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

VA Medical Center in Hines, Illinois
March 3, 2016

1. Summary of Why the Investigation Was Initiated

Allegations made publicly by the complainant were the focus of the investigation at the Hines, IL, Veterans Affairs Hospital (VAH) conducted by the Department of Veterans Affairs (VA) Office of Inspector General (OIG). The complainant primarily alleged that the VAH Hines Mental Health Division maintained "secret backlog lists." The complainant also alleged that she had been told that wait times were manipulated to ensure that the staff received large bonuses and that, because of this, patients were harmed. The complainant was interviewed by the VA OIG prior to the referral dated June 5, 2014, that the Office of Special Counsel sent to the VA Secretary pursuant to Title 5, United States Code, Section 1213, with allegations from the same complainant. Therefore, the investigation focused on the complaints she raised during her interview with the VA OIG.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** In conducting this investigation, the VA OIG interviewed the complainant, and 20 witnesses at the Hines VAH, including medical support assistants (MSAs), MSA supervisors, Patient Administration Services (PAS) managers, administrative staff, clinical staff and senior level VAH and VISN 12 leadership.
- **Records Reviewed:** VA OIG conducted a key word search and review of approximately 245,000 official emails from selected relevant VAH Hines and Veterans Integrated Service Network (VISN) 12 employees. VA OIG reviewed available Letters of Inquiry issued to VAH Hines MSAs, as well as complaints taken by the Hines Patient Advocate office. The OIG Office of Audits and Evaluations conducted relevant wait time data analysis on "desired date"/appointment date metrics in addition to reviewing data analysis reports from VAH Hines management.

3. Summary of the Evidence Obtained During the Investigation

Interviews Conducted

Interview With Complainant

After several unsuccessful attempts to schedule an interview, the complainant was interviewed on May 27, 2014. The complainant stated that when veterans diagnosed with post traumatic stress disorder (PTSD) or traumatic brain injury (TBI) were referred to the Trauma Services section of Mental Health, they were not able to receive treatment in a timely manner, many times waiting many months for treatment.

In response to the mandate from VA Central Office that patients receive care within 14 days, the psychologist and Trauma Services program manager developed the Clinical Observations

Recording and Encoding (CORE) Program. Upon receiving referrals to Trauma Services, MSAs schedule the veterans for CORE, which is a 2-day orientation program explaining PTSD. While this counts as "treatment within 14 days," the complainant stated it is not really treatment.

The psychologist and Trauma Services program manager then managed a Microsoft Excel spreadsheet on a shared network drive, upon which she tracked veterans. When appointments opened up, she gives the veterans' information and appointment dates to MSAs and had them make the appointments in Veterans Information Systems and Technology Architecture (VistA). In this manner, although veterans may have waited many months to be seen by a psychologist, it appears as though they are not waiting long for treatment. The complainant stated she had seen this spreadsheet, that it was discussed at staff meetings, and that generally she was told that the spreadsheet was in response to the VA Central Office 14-day wait time mandate, and the fact that putting the appointments in VistA would show longer wait times.

When she and other staff raised objections and complained about access problems in Mental Health, they were told that was just the way it was and that they would get used to it. The complainant provided two emails in support of her claims. One was from the Hines Mental Health Chief, dated May 6, 2014, about which the complainant alleged the chief admitted to using an Excel spreadsheet developed by an employee in Psychology to manipulate wait times. The other was from the facility director, dated May 8, 2014, which the complainant alleged explained the manipulation of wait times and admonishes employees to report wait time truthfully.

The complainant asserted her belief that wait times were artificially lowered in this manner so that upper management would receive large bonuses. She believed low wait times is one of three critical elements in their yearly performance evaluations, and that some have received "five-figure" bonuses. The complainant's attorney stated that about 1 week prior to the interview, he spoke to a Hines VA doctor who reported Excel spreadsheets similar to the one used in Trauma Services (Mental Health) were widely used throughout Hines, and that the matter was discussed in a staff meeting held several years ago and attended by the VISN 12 Director.

The complainant had no first-hand knowledge of any other scheduling manipulations or improprieties at Hines. She also stated that she had no first-hand knowledge of any patient deaths or drastic changes in patient conditions related to wait times or scheduling manipulation at Hines. She stated that she had been contacted by 20 to 25 people who claimed to have knowledge of additional scheduling manipulations and/or deaths occurring at Hines, but she refused to provide their names. The complainant stated she would only release additional information if given a written document stating that she would not be held responsible for violating HIPAA [Health Insurance Portability and Accountability Act][*]. The

[*] It would not be a violation of HIPAA or any other confidentiality statute to provide the information to VA OIG. However, absent a determination that the complainant did not violate HIPAA or other confidentiality statutes in obtaining the protected information, VA OIG is not in a position to give this complainant, or anyone else, written or verbal assurance that they would not be responsible for violating HIPAA. Determinations regarding HIPAA violations are the responsibility of the Department of Health and Human Services or VA, not the VA OIG.

complainant denied having any additional emails, documents, or other evidence to provide.

The complainant and her attorney were contacted toward the completion of the investigation and asked to provide any additional evidence or information not previously made available to the OIG to ensure a thorough investigation of allegations. Neither the complainant nor her attorney responded to the request.

Issue 1: Secret Waiting Lists

Mental Health

- Witness 1 (Mental Health, Trauma Services) stated that the program manager of Trauma Services created a database to aid in tracking veterans' treatments beginning in approximately 2008. The database actually consists of three separate databases: one for referrals, one for CORE, and one for treatment. The database is used in addition to VistA, the Computerized Patient Record System (CPRS), and other VA programs. It is not used in their place or used to circumvent them in any way.

  CORE is an orientation program used as a clinical tool to begin the process of treatment for PTSD. The program was created with no consideration for VA Central Office-mandated wait time goals. When a veteran is referred to Trauma Services, an appointment is made for immediate outreach and consult. Once contacted, the veteran is scheduled for CORE. Even though CORE is a group orientation, individual sessions are provided for those with special considerations, scheduling conflicts, and so forth. The program is staffed by several of the nine psychologists and one social worker assigned to Trauma Services. During the assessment portion of the orientation, veterans meet individually with staff members who take immediate treatment action if necessary. After CORE, veterans may attend different treatment "tracks," including preparation for trauma focus and trauma focus. While those who desire to go straight to trauma focus may do so, several different programs are designed to prepare patients for trauma focus. Since these are scheduled in sessions, veterans may have to wait until a new session starts, but weekly therapy meetings are available to them while waiting.

  The witness stated that while she would always like to have more staff, she felt that staffing levels were currently sufficient to provide meaningful care within the VA Central Office wait time goals. The aforementioned program structure was specifically designed to address problems relating to the treatment of PTSD, including reluctance to seek and remain in treatment.

  The database is used to comprehensively track veterans' care, in a way currently not possible with VistA, CPRS, and other VA programs. The database is held on a shared protected drive, to which all clinicians in her section have access. The chief of Mental Health is aware of its existence, as is the National Center for PTSD. It is not secret. Concurrently, veterans are immediately scheduled for appointments in VistA as available. No Trauma Services clinicians have scheduling access. Clinicians complete scheduling sheets for each veteran and submit them to two PAS MSAs (assigned to Mental Health) and a program support assistant for entry into VistA. The witness is vaguely familiar

with allegations of desired and appointment date manipulations within the VistA system to lower wait times. When asked if MSAs in Trauma Services were engaged in this type of manipulation, she stated she was not specifically familiar with the exact manner in which they scheduled appointments. She asserted that the allegation that the database was intended as a manner in which to artificially lower wait times is "ridiculous." She further explained that the VistA system is not reflective of the nature of ongoing mental health treatment, and the concept of desired date is not really applicable in this context. While she is not certain of what desired dates MSAs are entering in VistA, she maintained veterans are being seen in a timely manner, within goals, and when they want to be seen.

When the VA OIG special agent mentioned that this database was referenced in an email from the Mental Health Chief, dated May 6, 2014 [provided by the complainant], the witness advised this database was not the database to which he was referring in the email. Rather, he was referring to a similar database used by the intake section of the Mental Health Service Line.

- Witness 2 (Mental Health provider) stated that since his hiring at Hines, the witness has been concerned with access, and ensuring that veterans have immediate treatment options. In pursuit of increasing access, the witness oversaw the development of the Intake Center, and databases capable of tracking veterans' care in ways the archaic VistA system was not able. The databases used by Mental Health to track treatment have evolved, and the ones currently used by Trauma Services and the Intake Center were developed by an employee in Psychology. They are not secret. He stated that the databases are not used instead of the VA scheduling system. MSAs working to schedule Mental Health appointments have always been instructed by Mental Health staff to be truthful and accurate in their data entry.

  The witness noted that there had been confusion about "desired date," "create date" and other terms used in the VistA system, and that the limitations of that system made it ineffective in managing access and resources. The witness explained that the databases were successful and initially showed access issues, which were addressed by the chief of Mental Health. Currently, the witness is satisfied with access in Mental Health.

  Witness 2 stated that the CORE Program was created by an employee in Psychology and approved by the chief of Mental Health. It was not created in response to a performance measure, but instead was developed as a tool to offer group sessions to better serve veterans reluctant or apprehensive to come in for mental health treatment. If a patient in CORE or any other area of the hospital is found to need immediate intervention and treatment, they receive treatment immediately.

  Witness 2 advised that prior to going public with the complainant's allegations, CBS news was granted an interview with the chief of Mental Health. When the story ran soon after, Mental Health was not mentioned, leading the chief of Mental Health to believe his rebuttal to the complainant's allegations had been successful. On June 11 or 12, 2014, a CBS reporter contacted the chief of Mental Health "off the record" and after explaining that he had excluded the allegations against Mental Health in his previous story, advised

that he had more questions about the director. It was felt that the reporter was implying some type of quid pro quo, and he did not respond, but the request was forwarded to the director's office.

The witness noted that many of the staff in Mental Health were very upset because the complainant has suggested that the very programs implemented by Mental Health to increase access and improve treatment were in fact designed to hide access issues. The witness asserted that this is not the case.

- Witness 3 (VAH director) believed the complainant was referring to the Mental Health tracking tool as the "secret list," but maintained there are no secret lists at VAH Hines.

- Witness 4 (VISN director) with regards to complainant's allegation of secret lists, he believes the complainant was referring to Mental Health's tracking tool, which he was aware of.

Non-Mental Health

Although the complainant's allegations focused primarily on the Mental Health unit, she stated that she thought similar practices were occurring throughout VAH. The VA OIG investigation also addressed whether there were "secret" wait lists in other areas.

- Witness 5 (MSA, non-Mental Health) stated that in regards to secret lists, the witness believed there was no such thing. He believed computerized listings of pending consult appointments, which often become backlogged, could be misconstrued as such. He believed there is no ill intent in doing this; rather, system scheduling limitations gives them no other alternative.
- Witness 6 (MSA supervisor, non-Mental Health) had never heard of any kind of secret list, and surmised that the complainant may be referring to either the Electronic Wait List, recall reminder list, the pending consults list, or the Mental Health section's "Calendar List," none of which are secret.
- Witness 7 (MSA supervisor, non-Mental Health) advised that she was not aware of any secret lists. Approximately 3 or 4 weeks before the interview, PAS did find out there was a lengthy New Enrollee Appointment Request (NEAR) list in eligibility, which has now been "cleared up."
- Witness 8 (MSA, non-Mental Health) had no knowledge about secret lists or what that may be referring to.
- Witness 9 (MSA supervisor, non-Mental Health) had never heard of any secret wait lists or backlog lists. The witness noted that just before this investigation began, PAS supervisors knew of a list containing 500 to 600 new enrollees, and Saturday overtime was offered to volunteers to come in and try and get veterans on this list scheduled. The witness noted that the assistant director was very involved in this process.
- Witness 10 (PAS supervisor) stated that it was possible that some may perceive the pending consults listing to be the secret wait list; but noted that it is a legitimate, tracked computerized list.

- Witness 11 (physician, Primary Care) had no knowledge of secret wait lists, but stated pending consults are not typically scheduled in a timely manner.
- Witness 12 (Nursing, Outpatient) believed that Surgical Prep used some sort of patient tracking list, but otherwise doesn't know of any secret lists or anything inappropriate. In the past, the witness had seen a backlogged procedures list in the Gastrointestinal Laboratory, that is, patients waiting for colonoscopy procedures, but she doesn't feel this is a secret list or otherwise inappropriate.
- Witness 13 (Clinical Administration, non-Mental Health) stated that, in 2013, nurses on the surgical floor used patient scheduling logs. The witness did not agree with the use of these logs and was vocal about her opposition. The scheduling logs contained personally identifiable information (PII—patients' last names and the last four digits of their Social Security numbers), which she felt was a security concern. The log also included a calendar date for when a procedure was to be performed. She believed it to be a wait list or schedule log that was kept for patients waiting for pain treatment until an appointment was available. When an appointment was available, they had an MSA schedule the appointment. She believes this method caused excess delay in pain treatments because the log was not visible but was locked in a drawer instead of being placed in an approved computer system. The logbook was maintained by two nurses (one of whom is Witness 14 below). In approximately March 2014, when wait time investigations became known, the logbook was taken out of use and "shredded." The information began to be put in an Excel spreadsheet on a SharePoint site, which she helped implement in approximately April 2012.
- Witnesses 14 and 15 (Nursing, non-Mental Health): Witness 14 created the log described by Witness 13, which she referred to as a "Patient Tracking List" or "Scheduling List," in approximately 2011. The witnesses stated that it is not a waiting list, and it is not secret. [Witness 15 was Witness 14's supervisor.] The witnesses noted that pain treatment schedules vary weekly, depending on provider availability and providers' specialties in administering injections, etc. MSAs do not have the working knowledge to efficiently schedule patients for the multitude of treatments they require. Therefore, when nurses work a patient needing treatment into an appointment slot based on the provider availability, they then immediately have an MSA schedule the treatment in the VistA system. In their view, this is the only practical and timely way to get patients in need of pain treatment scheduled. When Witness 13 objected to the log, it was transferred to the computerized log in the SharePoint system. Witness 14 stated it was known that logbooks were not to be used; however, this book was viewed as necessary for the efficiency of treating the veterans. The log was never used for the purpose or intention of hiding wait times, and once it became known that this could be considered a forbidden "logbook," it was taken out of use.

Witnesses in the non-Mental Health areas talked about a spreadsheet informally referred to as the "Priscilla Report."

Testimony regarding the Priscilla Report included:

- The Priscilla Report is officially known as an Information Resource Management (IRM) Data Run, automatically generated in the VistA computer system, which she imports into an Excel spreadsheet and emails to a group comprising managers overseeing MSA leads and other various supervisors. The purpose of the report is to identify patient wait times that are in excess of 14 days. Wait time is calculated as the time between the patient's desired appointment date (or a doctor's consult date) and the date of the actual appointment scheduled. The witness noted that these are unrealistic standards that VAH cannot meet. (Witness 17)

- The Priscilla Report is a list generated to identify all scheduled appointments that fall outside the established acceptable 14-day wait time. This report is used to identify "clerical" errors made by MSAs. Contrary to the service chief, the witness stated the MSAs are then asked to contact the veteran to clarify the desired date and change it in the system. (Witness 18)

- The MSA lead then distributes the lists [Priscilla Report] as applicable to the MSAs with instructions to "fix errors" in the scheduling. "Fix errors" means that MSAs are to go back into VistA, cancel the appointment in question, then immediately re-make the appointment with a desired date showing the same date as that of the appointment date, which decreases the wait time to zero. After the MSAs make the requested changes, she reports the changes back to her supervisor. If the changes are refused, she does not get further involved. She explained that the column on the far right of the spreadsheet was the difference in number of days between the veteran's desired date of appointment and the date the appointment was created, that is, entered into the computer system. She stated any zero in this column was an error by the MSA who entered the appointment and she was tasked with having the MSAs go back to fix the errors as stated above. (Witness 16)

- The new service chief directed the review of the Priscilla Report, usually on a weekly basis, and also directed the correction of errors by changing the desired dates to the actual appointment dates. In one such meeting, he told MSA staff that the Hines's numbers were "in the red," that Hines was the only medical center in the VISN getting "dinged," and that other facilities were entering appointments using a desired date that matched the appointment date, as long as the veteran agreed to the appointment. This was referred to as the "back-out method." The witness did note that those appointments whose create date is the same as the desired date are indeed frequently occurring errors resulting from MSAs going through the system too fast. (Witness 7)

- She attended the meeting, which occurred in July or August 2013, during which the service chief told MSA supervisors that they were to start using the back-out method. Most MSA supervisors were unhappy with this, and the service chief instructed them to "make the numbers look good" by trying to get the veteran to agree to the "next available" appointment. Another PAS supervisor told her verbally on different occasions to have MSAs on the Priscilla Report remake appointments in VistA so that the desired dates match the appointment dates. The PAS supervisor pushed MSA supervisors to use a Letter of Inquiry for MSAs who were frequently on the Priscilla Report. However, the witness never used a Letter of Inquiry. (Witness 9)

- The witness' current duties include support and oversight to PAS Section Chiefs, who oversee MSA Supervisors and MSAs. The witness feels that the changing of desired dates by the MSAs as a result of the Priscilla Report and other data pointed out to her by two providers was an attempt to correct errors made by MSAs wherein desired dates were the same as create dates. If this was the case, MSAs were supposed to make comments in the system to reflect why this was the case. The witness was not aware of any intentional manipulation of data to decrease wait times. If the witness had felt that were the case, she would not have condoned it. The witness recently initiated an audit of the wait time numbers, in which approximately 1,200 patients' wait times were reviewed for accuracy. Her data showed that from February 2013 to May 2014, 27 percent of patient wait times exceeding 14 days were due to MSA scheduling errors, 59 percent were due to legitimate access issues, and 14 percent were due to MSAs not inputting required comments in VistA to account for the desired date matching the create date. (Witness 19) The director asked employees to follow the rules and to report unethical scheduling practices to the VAH Compliance Officer. Also, during the weekend of May 3, 2014, VAH management approved overtime for MSAs to clear backlogs and pending consults. Witnesses told the OIG investigators that shortly after the matter was reported to the media, the service chief advised the staff that he had been misunderstood and that he did not mean that they should go back to "questioned" scheduling methods. (Witnesses 6, 7, 10, and 20).

- The service chief disputed statements by others that he held a meeting with all MSAs and told them that their supervisors had taught them the wrong way to schedule appointments. He stated that he has used the Priscilla Report, which is generated to identify the number of appointments exceeding the 14-day established acceptable wait time period between desired appointment date and actual appointment date. The intent of this list is not to manipulate numbers in order to shrink the percentage of appointment wait times exceeding 14 days, but rather to identify clerical errors made by MSAs when scheduling appointments.

  As the service chief, he re-implemented old methods of scheduling wherein an MSA could select next available appointment, then view the grid of available appointments. They could then "back-out" of the appointments, which would allow them to input the desired date after viewing the grid of available appointments and getting the patient to agree to an available date. Often, due to a system default, the MSAs mistakenly end up entering the create date as that of the desired date, which would only be accurate for a walk-in, same-day appointment. If this is the case, the MSA is required to enter a notation in the comment field, stating this is the case and is not a mistake.

  When he became the service chief, the MSA supervisors under him "misunderstood" his intent and directions in these methods of scheduling practices, and the purpose and use of the Priscilla Report. He has since learned that they thought he directed them to correct these errors by going back into VistA and make the desired date and appointment dates match. He never told anyone to go back and change dates. He did not realize they were doing so, and his intent with the Priscilla Report was only to educate MSAs. He stated he thought the scheduling practices under the prior service chief, that is, not letting MSAs back-out of the grid, was too restrictive.

In approximately September 2013, he met with the MSA supervisors and instructed them to view appointments as part of the discussion with the veteran, and if the veteran didn't care and agreed to another available date, that became the desired date. He later realized this was too liberal and was in the process of updating these directions just prior to this investigation. Allowing MSAs to back-out of the grid and get the patients to agree to another date was a mistake and "not in line with our directive." He agreed that wait time data, that is, desired dates, were being changed, which resulted in better "wait time" numbers at VAH Hines, but blamed the MSAs' and MSA supervisors' misunderstandings for the situation.

Although he found out weeks before the investigation that MSAs were changing desired dates subsequent to the Priscilla Report, he did nothing to stop this. He denied receiving results of Priscilla Report "fixes," as well as reporting fixes up his chain of command. He steadfastly denied instructing MSA supervisors or anyone down the chain of command to purposely alter dates in VistA in response to the Priscilla Report.

Issue 2: Bonuses

The complainant asserted that wait times were artificially lowered so that upper management would receive large bonuses. She believed low wait times is one of three critical elements in their yearly performance evaluations, and that some have received "five-figure" bonuses. We did not substantiate that upper management whose performance appraisals might have been influenced by wait time metrics received a five-figure bonus. We reviewed performance awards for the director, assistant director, chief of staff, and chief, PAS, for 2011, 2012, and 2013. None of the awards were five-figure amounts.

The OIG received a similar complaint from Senator Mark Kirk regarding bonuses, including an allegation that $16.6 million was paid in bonuses since 2011. Based on our interview with the VISN Director, we did not substantiate that $16.6 million was paid in performance bonuses since 2011. The VISN Director told investigators that the bonus system does not provide much financial incentive to hide data and Hines is not different from other VISN 12 facilities in bonus amounts, and so forth. His bonus and the director's were determined via a point system by the Corporate Senior Executive Office in Washington DC, and he does not believe high access numbers in a large facility like Hines would be a significant factor. He stated that the bonus amounts released to the press and to Senator Kirk also reflect salary incentives and retention bonuses, not just performance awards. He stated that, of the $16 million alleged, $9.5 million was in salary incentives and retention bonuses (which are widely known and deemed necessary by VA). Overall ratings drive performance awards and access measures alone are not large enough to significantly influence overall awards.

Issue 3: Intentional and/or Malicious Falsification of Wait Times

Although the complainant did not provide any specific complaint or evidence regarding falsification of wait times, the VA OIG investigation addressed the issue. On June 30, 2014, approximately 245,000 VA official emails were obtained by the OIG Forensic Laboratory for 10 VA officials.

There were no emails found that were indicative of intentional and/or malicious falsification of wait time data within VAH Hines. To the contrary, multiple emails from 2010 to the present by Hines and VISN 12 leadership clearly show the acknowledgement of, and intolerance to, "gaming" strategies and intentional falsification of wait time data. They also show ongoing dialogue between Hines providers and management stressing that wait times cannot be hidden, supporting their belief that MSA input errors and desired date reliability was in question, their frustrations with the limitations of software systems, and that more resources were needed to truly address access issues.

Alleged Deaths Due to Wait Times

Although the complainant told the investigators that she was contacted by 20 to 25 people who claim to have knowledge of additional scheduling manipulations, and/or deaths occurring at Hines, she refused to provide the names of the individuals who contacted her and did not provide any other information regarding this issue. None of the witnesses interviewed by the VA OIG investigators had any knowledge of patient deaths or harm. One witness stated he was aware of two patients who had chosen to go to outside providers. One chose to go to an outside provider due to a delay in surgical availability for kidney cancer and the other due to a delay in coordination of a care plan at VAH Hines; however, he stated they were not directly attributable to scheduling manipulation or processes, but rather provider/surgical availability. These cases were referred by the VA OIG investigators to the VA OIG Office of Healthcare Inspections for review.

Records Reviewed

VA OIG reviewed approximately 245,000 official emails from selected relevant VAH Hines and VISN 12 employees, available Letters of Inquiry issued to VAH Hines MSAs, and complaints taken by the Hines Patient Advocate office. The OIG Office of Audits and Evaluations conducted relevant wait time data analysis on "desired date"/appointment date metrics in addition to reviewing data analysis reports from VAH Hines management.

4. Conclusion

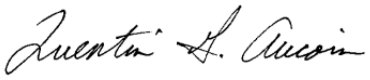
Although delays in access to care remain an ongoing issue at VAH Hines, this investigation uncovered no evidence to substantiate the existence of secret wait lists at VAH Hines. With respect to the Priscilla Report mentioned by witnesses, we found that the report, which was generated at the VAH, identified scheduled appointments that fell outside the established acceptable 14-day wait time. It was not a secret report.

In regards to the complainant's primary allegations of Mental Health treatment delays and usage of any secret lists associated with Mental Health programs, there is no evidence to suggest the tracking tools or group introductory sessions used by that department were in conflict with the aforementioned scheduling directives or used with intent to hide delays in treatment. It appears the Trauma Services database was used to assist in the tracking of modern mental health treatment in a way that worked around deficiencies in antiquated VA scheduling software. On May 8, 2014, the VAH director issued a memo to all employees

notifying them that taking steps to make wait times look good without actually improving the timeliness of appointments was inappropriate.

VA OIG determined that there was a violation of Veterans Health Administration (VHA) Directive 2010-027, *VHA Outpatient Scheduling Process and Procedures*. The investigation showed that MSAs throughout Hines were changing data within the VistA system under the direction of MSA supervisors, who asserted these orders originated from the service chief. Although the existence of MSA clerical errors due to antiquated confusing scheduling software appears valid, the service chief denied giving orders for MSAs to go back into VistA and change data subsequent to wait time IRM Data Reports being issued (Priscilla Report). The results of these changes, whether by design or by unintentional and indirect effect, resulted in decreased wait time datasets. The interpretation of scheduling processes, in specific regard to desired date interpretation and negotiation of desired date with veterans, appears to vary among the MSAs interviewed. The service chief admitted to implementing scheduling methods in which the MSAs could encourage agreement from veterans for alternate desired dates closer to the scheduled appointment dates. While arguably practical, this violates VHA Scheduling Directive 2010-027. There is no evidence to suggest management above the service chief had knowledge of these practices.

The OIG referred the Report of Investigation to VA's Office of Accountability Review on January 26, 2015.



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