed about information reported to VA OIG claiming that she had helped several CAVHCS employees delete patients from the EWL. She acknowledged her familiarity with the CAVHCS initiative to reduce patient wait times and her own involvement with the project. She stated that she did not have access to the EWL; therefore, she was not able to delete any names. She said her primary responsibility was to schedule appointments. She further stated that a nurse manager had given her a list of veterans who needed an appointment scheduled. She stated that she could not provide any information regarding the process before receiving that list. She also stated that she followed the VHA Scheduling Directive and did not observe any improper practices.

- Administrative employee 4 was interviewed about information reported to VA OIG alleging that she had helped several CAVHCS employees delete patients from the EWL. She acknowledged her familiarity with the CAVHCS initiative to reduce patient wait times and her own participation. She stated that the project had been active for several weeks before her involvement. She further stated that she and her colleagues took advantage of the overtime generated by the project. She said her involvement did not include activities beyond scheduling appointments and she did not delete any names from the Mental Health EWL.

- Administrative employee 5 was interviewed about information reported to VA OIG alleging that she had helped several CAVHCS employees delete patients from the EWL. Administrative employee 5 acknowledged her familiarity with the CAVHCS initiative to reduce patient wait times and that she had facilitated the deletion of veteran names from the Mental Health EWL. She recalled that, sometime during September 2014, CAVHCS leadership had approached her about the possibility of earning overtime by assisting on a project intended to reduce the number of patients on the Mental Health EWL. She said she took the opportunity to make some extra money for the holidays. She stated that her primary responsibility was to send letters to veterans the other workers had been unable to contact by phone. She said the letters asked the veterans to give their preference regarding a desired appointment date and notified them of alternative VA clinics or facilities that had available dates for the services they needed. She stated that she and several of her coworkers worked on the project after normal business hours and weekends; however, she could not recall the date the project started or the number of days she was involved.

- MSA1 was interviewed regarding her knowledge of, or involvement with, the deletion of veterans' appointments from the EWL. She stated that if the scheduling calendar was not "zeroed out," she would receive an email from a supervisor that notified her that a scheduling error occurred and required correction. She added that she felt uncomfortable making the adjustments because the practice was contrary to her training; however, she felt obligated to follow the instructions. She also stated that because of the abrupt departure of a Primary Care physician, an unforeseen backlog occurred that resulted in an increased number of patients who needed appointments in the Primary Care Clinic. In addition, she provided an original copy of a wait list she said she maintained as ordered by administrative employee 1. She explained that administrative employee 1 instructed specific MSAs to keep track of the backlog of patients with the paper list. She stated that the MSAs would draw from the list(s) and schedule the appointments across the remaining primary care physicians. MSA1 further stated that she received this instruction via email but was not able to produce the specific email as evidence.

- MSA2 was interviewed regarding her knowledge of, or involvement with, the deletion of veterans' appointments from the EWL. She stated that if the scheduling calendar was not zeroed out, she would receive an email from a supervisor that notified her that a scheduling error occurred and required correction.

- The supervisor stated that he left VA employment in early 2014. He added that he supervised MSA employees who were responsible for patient scheduling. He stated that he did not recall sending email(s) instructing them to correct scheduling errors; however, he did recall verbally telling them that they needed to correct the scheduling errors if the scheduling calendar was not zeroed out. He further stated that he was aware that this action wasn't right and the MSA employees were improperly doing their job when it came to scheduling, but added that he had no choice but to tell them to correct the scheduling errors because those were instructions that were being forcibly pushed down from the top by CAVHCS senior manager 1. He explained there were times when MSA employees questioned why they were being instructed to schedule a certain way when

that way contradicted what was printed in the directive and he could advise them only that CAVHCS senior manager 1 wanted things done the way he wanted them done with no questions asked. He also stated that the MSA employees were only doing as they were taught upon being hired.

Records Reviewed

- VA OIG obtained a copy of an AIB Report of Investigation (dated May 15, 2014) that looked into allegations of scheduling irregularities and the maintenance of paper lists. Review of the AIB report disclosed that, based on employee testimony and a review of electronic mail messages, the AIB substantiated that nurses in primary care at the Tuskegee campus maintained paper wait lists; MSAs (as well as Lead MSAs) had scheduling access removed, thus preventing them from scheduling or viewing availability with certain clinics; desired dates were manipulated or altered appointments were made and/or used inappropriately during the creation of the appointments to restart the wait time clock; and consults were being canceled, denied, or administratively completed without patients being scheduled for an appointment or receiving the requested care.

- The AIB concluded that due to a violation of scheduling practices, as well as failure to follow established directives, delays in patient care occurred because patients were not appropriately scheduled in VistA, the recall reminder system, or the EWL. In addition, patient names maintained on paper lists, sticky notes, etc., could not have been accounted for in any system of VA records—potentially preventing timely care. The AIB also concluded that there was inadequacy of training, a lack of communication and cooperation between services within the facility, and ill-advised certification of compliance with the scheduling directive by service line chiefs. The inappropriate practices were related to faulty processes, staffing shortages, inadequately trained personnel, lack of oversight, as well as ineffective communication and information flow.

4. Conclusion

Our investigation determined that CAVHCS participated in the ACI and, as part of this initiative, veterans' names were deleted from the EWL. One MSA stated that she was instructed by administrative employee 1 to maintain a paper wait list. Administrative employee 1 denied that she instructed anyone to maintain such a list. Two MSAs stated that they were instructed by a supervisor to correct any scheduling that was not zeroed out. The supervisor acknowledged that he gave those instructions and said it was what CAVHCS senior manager 1 wanted done.

The AIB investigation, which occurred prior to the VA OIG investigation, determined that paper wait lists had been maintained; desired dates had been manipulated; and consults had been canceled, denied, or administratively completed without patients being scheduled for appointments or receiving care. VA addressed the issues disclosed during the AIB investigation. As a result, four senior managers are no longer employed at CAVHCS.

The U.S. Attorney closed his investigation without taking any action.

VA OIG referred the Report of Investigation to VA's Office of Accountability Review on August 25, 2016.

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