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

## Central Alabama Veterans Health Care System
## VAMC Tuskegee, Alabama
## VAMC Montgomery, Alabama
## May 4, 2017

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

This investigation was initiated following a Department of Veterans Affairs (VA) Office of Inspector General (OIG) investigation at the Phoenix, AZ, VA Medical Center (VAMC) where allegations had been made about Medical Administration Service clerks within the Veterans Health Administration (VHA) system using unofficial lists or engaging in inappropriate practices to make patient wait times appear more favorable. These practices were strictly prohibited and contrary to VHA policy.

In early May 2014, VA OIG notified Central Alabama Veterans Health Care System (CAVHCS) senior leader 1 via email that VA OIG agents would visit his facility to proactively inquire about scheduling improprieties and possible destruction of related patient medical records. CAVHCS senior leader 1 emailed back that he welcomed the VA OIG visit and noted that he had chartered an Administrative Investigation Board (AIB) to review scheduling irregularities at the facilities under his leadership.

### 2. Description of the Conduct of the Investigation

- **Interviews Conducted:** VA OIG interviewed six VA employees.
- **Records Reviewed:** VA OIG reviewed an AIB report, numerous VA emails, a VA memo, open source data, and minutes of a VA town hall meeting.

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

#### Interviews Conducted

VA OIG interviewed CAVHCS senior leader 1, VAMC Tuskegee senior leader 1, VAMC Tuskegee senior leader 2, VAMC Tuskegee senior leader 3, and VAMC Tuskegee senior leader 4 concerning the use of paper wait lists and the practice of "zeroing out" appointment dates to circumvent VHA scheduling protocols. All of the interviewees described the scheduling methods in the proper manner and in accordance with VHA directives. All interviewees denied having any knowledge of the use of paper wait lists, adverse medical outcomes relating to veterans' health care, the destruction of any records, or any deviation in policy dealing with scheduling. During the interview, CAVHCS senior leader 1 referred to an ongoing AIB that was impaneled by VA to investigate a non-related matter involving employee misconduct at the VAMC Montgomery, AL, campus.

- CAVHCS senior leader 2 contacted VA OIG to report that she possessed emails suggesting CAVHCS senior leader 1 had been notified by CAVHCS staff members, as early as April 2013, of existing concerns related to the improper use of paper wait lists, the manipulation of wait times, and issues relating to veterans' access to care. CAVHCS senior leader 2 also indicated that the information found in the documents in her possession contradicted statements made by CAVHCS senior leader 1 to a Congressional leader and CAVHCS staff.

- A VAMC Tuskegee service chief stated that she had warned CAVHCS senior leader 1 about veteran access issues in December 2013. She also stated that she obtained copies of paper wait lists, which she ultimately provided to VAMC Tuskegee senior leader 1 for information and action. She added that VAMC Tuskegee senior leader 1 ignored her concerns and did not provide any information relating to the status of the VHA investigation or the whereabouts of the forfeited wait lists.

**Records Reviewed**

- VA OIG reviewed the AIB report[1] documenting the AIB proceedings and referenced by CAVHCS senior leader 1 during the earlier interview. The review disclosed that CAVHCS senior leader 1 apparently convened this AIB in February 2014, specifically to investigate violations of the clinical process and VHA scheduling practices. The AIB addressed the questions VA OIG had posed to CAVHCS senior leader 1 during the May 2014 interview; however, he stated that it was a non-related matter. The AIB Report of Investigation (AIB report) detailed these findings, as summarized here:

    - Delays in patient care occurred because patients were not appropriately scheduled in the Veterans Information Systems and Technology Architecture (VistA), the Recall Reminder System, or the Electronic Wait List (EWL). Patient names were maintained on paper lists, sticky notes, etc., and could not have been accounted for in any system of VA records. Therefore, appropriate action to ensure patients received timely care or treatment did not occur.

    - It was apparent that medical center staff were aware of the CAVHCS scheduling practices/EWL practices.

    - Staff were instructed to alter "desired dates" when clinics were canceled to ensure the zero-day wait time continued to be reflected in the reports.

    - The access to SD Build Key (access to scheduling system) was too widespread and lacked proper oversight, thereby making it impossible to ensure clinic profiles and availability were processed correctly, and if appointments were scheduled appropriately.

    - There was a process in several clinics that did not allow the reminder system to generate postcards notifying the patients it was time to call for their appointment. The process was ineffective and resulted in veterans not receiving care.

[1] The AIB report is dated May 15, 2014.

- In January 2014, two senior staff certified a memo to CAVHCS senior leader 1 indicating that CAVHCS had complied with the VHA scheduling directive. As late as December 2013, a review concluded paper lists were still in use. The AIB concluded there was less than full disclosure regarding the certification of compliance with the scheduling directive.

- There were variations in clinic grids/schedules regarding future appointment access and the use of Out Patient Recall Lists, the EWL, and appointment schedules among staff throughout the CAVHCS facilities.

- The direct violations of clinic processes and of the VHA directive were inconsistent with VHA policies, procedures, and guidelines. These incorrect procedures could potentially delay the delivery of preventive services, lead to missed or delayed diagnoses, and cause poor outcomes in high-risk patients, increasing institutional risk and liability for adverse patient outcomes. The AIB concluded that the inappropriate practices could be the result of faulty processes, staffing shortages, inadequately trained personnel, and lack of oversight, as well as ineffective communication.

- CAVHCS senior leader 3 provided VA OIG with the email correspondence referenced by CAVHCS senior leader 2. A review of the emails disclosed that a VAMC Montgomery service chief had emailed CAVHCS senior leader 1 in April 2014 informing him that a medical staff member had reported a possible "gaming" of the scheduling system and access concerns in at least one clinical area within CAVHCS. CAVHCS senior leader 1 had immediately emailed back with, "I can speak to the matter in Ambulatory Care but not the other services." CAVHCS senior leader 1 also outlined the procedures he had implemented as a corrective action to address the matter.

- CAVHCS senior leader 3 provided additional emails from CAVHCS employees. Review of the email correspondence disclosed that CAVHCS senior leader 1 knew about the improper scheduling practices, as evidenced in the following.

  - In late 2013, a medical support assistant (MSA) sent an email to a CAVHCS service chief informing him that she had received a paper wait list from an employee and also of the apparent continued manipulation of patient wait times.

  - In late 2013, the CAVHCS service chief forwarded the information to CAVHCS staff advising them of the findings and suggesting that they develop a plan of action to address "paper list."

  - In early 2014, a CAVHCS service chief forwarded an email to CAVHCS senior leader 1, CAVHCS senior leader 2, and VAMC Tuskegee senior leader 1 that contained, as an attachment, a fact-finding report regarding clinic access in Primary Care.

  - In early 2014, a CAVHCS service chief provided additional recommendations for addressing improper scheduling practices.

- In early 2014, CAVHCS senior leader 2 emailed CAVHCS senior leader 1 regarding the initiation of an AIB to investigate patient access issues at VAMC Tuskegee.

- In early 2014, CAVHCS senior leader 2 emailed Veterans Integrated Service Network (VISN) 7 senior leader and CAVHCS senior leader 1 regarding AIB members.

- In early 2014, CAVHCS senior leader 1 emailed VISN 7 senior leader and CAVHCS senior leader 2 regarding the status of AIB selections.

- In mid-2014, CAVHCS senior leader 1 emailed CAVHCS senior leader 3 and referenced a May 2014 meeting with CAVHCS senior leader 3 and a VAMC Tuskegee service chief who had informed him of the use of "paper waiting lists" being used for Social Work appointments. CAVHCS senior leader 1 requested a status update.

- In mid-2014, CAVHCS senior leader 3 responded to CAVHCS senior leader 1 with recommendations and actions.

- In mid-2014, CAVHCS senior leader 1 responded to CAVHCS senior leader 3 regarding findings related to the use of paper lists.

- In mid-2014, CAVHCS senior leader 3 sent an email to CAVHCS senior leader 1 suggesting an impartial investigation.

- In mid-2014, CAVHCS senior leader 1 sent an email to CAVHCS senior leader 3 indicating he was not aware of allegations relating to paper lists.

- VA OIG reviewed a memo dated January 2, 2014 and titled, "Fact Finding Document: Access Concerns in Primary Care." The document was prepared at the request of CAVHCS senior leader 1 before the initiation of the AIB. Review of the memo disclosed that CAVHCS senior leader 1 knew about improper scheduling practices and wait time manipulation much earlier than what he had reported to VA OIG in May 2014.

- VA OIG reviewed a copy of the minutes to the June 12, 2014 town hall meeting held at the CAVHCS East Campus, Tuskegee, AL. The review disclosed that CAVHCS senior leader 1 spoke to CAVHCS employees informing them of several issues, including the VA OIG investigation into improper scheduling practices. During the presentation, CAVHCS senior leader 1 indicated that an employee had informed him of possible scheduling practices at his facilities in December 2013. [This statement is contrary to the statement CAVHCS senior leader 1 made to VA OIG in May 2014, when he stated that he had no knowledge of the use of paper wait lists or the manipulation of patient appointments.]

- VA OIG reviewed open source data presented through multiple media outlets. The review disclosed that CAVHCS senior leader 1 claimed on several occasions that he did not become aware of scheduling issues at CAVHCS facilities until December 2013.

These statements were again dissimilar to the information he had reported to VA OIG in May 2014.

- VA OIG reviewed the May 2014 email string between CAVHCS senior leader 1 and a VA OIG supervisor. In the email, CAVHCS senior leader 1 was notified of a planned visit to his facility by VA OIG agents and of the visit purpose, namely allegations associated with the destruction of patient appointment records.

  In his response, CAVHCS senior leader 1 stated that he was unaware of allegations relating to the destruction of patient appointment records even though he had received a report of scheduling irregularities and chartered an external investigative board.

## 4. Conclusion

Our investigation determined that CAVHCS senior leader 1 provided false or misleading information to VA OIG investigators regarding his knowledge of the use of paper wait lists and the manipulation of patient wait times at facilities under his direction.

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

JEFFREY G. HUGHES
Deputy Assistant Inspector General
for Investigations

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