Written by **Raven Clabough** on March 17, 2016

New VA Inspector General Report Confirms Manipulated Wait Times at Arkansas Facility

A report by the Department of Veterans Affairs inspector general confirms that there has been wait-time manipulation at the VA medical center in Little Rock, Arkansas. While previous reports regarding various other VA facilities reveal manipulated wait times, the *Daily Caller* observes the Little Rock report is "particularly damning."

The "Administrative Summary of Investigation by the VA Office of Inspector General in Response to Allegations Regarding Patient Wait Times," released on March 15, explains that the investigation was conducted after a whistleblower made the Office of IG aware of "inappropriate scheduling practices at the VA Medical Center in Little Rock.

The report is based on interviews conducted with 13 employees of the facility, which revealed that the facility ultimately adopted a policy of incorrectly entering desired dates to match the available dates to give the impression that there were no wait times. The findings indicate that this practice has been going on at least since 2011.

During one interview, a primary medical support assistant (MSA) claimed that a colleague "taught him to manipulate the 'desired date,' and that all MSAs in Primary Care were trained to 'zero out' the wait time because it was how they were supposed to schedule."

That same MSA indicated that it was not clear as to why they were instructed to alter the date, but in 2011, when he began entering the correct date, 28 patients showed extended wait times, prompting an e-mail from his supervisor asking him to reset the appointments.

The Little Rock report also states that MSA Supervisor 1 admitted to the inspector general staff that "they were trained to always zero out the wait times by making the desired date the same as the next available appointment date."

Overall, a review of the training records indicates that VAMC Little Rock employees were instructed on the appropriate methods for scheduling patients, but employee e-mails reveal that certain supervisors instructed their staff to conduct scheduling in "a manner inconsistent with the training."

The report concludes,

> The investigation substantiated that both non-supervisory and supervisory VAMC employees were improperly scheduling patient appointments by manipulating the appointment dates in the VA computer system, resulting in the appearance of significantly lower wait times for veterans' clinical appointments.

Arkansas Online reports that spokeswoman Debby Meece said that the inspector general's findings prompted the Central Arkansas Veterans Healthcare System, which operates a hospital in Little Rock and another in North Little Rock, to adjust many of its scheduling practices. The department claims it has completed 49,000 more appointments in 2015 than in 2014 and that the majority of its patients were seen within 30 days of their request, Arkansas Online writes.

Meece also reported that administration action was taken against the employees identified in the report, but was unable to specify which actions were taken because of privacy concerns, saying only that they were "not insignificant."

As noted by Arkansas Online, the problems uncovered at the Central Arkansas Veterans Healthcare System were not the first to be found in Arkansas after the Phoenix scandal broke. ArkansasOnline writes,

> A similar problem surfaced in a February 2015 report that found the VA's Regional Benefit Office in Little Rock altered 48 overlooked disability claims to make them appear as if they had just been filed. Some of the claims were more than 2 years old.

Since 2014, the Veterans Administration has been under harsh scrutiny after reports exposed that the Phoenix facility had been altering its scheduling books and that at least 40 veterans had died while awaiting care. Reports later revealed similar issues with lengthy waiting times in at least 10 states. Investigation into the Veterans Affairs wait-time scandal has revealed a number of startling revelations, including evidence of fraud and regulatory violations related to scheduling issues at over 50 VA medical facilities.

The Little Rock report is just the latest in dozens that have been released in recent weeks, following mounting pressure for the VA inspector general to reveal its findings about VA hospitals across the country. Though the VA inspector general completed its investigation in December after reviewing 73 medical facilities, months passed without the release of any reports, prompting *USA Today* to file a Freedom of Information Request.

According to *USA Today,* IG spokeswoman Catherine Gromek attempted to defend the delay by suggesting that the office did not want to disrupt possible disciplinary action by the VA, even as numerous instances of violations received no discipline.

U.S. Representative French Hill (R-Ark.) pointed to the latest report as further evidence that Congress should pass the VA Accountability Act of 2015, which he cosponsored. Under the bill, the Veterans Affairs secretary would have the power to terminate employment of employees that are not performing. The bill is currently in committee in the Senate. "There is a simple solution to this problem, not just here in Little Rock, but throughout the entire VA system," Hill said in an email through a spokesman. "Those who work at VA and do not act in the best interest of our veterans need to be appropriately disciplined for their actions."