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

VA Medical Center in Salisbury, North Carolina
October 4, 2016

1. Summary of Why the Investigation Was Initiated

The Department of Veterans Affairs (VA) Office of Inspector General (OIG) Hotline received an anonymous complaint alleging that management at the VA Medical Center (VAMC), Salisbury, NC, had been "gaming" by manipulating patient wait times in order to look as if the facility was meeting the goal of scheduling appointments within 14 days of a veteran's "desired date." The complainant alleged this manipulation began in 2007 under the leadership of former VAMC Salisbury directors and continued under the director at the time of the investigation.

A second complaint received by the VA OIG Hotline was investigated as part of this case. The complaint alleged that an unnamed employee in a specific office at the VAMC Salisbury was "calling in favors" for scheduling appointments of VAMC Salisbury employees who were also veterans. The allegation claimed the unnamed employee asked that those employees be given priority for the scheduling of appointments and that appointments be created when none previously existed.

This investigation was initiated in response to specific allegations; therefore, the scope of our investigative work was limited to those allegations.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** VA OIG interviewed more than 30 current and former employees.

- **Records Reviewed:** VA OIG reviewed Scheduling Reports; the Massachusetts General Hospital Utility Multi-Programming System (MUMPS)[1] report, emails regarding origination and implementation of the MUMPS report, six performance appraisals, one Network Director Performance Plan, the Executive Career Field Template, one Executive Career Field Performance Plan, the Functional Statement for Licensed Practical Nurses (LPNs) and Registered Nurses (RNs), and the Veterans Health Administration (VHA) Scheduling Directive.

[1] MUMPS refers to the Massachusetts General Hospital Utility Multi-Programming System. A routine using MUMPS captures scheduling information and generates a report with specific focus on information regarding desired dates.

3. Summary of the Evidence Obtained From the Investigation

Issue 1: Manipulation of Wait Times

Interviews Conducted

- In a meeting with the director, associate director, chief of staff, the executive nurse, chief of Management Support, Systems Redesign Coordinator, chief of Quality Management, and the risk manager regarding the allegation, the director stated that the week of May 11, 2013, a VA Team composed of VA employees from other Veterans Integrated Service Networks (VISNs) conducted interviews with VAMC Salisbury employees in order to determine if there were problems in scheduling at the facility. The director further stated that, at the conclusion of the visit, she was told no issues existed at VAMC Salisbury or any of the affiliated clinics other than a few employees at the Community Based Outpatient Clinic (CBOC) located in Charlotte, NC, who seemed to be confused about the desired date of the veteran and the correct application of the desired date when scheduling appointments.

- A service chief stated he was unaware of any scheduling issues at the facility. He stated approximately 800 employees had scheduling abilities at the facility, but fewer than 200 of those were Health Administration Service (HAS) employees. If any appointments were scheduled in error, he said they were not likely malicious in intent but were probably due to confusion, such as putting in the desired date as the "next available date" that the veteran had agreed to, rather than the veteran's true desired date of his/her appointment. He noted that an interim section chief was responsible for training and did so directly by the scheduling directive. He also stated some of the most challenging employees to train regarding scheduling were those who had been in the position the longest and were the "most seasoned." He added that some supervisors were placed in their positions because they had been at VA for a long period of time, not because they were the most qualified for a supervisory position, and this contributed to the challenge of having things done as they should be, rather than how they had always been done. When re-interviewed, the service chief denied instructing any of his front line supervisors to have their schedulers manipulate scheduling dates. He further stated that since arriving in his current position, he had made and continued to make strides to ensure scheduling practices at the facility were correct.

- The interim section chief stated she was unaware of any scheduling issues at the facility and was not aware of dates being manipulated in order to meet the goal of appointments falling within 14 days of a veteran's desired date. She stated that no scheduling audits had been performed to determine if appointments were scheduled correctly. She further stated the volume of data was an obstacle, but she was working with the service chief to implement an audit procedure. She noted that the front-line supervisors were tasked with pulling the daily MUMPS report to look for irregularities, which would signal issues or errors in scheduling. She also stated scheduling appointments within 30 or 14 days from the desired date was not a performance measurement for any schedulers, nor was it a measurement for staff in HAS.

- A supervisory medical support assistant (SMSA1) stated her medical support assistants (MSAs) scheduled between 500 and 700 appointments a day, with 80 to 85 percent of those being face-to-face, as opposed to veterans calling in on the telephone to make an appointment. She stated MSAs were trained to schedule based upon the desired date of the veteran, which "is always the date desired by the veteran" for an appointment. She stated she looked at the MUMPS report on a daily basis to identify "scheduling errors," which she defined as when the veteran's appointment was scheduled more than 14 days from the desired date and the "comments" entered by the MSA did not specify why the appointment falls outside 14 days. She also stated she addressed these types of scheduling errors on a daily basis and if an MSA continued to have scheduling errors that showed on the MUMPS report, it "becomes a performance issue."

  In a subsequent interview, SMSA1 provided a copy of the MUMPS report that she printed earlier that morning. An initial review of the report revealed the report was titled, "Appointment Management Error Report," and the footer of each page showed, "Appointments have to be remade to correct. The desired date should not be no more than 30 days from the appointment date (*sic*)." When asked why the MUMPS report was titled, "Appointment Management Error Report," when it showed all scheduled appointments with wait times exceeding 14 days, she replied that if an appointment showed on the MUMPS report, she would inquire and look at the comments entered by the scheduler to see why the wait was beyond 14 days. If the scheduler justified the wait time with a valid reason, such as there being an access issue for the clinic or physician, then she would deem the scheduled appointment okay. However, if the scheduler did not justify why the appointment was made with a wait time exceeding 14 days, it was an error that needed to be corrected by the individual who scheduled the appointment.

- MSA1 stated if she scheduled an appointment with a wait time exceeding 14 days, she was instructed by her supervisor to "correct" the appointment. She stated any appointment with a wait time greater than 14 days was considered a scheduling error that needed to be corrected. In order to correct it, she would change the desired date so it would fall within 14 days of the scheduled appointment date. The interviewee was unsure as to whether her performance appraisal included "grading" her on the percentage of appointments she scheduled within 14 days of veterans' desired dates.

- MSA2 stated he was called by his supervisor approximately once a month and told to remake an appointment due to his name showing on the MUMPS report. His supervisor did not tell him to change any dates but simply instructed him to remake the appointment. As an explanation of how he would remake an appointment, the interviewee stated that he might be asked to remake an appointment he had scheduled 4 weeks prior. Once instructed to do this, he would go in and remake the exact same appointment; however, the system would then reflect the current date as the date the appointment was made, rather than the original date, which was 4 weeks earlier, thus manipulating the wait time of the appointment. He stated he was taught in training to make all appointments within 14 days of the desired date, but he was not penalized if appointments were made with wait times exceeding 14 days.

- SMSA2 stated that she supervised 17 MSAs in her current position. She further stated she reviewed three reports on a daily basis, including the MUMPS report. If patient wait times exceeded 14 days, it showed there was an access issue or a staffing problem. However, that did not mean there was a scheduling error. She stated she had never instructed MSAs to change appointments or dates in order for appointments to fall within 14 days of the desired date.

- LPN1 stated she had attended scheduling training at VAMC Salisbury on May 23, 2014, which was taught by an interim section chief. During that training, she realized she had been trained to schedule incorrectly by manipulating the desired date so appointments were scheduled with wait times less than 14 days. LPN1 stated she had been trained in October 2013 to back out of the system if the next available appointment was beyond 14 days of a veteran's desired date, then re-enter the system and change the desired date to the next available appointment date. Her supervisor, who was also in the training on May 23, 2014, would send her an email and tell her to "fix" any appointment she had scheduled with a wait time greater than 14 days. The LPN stated she would "fix it" by canceling the appointment, then rescheduling the same appointment and changing the desired date so it fell within 14 days of the scheduled appointment date. She further stated that another LPN (LPN2) told her that the supervisor had threatened to take away her ability to schedule appointments for not "fluffing the numbers" in order to make wait times less than 14 days. LPN2 told her it was documented on her performance appraisal that she "was not a team player" due to consistently scheduling patient appointments with wait times beyond 14 days.

  In late 2013, she learned of a "Consult List" for her clinic (Women's Health) that contained names of patients, who were never scheduled an appointment, to be seen in the clinic. She stated some of the patients on the list had been waiting over 500 days for an appointment to be scheduled. She and another nurse in her clinic scheduled appointments for patients on the consult list and reduced the list from over 5 pages to 1 page, with approximately 14 to 15 patients remaining to be scheduled for an appointment.

- LPN1's supervisor stated she attended training at VAMC Salisbury on May 23, 2014, that was intended to clarify the desired date and how to appropriately schedule appointments for veterans. She learned during training that the desired date was always determined by the veteran and this differed from how she was taught years before. She stated she was taught to put in the desired date as the next available date the patient could be seen, rather than the true desired date of the veteran. She stated she reviewed the MUMPS report on a daily basis; it showed appointments scheduled by her nurses with wait times exceeding 14 days. She would then send an email to the scheduler and tell them to "fix it." She stated she did not know how they "fix[ed] it" and had never instructed them how to do so.

  She had been reviewing the MUMPS report since approximately 2009 and was told at that time that all appointments should be scheduled within 30 days, later reduced to 14 days, of the desired date. She referred to this as the "Golden Rule." The supervisor stated the percentage of scheduled appointments made by nurses under her supervision with wait times greater than or below 14 days was not part of her performance appraisal

and she was not evaluated on this by her supervisor. She added that appointments scheduled with wait times under 14 days was not something she evaluated her employees on during their performance appraisals.

- LPN2 stated she was trained by other LPNs on how to schedule appointments approximately 3 years prior to the investigation. She stated she never asked a veteran for his/her desired date, but rather told the veteran the next available appointment and if the veteran accepted it, she would enter that date as the desired date. She also stated that her supervisor had contacted her numerous times and told her to "fix" appointments for those she had scheduled with wait times exceeding 14 days. The supervisor never told her how to fix the appointments and the only way she knew how was to change the desired date. LPN2 stated that her supervisor threatened to take away her ability to schedule patient appointments if she continued to schedule appointments with wait times exceeding 14 days and was told to "do it appropriately." She was told in a performance review that she was "argumentative" due to her constantly scheduling appointments with wait times exceeding 14 days and continuing to show up on the MUMPS report. She stated the wait times issue did not affect her overall rating on her performance appraisal, but she was told that it was something she needed to work on in the future.

- An administrative employee in Primary Care stated he had reviewed the MUMPS report in the past and saw that it showed scheduling was done incorrectly because the desired date matched the date of the appointment a majority of the time, which was highly improbable. He mentioned this to the interim section chief, who was responsible for training. When asked about patient care issues at the facility, he replied that he knew of a physician who would have information pertinent to this investigation but wanted to speak with the physician first before giving his name. (The physician was interviewed by VA OIG and is identified as "a provider.")

- A manager in Primary Care stated that the Executive Career Field template was sent down from VA Central Office (VACO) staff on a yearly basis and contained measures or goals of each facility. However, he stated that seeing patients within 14 days of the desired date was only a measure and it did not drive him or his service. He was "absolutely" evaluated by seeing patients within 14 days of the desired date, as well as other performance measures, but his focus was on quality of care rather than performance measures. In regard to patient care issues, he was not aware of any patient care issues related to improper scheduling at the facility.

- A nurse manager in Primary Care stated she had reviewed the MUMPS report in the past, and that was usually the responsibility of the nurse manager. However, she stated if a nurse continued to show up on the MUMPS report, it suggested that the nurse needed to be retrained in scheduling appointments or that there was an access issue. She stated that 14 days was a goal but not a mandate, and it was primarily a tool that may show an access issue in a certain clinic. She further stated she had never instructed, nor heard of others instructing, employees under her supervision to change dates in order to have patient wait times less than 14 days. In regards to performance appraisals, she stated the scheduling of appointments within 14 days of desired date was not a performance measure. When shown a performance appraisal of a supervisory RN in which she

specifically commented on scheduling appointments within 14 days, the nurse manager stated it was poorly documented in the performance appraisal, but the employee was not measured or evaluated on appointments scheduled with wait times exceeding 14 days. She concluded by stating that if there were scheduling issues at VAMC Salisbury, they were "not malicious," but rather the product of a "knowledge deficit" of the employees scheduling the appointments.

- A provider stated he came to the conclusion soon after coming to work at VAMC Salisbury that they (physicians) were "participating in malpractice if not on a daily basis, a very frequent basis" due to having to "fight the system" to provide proper care to patients. He stated that he became aware of a large backlog in Urology in 2009 in which patients waited as long as 2 years to have appointments scheduled with no follow-up.[2] He further stated no one was held accountable and he discussed this with his boss. He did not indicate that the backlog continued into 2014, which was supported by other witnesses. He did state there were issues in other services and agreed to provide information on specific patients who were directly affected by lack of proper scheduling. He provided the names of 15 patients, which were given to the VA OIG's Office of Healthcare Inspections (OHI) for review.

- MSA3 stated the majority of appointments made in Urology were follow-up appointments scheduled before the patient left the clinic. She stated that most patients were seen within 14 days of their desired date because Urology had "a lot of providers" and there was no problem seeing patients in a timely manner. She had always scheduled appointments based upon the desired date of the veteran and had never been told to "fix" appointments so they fell within 14 days of the desired date.

- MSA4 stated he had been instructed on several occasions to "change appointments to be within 14 days of the desired date" by SMSA1 and SMSA2 and a former SMSA. He, as well as other schedulers in a specialty clinic (Dental Clinic), was told to remake appointments so the reports would show no wait times.

  He stated that from 2008 through 2010, he was told to go into the scheduling system, check for the next available date, then exit the system. After doing so, he would then go back into the system and use the next available date as the patient's desired date so the wait time would equal zero days. He said that he was instructed to do this by his supervisor, SMSA2. He stated SMSA2 instructed him to change the desired date so the wait time would be zero days because she said Building 1 (the Executive Building management) "wanted it that way." This was all done verbally and nothing was ever put in writing or in an email. He stated he was also instructed to do this by SMSA2 and MSA5 (only two to three times), but mostly by SMSA1. He added that manipulation of wait times was done mostly during the tenure of a former director. He stated scheduling practices improved in 2010 under the tenure of a former and another former director and had gotten even better since the current director had been in charge of the facility. He estimated that 90 percent of all appointments made at the facility now were done

[2] *Healthcare Inspection: Access to Urology Service, Phoenix VA Healthcare System, Phoenix, Arizona*, Report No 14-00875-03, October 15, 2015.

correctly using the patient's desired date. He stated that correct scheduling began long before this investigation started.

- A former employee of VAMC Salisbury stated the (1) Clinic Appointment Availability Report (CAAR), (2) the Clinic Utilization Statistical Summary (CUSS), and (3) the MUMPS report were used at VAMC Salisbury to assist MSAs in scheduling. She explained that the CAAR report was used to ensure MSAs had correctly entered the veterans' desired dates and it was implemented at the VISN level by a VACO employee. She stated the CUSS report was used to examine past and future data of scheduled appointments. She added that the CUSS report had "always been around" and she did not know who implemented its use at VAMC Salisbury. She stated the MUMPS report was used by supervisors in conjunction with the CAAR report to ensure appointments were being input correctly and to monitor possible access issues. When shown the MUMPS report, she identified it and stated, "We [created] our own general template in Salisbury." When asked why the report was named an error report (in the heading), she stated, "We just named it . . . it wasn't an error report." She stated that the Data Management Section created the report's header and footer and the report was a compilation of hers and two other individuals who worked at VAMC Salisbury at the time.

- SMSA3 stated she was trained to follow the standard operating procedure regarding scheduling, and it clearly showed the veteran's desired date should never be changed. She further stated, as long as you followed the standard operating procedure, "You can't go wrong." She stated she had never instructed anyone to change appointments or desired dates in order to schedule patients with a wait time of 14 days or less. However, she stated she had heard MSAs say they were told to do that "before her time," but she instructed them not to do it and to simply do it the right way. She stated she reviewed the CUSS and MUMPS reports to look for access/capacity issues and trends in scheduling. She was out for a period of time but after returning, she attended scheduling training conducted by the interim section chief. The training helped her MSAs to better understand things, such as the desired date and why they do things the way they do. Also, since returning, she had begun performing random audits from a weekly audit report generated by the facility. She stated she would randomly select patient appointments made by her MSAs and look to be sure they were scheduled correctly. She did not look at wait times but looked at remarks and potential errors. At the conclusion of the interview, she was asked again if she ever instructed anyone to change dates so the wait times would be less than 14 days. She replied that she has "never, ever, ever told anyone to reschedule dates or appointments."

- MSA5 stated scheduling employees and supervisors were afraid of being held accountable if they scheduled an appointment beyond 30 or 14 days of the desired date. She further stated she thought she would have been reprimanded as part of her performance appraisal if appointments were scheduled beyond the time frames. She explained that her performance appraisals never specifically stated anything about scheduling appointments within 14 or 30 days, but there was an element of the appraisal in which they were rated on following VA standards or directives, such as the VHA Scheduling Directive. When she was a supervisor, she reviewed the MUMPS report in order to identify scheduling errors. She stated a scheduling error was when Clinical Wait

Time (CWT) 1 and CWT2[3] were the same date, no matter if it was today's date or dates 6 months from now. If she noticed that an appointment was made by an MSA under her supervision with CWT1 and CWT2 being the same date, she would contact the MSA and tell him/her to correct the error. As long as CWT1 and CWT2 dates were different, it was not a scheduling error that needed to be corrected. She also stated that if an appointment was made within 14 days of the desired date, there was "no need to correct anything." After she became an MSA several years ago, she received proper training and was told it was okay to schedule appointments beyond 14 or 30 days as long as she put "access issue" or another legitimate reason in the comments section of the file.

- MSA6 stated he was supervised by SMSA1 for approximately one year. Prior to being supervised by SMSA1, he was supervised by SMSA2. He stated he was never told to make patient appointments fall within 14 days of the veteran's desired date. He further stated there were several clinics in the specialty service where he currently worked and it was common for wait periods to be greater than 30 days.

- MSA7 stated her prior supervisors were SMSA1 for approximately one year and SMSA2 for four to five years. She stated that both SMSA1 and SMSA2 instructed her to "fix" scheduling dates, as well as how to do it, that showed as errors on the MUMPS report. She further stated that SMSA2 would not force her to change the dates, but instead told her not to make the changes if she wasn't comfortable doing so. She said she went "around and around" with her supervisors on occasion when asked to make the changes. She stated she was first asked to change dates of veteran appointments five to six years earlier by another VA employee. She stated she received formal scheduling training in 2014 and had not been asked to change dates since that time.

- MSA8 stated his first supervisor at VA was SMSA2. He stated he did not know anything about the electronic wait list and was not aware that veteran appointments were supposed to be made within 14 days of the patient's desired date. He stated that in the specialty clinic where he was employed, there were only two providers and a low volume of appointments, so wait times were not an issue. He further stated he was never instructed to manipulate patient wait times.

- MSA9 stated she her prior supervisors were SMSA1 and SMSA2. She stated she was never instructed by her supervisors to change dates on appointments to make them fall within a certain time frame.

- A program support assistant stated she was supervised by SMSA1 and SMSA2. She stated she was never instructed to change wait times or desired dates.

- A specialty technician stated her prior supervisors, including SMSA1 and SMSA2, all told her to change scheduling dates to ensure patient appointments fell within 14 days of the veterans' desired dates. She also stated that appointment

[3] Clinical Wait Time 1 is the amount of time from the create date to the appointment date. Clinical Wait Time 2 is the amount of time from the patient's desired date to the appointment date.

errors, such as those with wait times greater than 14 days, were part of her performance appraisal.

- MSA10 stated he had never been asked by any of his supervisors to change or manipulate dates concerning scheduling of appointments.

- A VAMC employee stated that while working as an MSA, her supervisors, including SMSA1, SMSA2, and SMSA3, would approach her to discuss appointments she had made for veterans that caused her name to appear on the MUMPS report. She stated if she were certain the dates were correct for the scheduled appointments, she would argue the point, but there were times when she would change dates on veteran appointments as directed by her supervisors.

- MSA11 stated she had never been approached by her supervisors, including SMSA1, SMSA2, and SMSA3, and asked to change scheduling dates due to excessive wait times. She clarified that SMSA2 and SMSA3 would approach her and other MSAs to change dates on scheduled appointments that were identified on the MUMPS report.

- The VAMC Salisbury Director stated she implemented a plan to improve access for veterans in May 2013 after she became aware of "unacceptable delays" in treatment for veterans at the facility. She said she felt wait times were good for veterans, but there were still some delays that needed addressing at the time the news about the problems at VAMC Phoenix[4] went public. After hearing of the issues in Phoenix, she began looking at VAMC Salisbury to see if similar issues may have been present. As a result, in approximately March or April 2014 (prior to this investigation), it was discovered that new enrollees were not being placed on the New Enrollee Appointment Request (NEAR) list appropriately and it was immediately corrected and was now in compliance with the VHA directive. She stated she felt wait times were not an issue at the facility at that time. However, to determine if the facility was correctly scheduling patient appointments, she obtained an audit tool from a VA facility on the West Coast.

  The director felt a false sense of security after a VA Team came to VAMC Salisbury the week prior to the initiation of this investigation and told her there were no scheduling issues at the facility. She stated she did an interview with the local newspaper immediately after the VA Team left and shared the information with the local reporter. She further stated that retraining for all individuals who scheduled appointments at the facility began in June and was completed in September 2014. She stated feedback had been positive for the retraining, and she was told by several employees that they discovered during the training they had been scheduling incorrectly but had been unaware that the way they had been scheduling was incorrect. She explained that a new position had been approved in the HAS, to be filled in early 2015 (VA OIG never determined if this was done), with the primary responsibility of assessing the competency of the MSAs in regard to scheduling, to running the audit tool, and to providing feedback and

[4] Any reference to Phoenix in this summary refers to wait time allegations that surfaced at VAMC Phoenix in early 2014.

education based upon the results of the scheduling audits. She also stated there had been a lot of supervisor turnover in the HAS within the past year because she had held supervisors to the standard of doing things the right way. The director concluded by stating she believed that past management teams at VAMC Salisbury focused on "meeting the metrics" or "hitting the number rather than the real intent behind the metrics." She stated the current management team was trying to "change the mindset" on things—not just scheduling. She stated goals were important, but doing the work required to reach the goal was more important.

- A VACO employee stated she was unsure about the origin of the MUMPS report or when it was first used by VA, but she used it while employed in VA clinics between 2000 and 2004. She stated some facilities chose to use the report while others did not, which was a shame because the MUMPS report was an excellent report to see if the facility had any "gaming" issues going on. She explained that the MUMPS report listed all patients who had appointments scheduled beyond a certain amount of time, such as 14 or 30 days. In addition, the MUMPS report showed a veteran's scheduled appointment date, as well as a veteran's desired date. She stated the wait time column on the report could be looked at to see "if anything fishy was going on." She explained that if a scheduler were going in the system, checking for the next available date, then exiting, re-entering the system, and scheduling the appointment on the next available date, the wait time would show as zero. The MUMPS report would allow the reviewer to see if a scheduler had an excessive amount of wait times equaling zero days, which should be a red flag. When asked to review a page of the MUMPS report printed from VAMC Salisbury at the onset of this investigation, and whether the header and footer were part of the program and were sent down from the VISN, she replied, "Oh good Lord, no." She told employees at VAMCs that the MUMPS report was to be used as a training tool and should never be used as a malicious report toward schedulers or anyone else. She explained the report was intended to be used to identify scheduling issues or trends that might show a scheduler needed retraining in order to correct problems.

- The Network [VISN] Director was briefed regarding scheduling issues at VAMC Salisbury, to include how the case originated, the details of the investigation, and the findings. He was advised the investigation revealed that patient appointments were being "fixed" by some schedulers at VAMC Salisbury at the request of their supervisors, so that scheduled appointments would appear to fall within 14 days of a veteran's desired date. In addition, he was advised that instances were found in which the number of appointments scheduled within 14 days of the desired date was listed as criteria on VAMC Salisbury employees' yearly performance appraisals, as well as being a component of the VAMC Director's performance plan sent from VISN staff. He stated he was aware of this and his performance plan included a rating for it, as well. The director was also briefed on the second allegation involving a VAMC Salisbury employee who was allegedly "calling in favors" by having appointments for employees scheduled before non-employee veterans at the facility. This was investigated and was found to be unsubstantiated.

Records Reviewed

- VA OIG reviewed a report of all appointments scheduled by facility staff on May 15-16, 2014. Review of the report revealed that more than 7,500 appointments were made over the 2-day time period, and an abnormally large number of the appointments were made with a wait time of zero days, even appointments that were made several months into the future.

- VA OIG reviewed documentation in reference to the origination of the MUMPS report and its use at the facility, which revealed that the MUMPS report was generated from a computer script that was installed prior to April 21, 2009, and was implemented at the VISN level by a VISN 6 employee.

- VA OIG reviewed the 2012 and 2013 performance appraisals for the supervisor of LPN1 and LPN2 found that it contained the following language: "She also provides leadership ensuring appointment made by nursing is in compliance to the 14-day rule of desired date of the Veteran's request. The MUMPS report is reviewed daily and those appointments noted outside the 14 days are corrected by the responsible staff the following day."

- VA OIG reviewed LPN2's 2012 performance appraisal and found that it contained the following language: "She occasionally misses the 14 days' time limit for appointments; however, it is addressed timely when prompted to her attention."

- VA OIG reviewed MSA7's 2010 performance appraisal and found that it contained the following language: "Patients are to be checked-in and out of all appointments are to be scheduled accurately. To be considered fully successful, no more than 10 errors per year."

- VA OIG reviewed the specialty technician's 2010 performance appraisal and found that it contained the following language: "Patients are to be checked-in and out of all appointments are to be scheduled accurately. To be considered fully successful, no more than 10 errors per year." The 2012 performance appraisal contained language stating:

  - "Information is correctly input into VISTA [Veterans Health Information Systems and Technology Architecture] pertaining to scheduling appointments, cancelling, no-showing, rescheduling appointments and recall reminder";
  - "No more than five (5) scheduling errors per year. Scheduling errors are tracked by the Clinic Appointment Availability Report (CARR), Encounter Actions Required Report (EARR), quarterly scheduling audits, and the Appointment Management Errors Report (MUMPS)"; and
  - "No more than ten (10) scheduling errors per year. Scheduling errors are tracked by the Clinic Appointment Availability Report (CARR), Encounter Actions Required Report (EARR), quarterly scheduling audits, and the Appointment Management Errors Report (MUMPS)."

The same wording found in the specialty technician's 2012 performance appraisal was also found in her 2013 and 2014 performance appraisals.

- VA OIG reviewed the "Performance Plan for FY 2012" and found that it contained the following language:

  The fiscal year (FY) 2012 Network Director Performance Plan communicates to Network Directors of the VHA the expectations of the Department of Veterans Affairs (VA). The Plan consists of 5 Critical Elements, 37 Performance Measures:

  - Leading Change (15% weight)
  - Leading People (15% weight)
  - Business Acumen (10% weight)
  - Building Coalitions (10% weight)
  - Results Driven (50% weight)

  A sub-element under the "Results Driven" section of the report, which carried a cumulative weight of 50 percent, on page 8, stated "The Network Director assures excellent access to VA care by ensuring Specialty Care (Including Mental Health) patients will not wait more than 14 days from desired date." This is one of 14 performance measures required for this section.

- VA OIG reviewed information submitted by the provider identifying 15 specific patients and details regarding delay of care, which may have been due to scheduling errors/issues at VAMC Salisbury. The information was provided to OHI for review. OHI reviewed the 15 cases and did not find any indication of patient harm due to scheduling errors or issues.

- VA OIG reviewed emails provided by MSA4 and found nothing of evidentiary value related to this investigation.

- VA OIG reviewed a presentation a former VAMC Salisbury employee used to train MSAs on the CAAR, CUSS, and MUMPS reports. Slide 32 of the presentation contained the exact same header and footer as the one shown to her during the interview. The header read, "Appointment Management Error Report" and the footer read, "The desired date should not be no more than 30 days from the appointment date *(sic)*."

Issue 2: Priority Scheduling of Employees Who Were Veterans

During the investigation, an allegation was received by the VA OIG Hotline alleging that an unnamed employee in a specific office was "calling in favors" for scheduling appointments of VAMC Salisbury employees who were also veterans. The complainant alleged that the employee asked that veteran employees be given priority for scheduling appointments and appointments be created when none previously existed. No further information was received. The investigation identified the unnamed employee and an MSA with scheduling capabilities with whom he had a connection.

Interviews Conducted

- The identified employee stated he had never requested the MSA with whom he had a connection to schedule appointments for anyone, including employees of the facility.

- The MSA stated neither the identified employee nor anyone else had requested she schedule appointments for employees of the facility and give priority to them over non-employee veterans. She further stated this was a conflict of interest in her opinion and she would not do so even if requested.

Records Reviewed

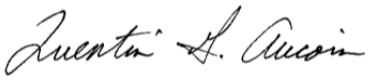
A report documenting appointments made by the MSA within the past year was cross-referenced with employees of VAMC Salisbury. The review identified only one former employee of the facility who had an appointment scheduled by the MSA. Records were requested for another employee with scheduling capability who could have possibly been involved. Review of a report obtained from VAMC Salisbury showed that the employee had not scheduled any appointments for the past year.

4. Conclusion

The investigation, which took place from May 2014 through March 2015, found over half of the schedulers who were interviewed were routinely "fixing" patient appointments at the request of their supervisors, so scheduled appointments would appear to fall within 14 days of a veteran's desired date. Our investigation also revealed that the number of appointments scheduled within 14 days of the desired date was listed as criteria on some VAMC Salisbury employees' yearly performance appraisals. In addition, the VAMC Salisbury Director's performance plan sent by the VISN staff contained a sub-element regarding scheduling appointments within 14 days of the desired date. This sub-element was one of 14 required performance measures under the Results Driven section. The entire Results Driven section carried a cumulative weight of 50 percent.

The investigation did not substantiate the second allegation that an employee at the facility was "calling in favors" to give priority scheduling for appointments for VAMC employees who were also veterans.

The OIG referred the Report of Investigation to VA's Office of Accountability Review on September 24, 2015.



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