Department of Veterans Affairs
Office of Inspector General
October 27, 2014

A Statement from the Acting VA Inspector General

The Phoenix VA Health Care System is again in the news due to media reporting on a September 2, 2008, VA Office of Inspector General memorandum of administrative investigation into allegations involving altered appointments and failure to use the electronic wait list. Suggestions from the media and some Members of Congress that the OIG kept secret inappropriate scheduling practices are belied by nearly a decade of reporting that is outlined in the attached chronology, *Keeping Congress and VA Secretary Informed: VA Office of Inspector General's Reporting on Patient Wait Times from 2005-2014*. We encourage serious readers to consider the persistent alarms the OIG has raised on patient wait times and scheduling practices—alarms acknowledged on numerous occasions by Congress at oversight hearings.

In regard to the September 2008 memorandum, our investigation concluded that altering appointments was an accepted past practice to avoid wait times greater than 30 days, and that through a failure to properly communicate a requirement to adhere to policy, some employees continued this practice without management's awareness. Several supervisors and schedulers reported the practice had stopped, but at different times, and both management and staff were confused as to the proper way to schedule appointments. At the time, we believed that a warning in the form of a memorandum of administrative investigation was sufficient to advise the Phoenix HCS Director of the problem so the Director could take corrective action.

Moreover, less than 4 months earlier, the OIG published a report, *Audit of Alleged Manipulation of Waiting Times in Veterans Integrated Service Network 3*, which includes the VA Under Secretary for Health's assurance that the Veterans Health Administration was already addressing our concerns with national solutions, to include new scheduling policy, software modifications, and training for 41,000 schedulers. While 20/20 hindsight is a trait in common abundance, we could not predict 6 years ago the string of broken promises to fix wait times and scheduling problems.

It should be noted that the OIG's final report, *Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System*, cited the 2008 memorandum in Appendix E, contrary to assertions that the memorandum was kept secret. While the vast majority of OIG oversight reports are published on the OIG website, reports of administrative investigation—which contain protected Privacy Act information—typically are provided to congressional oversight committees upon request and may be released publicly if we receive a request under FOIA. We provided a copy of the September 2, 2008, memorandum to the U.S. House Committee on Veterans' Affairs on October 2, 2014, which was the first time a request was made for this memorandum. To set the record straight, we are releasing a redacted version of this memorandum on the OIG website today.

RICHARD J. GRIFFIN
Acting Inspector General

Click here to read:

Keeping Congress and VA Secretary Informed: VA Office of Inspector General's Reporting on Patient Wait Times from 2005-2014

Memorandum of Administrative Investigation – Improper Altering of Patient Wait Times and Failure to Use Electronic Wait List, Phoenix VA Health Care System, Arizona