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

VA Medical Center in Augusta, Georgia
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 pursuant to a VA OIG Hotline referral that alleged administrators at the VA Medical Center (VAMC) in Augusta, GA, had directed staff to close pending consults without cause. According to Veterans Health Administration (VHA) directives, such practice was strictly prohibited and contrary to VHA policy. This investigation was conducted jointly by VA OIG's Office of Investigations and Office of Healthcare Inspections (OHI).

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** VA OIG interviewed nine VA employees (two of whom are no longer employed at VA), including administrative employees and senior staff.

- **Records Reviewed:** VA OIG reviewed VA emails and approximately 2,700 consults that former service chief 1 had directed to be improperly closed.

3. Summary of the Evidence Obtained From the Investigation

The individuals identified as former service chief 1 and former service chief 2 were both VA employees at the time of their interviews (June/July 2014); however, since then, they both left VA employment while the investigation was ongoing.

Interviews Conducted

- Former service chief 2 stated that she did not direct staff to discontinue consults without cause. She said she had provided several delinquent consult lists exceeding 90 days to various VAMC Augusta supervisors, including former service chief 1; her goal was to assign consults to staff for them to "complete" once verification had been received that the service was rendered to the patient. She stated that the last wave occurred approximately 2 months preceding her June 2014 interview when she sought the assistance from various staff. Former service chief 2 initially stated that she only provided verbal guidance to supervisors on how to proceed with the "consult clean-up"; however, she stated that she expected her supervisors to pass on the guidance to the employees who completed the consults. She also stated that she, along with other supervisors, never provided any formal training to include Microsoft PowerPoint presentations, emails, or other classes on how to properly complete consults.

  When reinterviewed, former service chief 2 said she learned in February 2014 that former service chief 1 had directed his staff to enter "Service completed or patient refused

services" in order to discontinue consults. She stated that she subsequently directed former service chief 1 to reassign his delinquent consult list to appropriately trained staff; however, she said she never followed up with the assignment. She stated, "I do not recall" notifying anyone of the manner in which former service chief 1 completed the consults. She added, "I do not recall" taking any action to look into the consults that former service chief 1 directed to be discontinued. She further stated, "I don't recall," when questioned about a June 6, 2014 email the VAMC coordinator had sent to her inquiring about concerns regarding former service chief 1's improper discontinued consults.

- Administrative employee 1 stated that consults were being closed out with the comments "patient refused services" and "services have been completed." She explained that administrative employee 2 was one of the employees directed to close the consults using these comments. She also provided the identity of a veteran whom she had contacted personally and confirmed that he never refused care—even though his medical consult record reflected that he had refused care.

- Administrative employee 2 stated that, during the week of February 10, 2014, former service chief 1 requested that she and her colleagues (administrative employee 3, administrative employee 4, and another employee now deceased) be available to meet with him. She explained that former service chief 1had arrived at the meeting with an interoffice envelope that contained several lists of consults, which were divided among colleagues. She said that former service chief 1 had directed them to open all pending consults from October 1, 2012 through September 30, 2013 and to enter the notes: "Pt refused service or administratively closed" in the comments section. She further stated that she had asked former service chief 1 whether that was appropriate given that she did not see or talk to the patient. She reported that former service chief 1 had told her "this is what I've been told to do." She stated that she had continued to tell former service chief 1 that she was not comfortable doing what he had asked her to do, to which he had replied "as long as you stay within those parameters of October 1, 2012 to September 30, 2013, we would be OK because they were just closing out consults." She added that they received verbal instructions only from former service chief 1 and that at no time did anyone contact a single patient or review records for services provided before entering the comments.

- A VAMC coordinator stated that, on June 6, 2014, she had emailed former service chief 2 and VAMC senior leader 1 to share her concerns about how consults were being addressed. She said that it was her responsibility to oversee consult management; she had noticed that several entries had been made and consults annotated with: "consult complete or patient refused services." She explained that administrative employee 2 appeared to have completed several consults with the same comment. She said she had questioned administrative employee 2 about the comment and administrative employee 2 had replied that she and her coworkers had been told by former service chief 1 to assist with the consult cleanup. She further stated that administrative employee 2 had told her that she (administrative employee 2) had been directed by former service chief 1 to enter the comment "consult was complete or patient refused services." She recalled having confirmed with administrative employee 2 that she (administrative employee 2) had

never called a patient despite making the comment "patient refused service." She stated that she had brought this matter to the attention of former service chief 2 and VAMC senior leader 1 in an email; she had also spoken about it with VAMC senior leader 1 in person. She reported that former service chief 2 never responded to her concerns about the comments and that VAMC senior leader 1 had told her the issue did not occur while he was in a position of senior leadership.

- Administrative employee 3 stated that, during the week of February 10, 2014, former service chief 1 requested that she and her colleagues (administrative employee 4, administrative employee 2, and another employee now deceased) be available to meet with him. She further stated that former service chief 1 had arrived at the meeting with an interoffice envelope that contained several lists of consults; those were divided among the colleagues. She said former service chief 1 directed them to open all pending consults from October 1, 2012 through September 30, 2013 and to add "Pt refused service or administratively closed" into the comments section. She added that she had kept a typed record of former service chief 1's instructions on how to close out the consults, which she subsequently provided to VA OIG.

- Administrative employee 4 stated that, during the week of February 10, 2014, former service chief 1 requested that she and her colleagues (administrative employee 3, administrative employee 2, and another employee now deceased) be available to meet with him. She further stated that former service chief 1 had arrived at the meeting with an interoffice envelope that contained several lists of consults, which were divided among the colleagues. She said that former service chief 1 had directed them to open all pending consults from October 1, 2012 through September 30, 2013 to add, "Pt refused service or administratively closed" to the comments section. She also stated that former service chief 1 initially had walked behind each one of them to offer them step-by-step instructions on how to complete the consult and what to enter in the comments section.

- Former service chief 1 acknowledged that while employed as the service chief at VAMC Augusta, he had directed administrative employee 2, administrative employee 3, administrative employee 4, and another employee now deceased, to complete the consults by entering "Service completed or patient refused services." He stated that his supervisor, former service chief 2, had told him to get the job done; however, he added that she had never requested him to complete the consults by making false entries. He also stated that he had been under a lot of pressure to complete the consults because he was in the process of transferring to another position within VA.

- VAMC senior leader 1 stated that he had been made aware of the June 6, 2014 email and subsequently had met with the VAMC coordinator to discuss the issue of the inappropriate consult completions. He explained that he was not familiar enough with the issue to make a determination and had requested a second meeting with the coordinator. He further stated that he had briefly discussed the allegation with VAMC senior leader 2, but he only knew of the one case identified by the VAMC coordinator; he

said he intended to follow up once he learned additional information. He reported that he was scheduled to meet with the coordinator for a second time to discuss this matter.[1]

- VAMC senior leader 2 stated that VAMC senior leader 1 briefed him on one case identified by the VAMC coordinator regarding an alleged improper consult closure. He further stated that he was never briefed by former service chief 2 on any improper consult closures, particularly the other closures directed by former service chief 1.

Records Reviewed

- A review of former service chief 2's VA email history disclosed a February 20, 2014 email she sent to former service chief 1 asking about why he directed his staff to use "service rendered or patient refused." There was no record of a response.

- The investigation initially disclosed that four administrative employees had improperly closed 1,514 consults on February 10 and 11, 2014, per instruction from former service chief 1. Further investigation identified an additional 1,212 consults that had been improperly closed by the same staff on February 6 and 7, 2014.

- OHI investigators reviewed a Microsoft Excel spreadsheet listing 1,514 consults that former service chief 1 had directed to be improperly closed. OHI's review disclosed that consults were closed with the statement, "Services provided or patient refused services," but without review of the records or contact with the patients. OHI also reviewed an additional 1,212 improperly closed consults identified by further investigation. The results of OHI's review were provided to facility leaders for follow-up, as needed. OHI's review did not identify cases of patient harm, to date; however, OHI investigators noted that the facility was still tracking two screening mammogram consults. (See https://www.va.gov/oig/pubs/VAOIG-14-02890-168.pdf)

4. Conclusion

The investigation revealed that former service chief 1 admitted to VA OIG investigators that he had instructed four employees to close approximately 2,700 Non-VA Care Coordination consults and had them write the incorrect statement, "Services provided or patient refused services," even though employees did not review the records or contact the patients. The deleted consults included requests for mammograms, surgery, and pain management.

In May 2016, former service chief 1 was convicted at trial of *Making False Statements in Relation to Health Care and Making a False Statement to a Federal Agent.* The investigation also disclosed that former service chief 2 had been informed, on two separate occasions, of former service chief 1's instructions to employees but had failed to take any action. No cases of patient harm have been identified, to date; however, at the time of this report, the facility was still tracking two screening mammogram consults.

[1] VAMC senior leader 1 was not in a position of senior leadership at the time of the closures.

VA OIG referred the Report of Investigation to VA's Office of Accountability Review on August 23, 2016.

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