In regards to the VA Office of Inspector General report dated July 20, 2017 Veteran's *Health Administration Audit of Alleged Inappropriate Scheduling of Electromyography Consults at Memphis VA Medical Center. VA OIG* 16-02468-281

1. On page i paragraph 1 under the heading "What We Found" the report states beginning on Line 4 "We did not substantiate the EMG staff discontinued consults to disguise wait times."
    a. I was an employee working with the CHOICE program and the EMG staff, it was not until I made the Department Head aware of the long wait times that he canceled not only those of 30 days or more but almost all EMG's. If not meant to disguise the wait times then why not make the patients aware? This is certainly not patient centered care. Additionally, I am sure if emails regarding this issue were reviewed it would have been found that this was done to save on the budget for the facility and not in the best interest of the patients.
2. Under that same heading paragraph 2 it states that the Assistant Chief of the Business Office made the decision to discontinue the consults in February 2016 and to authorize a Veterans Choice Program (Choice) consult was inappropriate and circumvented established procedures. Why is there no mention that by the Assistant Chief making decision that that individual was technically making medical decisions without a license, a crime within itself not investigated or prosecuted?
3. It is noted on page i section 2 last paragraph that those individuals that had the consults cancelled waited an average of 169 days for care, but does not clarify if that is total wait times for just the Choice consult or total length of time from initial consult; because I know that when the consults were canceled many had already been waiting longer than 169 days.
    a. Additionally on page ii column 1 paragraph 2 it is noted that the veterans who received their EMG appointment waited an average of 198 days to receive care, again not noting if this was Choice program wait time or total time to receive care.
4. On page 6 of the report it is also noted that 37 veterans waited an average of 250 days or over 8 months for the exam.

a. On the same page paragraph 4 it is stated that the average wait time was 198 days or over 6 months, how can the OHI effectively determine if there were any adverse effects as there is no baseline data to review to know that if a condition existed how much it progressed prior to the completion of the exam and long-term sequelae of the condition/s.

5. On page ii column 1 paragraph 3 notes that the Office of Healthcare Inspections (OHI) found no evidence that any of the veterans suffered any adverse clinical impact because of the delay in their EMG care. This is highly doubtful as I know more than one veteran had multiple sclerosis with worsening dysphagia; this patient had been waiting over 400 days when the consult was canceled. Additionally, this persisted veteran at risk for aspiration pneumonia as well as other associated adverse effects with the inability to properly swallow.
6. 1 page 5 of report OIG recommendation was to have the VA Medical Center Dir. chief clear directions on scheduling procedures. The issue with this is clear directions were already set out and policy not only locally but from the Veterans Health Administration (VHA) nationally and they were deliberately ignored and not followed; as was the standard for the Memphis VA.
7. It is noted that one patient waited 467 days (1 year and 3 months) and was still waiting in March 2017 not including any time waiting prior to the initial consult being cancelled, which is unacceptable by any medical standards.
8. In regards to Finding 3 on page 12 of the report it is stated that the staff did not discontinue the consults to disguise wait times is misleading at best because the Choice directives were very clear and the new consults were not entered with the initial consult date therefore making the metrics look better to the region and VHA. This statement is deceptive at best especially since the OIG reports on page 13 that they were unable to identify the veteran who waited over 16 months for care when I personally provided the investigators from the OIG and OHI the consult and consult

number for this patient (and all of the other 139 veterans as well) that the investigators could have easily had any employee with CPRS access pull up and review that patients chart. Thus showing the investigation was deficient in actually trying to determine the truth and more so to help cover-up the issues within the Memphis VA.

This unauthentic investigation shows the length that the VHA and the OIG will go to cover-up the real issues in the VHA and the lack of care of our veterans, no one can honestly believe that an inspector for the OIG that answers to the VA secretary is going to provide honest and open information sharing when their boss (Secretary of the VA) does not want them too.