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

VA Medical Center in Phoenix, Arizona
May 4, 2017

1. Summary of Why the Investigation Was Initiated

The Department of Veterans Affairs (VA) Office of Inspector General (OIG) initiated an investigation in May 2014 regarding alleged Electronic Wait List (EWL) improprieties and metric manipulation occurring at the Phoenix VA Health Care System (PVAHCS). Specifically, it was alleged that individuals at PVAHCS were using a "secret" wait list in order to hide the fact that patients were waiting long periods of time for Primary Care appointments. Eventually the allegation was expanded to indicate that this was being done in order to manipulate performance metrics, which had an effect on senior management's performance ratings and bonuses. This investigation w as conducted jointly with the Federal Bureau of Investigation (FBI).

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** VA OIG Criminal Investigation Division (CID) conducted 215 interviews of 190 current and former VA employees. VA OIG Office of Audits and Evaluations (OAE) and Office of Healthcare Inspections (OHI) conducted an additional 77 interviews of 73 current VA employees. Some individuals were interviewed more than once. In total, OIG conducted 292 interviews with 237 current and former VA employees.

- **Records Reviewed:** VA OIG reviewed approximately 1,035,000 emails, their attachments, and other data files; approximately 86,000 Veterans Health Information Systems and Technology Architecture (VistA) MailMan messages, and approximately 69,000 associated files; the contents of 365 bankers' boxes of documents that were obtained from "preservation bins"; FY 2012 and FY 2013 performance appraisals for nine VA management officials; and the OAE, *Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System* (Report No. 14-02603-267).[1]

3. Summary of the Evidence Obtained From the Investigation

Overview of Investigative Activity

The VA OIG CID Phoenix Resident Agency was initially brought into this investigation to seize the VA computers of relevant employees for analysis and to assist OAE and OHI with interviewing VA employees. On May 2, 2014, CID obtained approval from the United

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

States Attorney's Office to seize the VA computers of VA employees who were relevant to this investigation. On May 2, 2014, VA OIG special agents seized the VA computers of: VA Medical Center (VAMC) senior leader 1, VAMC senior leader 2, service chief 1, service chief 2, service supervisor 1, medical support assistant (MSA)1, administrative assistant 1, clinic supervisor 1, and an administrative supervisor. VA OIG special agents subsequently seized Veterans Integrated Service Network (VISN) senior leader 1's VA computer and Blackberry on May 5, 2014. On May 12, 2014, CID opened a full criminal investigation on this matter in order to determine if there was an intentional scheme to have a secret wait list and to manipulate performance metrics. On May 30, 2014, the Phoenix FBI office informed us that FBI would be investigating this case jointly with CID and would be the lead agency.

During the course of our investigation, CID:

- Conducted 215 interviews of 190 current and former VA employees.
- Listened to audio recordings and/or reviewed bullet point write-ups of 77 additional interviews of 47 current VA employees. These interviews were conducted by OAE auditors or OHI inspectors without any CID agents at the interviews.

During the course of our investigation, OIG conducted the following documentary reviews:

- Reviewed approximately 1,035,000 emails, their attachments, and other data files. These were derived from the VA Exchange Computer System, the VA Exchange Archive Solution System, data files stored on employees' computers, and data files from employees' personal network storage locations.
- Reviewed approximately 86,000 VistA MailMan messages and approximately 69,000 associated files. VistA MailMan is a general purpose internal VA messaging system.
- Reviewed approximately 85,000 emails and associated files from private email accounts.
- Reviewed the contents of 365 bankers' boxes of documents that were obtained from preservation bins. Over 100 preservation bins had been set up throughout PVAHCS in order to allow staff to preserve any documents related to this investigation. These bins were set up by the VA in response to a request from the House Committee on Veterans' Affairs (HVAC) that the VA issue a "Preservation Order" to retain all documents associated with the Phoenix scheduling issue. The documents were scanned by a contractor and turned into approximately 774,000 portable document formats (PDFs). The PDFs were then reviewed.
- Reviewed meeting agendas and/or meeting minutes of 17 various PVAHCS management meetings and listened to 1,569 minutes of recordings taken during 19 PVAHCS management meetings.
- Reviewed 2012 and 2013 performance appraisals for nine VA management officials. This included reviewing employees' performance standards, performance appraisals, relevant personnel file documentation, performance based monetary awards, and any supporting documentation.

- Reviewed OAE, *Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA HealthCare System* (Report No. 14-02603-267).

  Due to the tremendous volume of work done on this investigation, the details of our work are conveyed in separate sections throughout this summary. The first six sections each focus on a specific documentary review. The remaining sections focus on the results of interviews conducted regarding a specific aspect of the original allegation or regarding other related allegations that arose during the course of the investigation.

  The sections are as follows:

  Documentary reviews regarding the EWL and metrics:

  - Review of VA emails/network files
  - Review of VA VistA MailMan messages
  - Review of personal emails
  - Review of preservation bin documents
  - Review of recordings and minutes of various PVAHCS meetings

  Documentary reviews regarding performance ratings:

  - Review of compensation received by PVAHCS senior staff

  Interviews conducted regarding the EWL:

  - Interviews related to the EWL implementation
  - Interviews related to the computer program failure that underreported EWL data to VA Central Office (VACO)
  - Interviews related to the New Enrollee Appointment Request (NEAR) list

  Interviews conducted regarding metrics:

  - Interviews related to the alleged manipulation of Desired Dates
  - Interviews related to the alleged manipulation of Desired Dates for specialty clinics
  - Interviews related to the program analyst1 Ethics Consult
  - Interviews related to the alleged manipulation of the Third Next Available metric

  Interviews conducted regarding PVAHCS staff and facility:

  - Interviews related to the VISN 18 site team visit to PVAHCS
  - Interviews related to PVAHCS scheduling certifications

  Interviews conducted regarding performance ratings:

  - Interviews of VISN senior leader 1

Interviews conducted regarding other issues:

- Other possible administrative issues identified

Review of VA Emails/Network Files

From April through June 2014, in furtherance of this investigation, the VA OIG Computer Crimes and Forensics Lab Services (CCFL) obtained emails from the VA Exchange System and the Exchange Archive Solution System, data files of office documents stored on employees' computers, and data files from employees' personal network storage locations. All of the seized electronic communications and files were obtained from VA email accounts, VA computers, and VA network folders assigned to the following 24 VA employees: VISN senior leader 1, VAMC senior leader 1, VAMC senior leader 2, VAMC senior leader 3, VAMC senior leader 4, VAMC senior leader 5, service chief 1, clinic senior leader 1, clinic senior leader 2, VA physician 1, VA physician 2, service chief 2, service chief 3, MSA1, administrative assistant 1, program analyst 1, program analyst 2, service supervisor 1, clinic supervisor 1, administrative supervisor, a VA appraiser, former service chief 1, former assistant service chief, and administrative employee 1.

These 24 employees had been previously identified as possibly possessing communications and electronic files relevant to this investigation. Rather than only obtaining communications that covered a specific time frame, CCFL obtained any and all records that were available to them across multiple systems and networks. All records were stored by CCFL within the Clearwell eDiscovery Platform for a subsequent review.

From May through July 2014, approximately 150 members of CID, Administrative Investigations Division (AID), OAE, and OHI used key word searches, key phrase searches, and date range searches to examine approximately 1,035,000 emails, their attachments, and other office document data files. All reviewed records underwent a three-tier review process. They were initially reviewed by a CID special agent, AID investigator, OAE auditor, or OHI Healthcare Inspector. Any identified notable documents were tagged as relevant and subsequently reviewed by a supervisor. A final review was then conducted by one of three CID special agents who were specifically assigned to the primary Phoenix EWL investigation team.

Selected notable documents were used during subject interviews, witness interviews, and some were included in the OAE August 26, 2014 final report, *Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System* (Report No. 14-02603-267). Some of these identified emails will be referenced later in this report. A review of these emails did not disclose findings of intentional misconduct regarding the EWL or metric manipulation.

Review of VA VistA MailMan Emails

From May through July 2014, in furtherance of this investigation, CCFL obtained message data from VistA MailMan for VA employees previously identified as potentially having communications pertinent to the investigation. VistA MailMan is a general purpose messaging system used internally by VHA to connect providers, patients, files, and services. VistA MailMan message data were obtained for the following 18 VA employees: VISN senior leader 1, VAMC senior leader 3, VAMC senior leader 4, VAMC senior leader 5, VA physician 1, VA physician 2, service chief 2, service chief 3, clinic supervisor 1, service supervisor 1, administrative supervisor, MSA1, administrative assistant 1, a VA appraiser, program analyst 1, program analyst 2, former service chief 1,and a former assistant service chief. CCFL attempted to obtain messages for VAMC senior leader 1, VAMC senior leader 2, and service chief 1, but that information was no longer available within the system. CCFL also processed a list of veterans' names of interest to the investigation against VistA MailMan data. All records were stored by CCFL within the Clearwell eDiscovery Platform for a subsequent review.

From May through July 2014, approximately 150 members of CID, AID, OAE, and OHI used key word searches, key phrase searches, and date range searches to examine approximately 86,000 VistA MailMan messages and approximately 69,000 files. All records were initially reviewed by a CID special agent, AID investigator, OAE auditor, or OHI Healthcare inspector. Any identified notable documents were tagged as relevant and subsequently reviewed by one of three CID special agents who were specifically assigned to the primary Phoenix EWL investigation team. The aforementioned approximately 86,000 messages and approximately 69,000 files were reviewed in addition to the 1,035,000 electronic files detailed in the section above. A review of these emails did not disclose findings of intentional misconduct regarding the EWL or metric manipulation.

Review of Personal Emails

During the extensive review of VA employee emails associated with this investigation, we determined VA employees were also using their personal email accounts to communicate on matters potentially relevant to this case and a spin-off case was being investigated concurrently. In October 2014, the FBI obtained via legal process personal emails from accounts belonging to numerous individuals associated with this investigation and with the spin-off investigation. In February and March 2015, FBI and CID special agents conducted a review of approximately 85,000 electronic files. The analysis was completed using key word/term searches as well as full document reviews. A review of these emails did not disclose any findings of intentional misconduct regarding the EWL or metric manipulation issues.

Review of Preservation Bin Documents

In response to the HVAC Chairman's request that VA preserve all documents associated with PVAHCS scheduling issues, PVAHCS set up over 100 preservation bins throughout the main medical center and outpatient clinics.

On July 24, 2014, as part of the criminal investigation, CID collected 365 bankers' boxes of documents from PVAHCS. Three hundred and sixty four boxes of preservation bin documents were turned over to the FBI, which hired a contractor to scan the documents into a PDF Format resulting in a total of 773,988 PDFs. The PDFs were subsequently uploaded to the Phoenix CID share drive for review. A review of each of the PDFs was then conducted by one of three VA OIG special agents who were specifically assigned to the primary Phoenix EWL investigation team. One additional box was physically reviewed by an agent assigned to the Phoenix CID. A review of these documents did not disclose any findings of intentional misconduct regarding the EWL or metric manipulation.

Review of Recordings and Minutes of Various PVAHCS Meetings

In July 2014, following an interview with VA OIG special agents, a former program support assistant provided agents with agendas, minutes, and audio recordings taken during various PVAHCS administrative meetings. In furtherance of this investigation, throughout July 2014, three VA OIG special agents, who were assigned to the Phoenix EWL investigation team, reviewed documents and audio files provided by the former program support assistant.

A review of the audio recording from the April 18, 2012 PVAHCS Chiefs and Supervisors' Monthly Meeting revealed that VAMC senior leader 1 joined the meeting to address the attendees. During VAMC senior leader 1's presentation to the meeting's attendees, she made a reference to the PVAHCS wait list. VAMC senior leader 1 encouraged everyone to be very ethical. She recalled that when she served in a management position at another VAMC, she heard providers telling clerks not to schedule veterans. She stated she heard staff telling veterans they would have to call back because they could not book an appointment within a couple of weeks. She said she did not want a similar environment at PVAHCS. She said that kind of "stuff" is "unethical" and "goes against the values of our organization." She said if that is happening in Phoenix, she needed to be told. She said they could deal with this type of problem if it were occurring in Phoenix, but covering it up is something she had a real issue with. She encouraged all the attendees to properly report any violation of policies, directives, rules, or laws. VAMC senior leader 1's presence in this meeting was not documented in the meeting's minutes.

In total, the three assigned VA OIG special agents reviewed meeting agendas and/or meeting minutes of 17 various PVAHCS management meetings and listened to 1,569 minutes of recordings taken during 19 PVAHCS management meetings. A review of these agendas, meeting minutes, and recordings did not disclose any findings of intentional misconduct regarding the EWL or metric manipulation.

Review of Compensation Received by PVAHCS Senior Staff

At the onset of this investigation, allegations were made indicating that senior managers of PVAHCS received bonuses as a direct result of successful patient access metrics (i.e., "desired date" to appointment date metric, Third Next Available appointment date metric). As part of our investigation of these allegations, VA OIG special agents conducted a detailed review of the senior management's performance appraisals for FYs 2012 and 2013.

In VAMCs, the top five management officials at the facility are referred to as the Pentad. Our review included performance appraisals of the following Pentad members:

- VAMC senior leader 1
- VAMC senior leader 2
- VAMC senior leader 3
- VAMC senior leader 4
- VAMC senior leader 5

The review also expanded to the following PVAHCS VA Senior Staff:

- Service chief 1
- Clinic senior leader 1
- Clinic senior leader 2
- VISN senior leader 1

In June and July 2014, VA OIG special agents conducted their reviews that consisted of reviewing employees' performance standards, performance appraisals, and other relevant personnel file documentation. Documentation supporting performance-based monetary awards was also analyzed.

Although the metrics associated with patient access were noted in some appraisals more than in others, our review determined that the scope of all the performance plans and performance ratings expanded well beyond patient access metrics. There were many other aspects considered in all of the employees' overall ratings.

In VAMC senior leader 1's ratings, meeting patient access metrics is primarily listed under the Results Driven element. This element was weighted at 50 percent of her overall rating in FY 2012 and 40 percent of her overall rating in FY 2013. The Results Driven element was further broken down into five sub-elements that made up the total rating for this element. The relevant metrics associated with patient access were a part of both appraisals, primarily in sub-element #2 of Results Driven. This sub-element could be viewed as comprising only 10 percent (50 percent divided by 5) of her FY 2012 performance rating and 8 percent (40 percent divided by 5) of her FY 2013 performance rating. Our analysis of the other senior staff performance appraisals indicated that meeting these metrics had a similar weighting in their appraisals.

Our review determined that the above-listed employees were not receiving monetary bonuses solely based on successful results within patient access. The metrics associated with patient access, in totality, generally comprised a small portion of the employees' overall rating. Additionally, we found there were instances where an employee did not meet a specific patient access goal, but still was viewed favorably because they showed some improvements in access.

Interviews Related to the EWL Implementation

CID interviewed multiple employees tasked with implementing the EWL, adding names to the EWL and scheduling from the EWL. The employees involved were service chief 1, service chief 3, clinic supervisor 1, an administrative supervisor, program analyst 2, a management analyst, lead MSA1, lead MSA2, MSA1, MSA2, MSA3, former service chief 1, and a former assistant service chief.

According to VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures*, the EWL is the official VHA wait list for outpatient clinical care appointments. The EWL is used to list patients waiting to be scheduled or waiting to be assigned a Primary Care Provider (PCP). No other wait lists are to be used for tracking requests for outpatient appointments. If an appointment cannot be scheduled due to lack of capacity, the veteran is added to the EWL. VHA measures new patient wait times from the date a scheduler creates an appointment in VistA, which becomes the appointment create date, with the date the appointment is completed. The date the scheduler adds the veteran to the EWL becomes the start date in lieu of the appointment create date. VHA also measures the desired date to appointment date. When scheduling a patient, the desired date (the desired appointment date on which the patient wants to be seen) is entered in the Appointment Management Program in VistA. The Appointment Management Program is used to view appointments for a selected patient or clinic and to execute appropriate action(s) against these appointments, such as check in and check out.

Phoenix did not include all veterans on its EWL. During the EWL implementation, numerous patients were listed on paper printouts while waiting to be added on to the EWL. The length of time these veterans waited for appointments prior to being scheduled or added to the wait list was never accurately reflected in VA wait time data. The reported wait time for these veterans did not start until scheduled or added to the EWL. The EWL implementation was carried out by employees under the general oversight of service chief 1; however, no evidence was found that service chief 1 was heavily involved with the details of its implementation. He had delegated that responsibility to program analyst 2. During interviews with VA OIG agents, both service chief 1 and program analyst 2 acknowledged that program analyst 2 had been tasked with this responsibility.

In January 2013, service chief 1 hired program analyst 2 and tasked her with the implementation of the EWL. Program analyst 2 had previous experience working with the EWL from when she worked with the VA at another facility. In February 2013, program analyst 2 began to implement the EWL as part of the VistA scheduling

system. MSA1, who was on limited duty at the time, was tasked by her supervisor, clinic supervisor 1, to assist. During this time, Primary Care providers used three different clinics. These clinics consisted of the New Patient Clinic, Urgent Clinic, and Routine Follow-up Clinic. The goal was to reduce the clinics to one for better efficiency and to reschedule patients who were scheduled out more than 90 days. These patients would have to be manually taken off the appointment system and placed on the EWL. Patient Access Care Teams (PACTs) were created so that each veteran would be treated by a consistent team of health care professionals to plan for whole-person and life-long care. PACTs consisted of a primary care provider, a nurse care manager, a clinical associate, and an administrative clerk. The transition to PACT required Health Administration Services (HAS) to move patients who were already scheduled for an appointment up to a year out, to be rescheduled to an earlier appointment, no more than 90 days out. As the new appointment schedules were constructed and patients added, it became difficult to reschedule all the patients. As the EWL was implemented, the names and information of patients who could not be rescheduled were kept in a drawer at each clinic to be added later. New patients who could not be scheduled were initially being told to call back. In March 2013, the PACTs would bring program analyst 2 scraps of paper with names to add to the EWL. Program analyst 2 had difficulty reading the handwriting so she requested printed screen shots of the patients' information.

Scheduling Processes

The enrollment and scheduling process in Phoenix during the implementation of the EWL (early 2013 through 2014) was described by Phoenix staff members. The process started when the veteran enrolled with the Eligibility Office where the employees would obtain information from the veteran regarding his/her military service, verify it, and determine eligibility for VA medical care. The majority of the new enrollments are done in-person. Veterans could also enroll online or via mail. The enrollment included a financial assessment (means test). An eligibility clerk entered the applicant's personal and military information into the system to register them. Once completed and determined eligible for medical care, the Eligibility Office provided the veteran a card to the Helpline, which the veteran was to call to schedule an appointment at PVAHCS.

The Helpline staff was able to schedule and cancel appointments, but their scheduling ability was taken away from them in April 2013 because of provider complaints of incorrect scheduling. After that time when a veteran called the Helpline to schedule an appointment, the Helpline employee would enter the request in the "patient inquiry" menu in VistA and print a screen shot containing the veteran's demographics. The screenshot was printed at a printer located in HAS' Data Management Services. A management analyst placed the screen shots in a drawer located in the office. The screen shots were picked up periodically by HAS employees, clinic supervisor 1, or MSA1. The screen shots were then evaluated and new veterans were added to the EWL by clinic supervisor 1, MSA1, or MSA4. Once the names were added to the EWL, the screen shots were destroyed. Eventually, the

patients would be moved off the EWL and scheduled for Primary Care appointments by MSAs.

If the veteran had an urgent issue at the time they enrolled, they were triaged by a registered nurse (RN) and sent to a walk-in clinic or the Emergency Department (ED). After a veteran was seen and treated in the ED, an electronic "view alert" was sent to assign the veteran to a PCP via an Appointment Consult. A consult is a specific document, most often electronic, which facilitates and communicates consultative and non-consultative service requests. The Helpline would receive the alerts and, in these instances, were able to schedule the veterans. After an OIG inspection in December 2013, the alerts were sent to MSA1 to schedule the veteran. MSA1 would consult with VA physician 4 to determine if the follow-up was routine or urgent. If urgent, the veteran would be scheduled an appointment. If the follow-up was routine, MSA1 would place the veteran on the EWL. As of April 2014, there were over 300 view alerts for consults— also referred to as "Schedule an Appointment Consults"—that had not been scheduled or placed onto the EWL.

From March 24 through the end of April 2014, the screen shots were no longer printed to Data Management Services. They were sent to a printer where administrative employee 2 would scan the screen shots and email them to program analyst 2, service chief 3, and clinic supervisor 1. Clinic supervisor 1 did not open the emails until May 2, 2014. Clinic supervisor 1 had been providing training to new employees for the six weeks prior to opening these emails and no one had informed her she would be receiving the emails of veterans to be placed onto the EWL. Despite being copied on the email, program analyst 2 and service chief 3 did not assist clinic supervisor 1 with entering the veterans on the EWL during that time because the responsibility had been passed to clinic supervisor 1 and her employees. During this six-week period, clinic supervisor 1 did see these emails but chose not to open them and was not aware of what they contained. Clinic supervisor 1 was not aware that the screen shots were no longer being printed at the printer in data management. When she told program analyst 2 she was receiving emails titled EWL, program analyst 2 informed her that the printer was not working and the names to be added to the EWL were now being emailed to her. Clinic supervisor 1 printed approximately 600 screen shots on May 2, 2014, and tasked MSA4 to enter the names onto the EWL. MSA4 was instructed by clinic supervisor 1 to use the date the emails were sent as the create date.

On May 2, 2014, administrative employee 2 stopped emailing the screen shots. Service supervisor 2 was given access to add veterans onto the EWL. Service supervisor 2 received the veteran demographics from his employees electronically and would then add the names to the EWL. On May 15, 2014, clinic supervisor 1 discovered a folder in her office with 70 print screens of veterans dating back to March 10, 2014, which needed to be placed onto the EWL.

Scheduling Responsibilities

In the fall of 2013, program analyst 2 informed clinic supervisor1 that she was responsible for adding patients to the EWL. Program analyst 2 continued monitoring patients coming on and off the EWL and checking if the numbers were moving. Program analyst 2 provided guidance to MSA1 and clinic supervisor 1 regarding the adding of veterans to the EWL and scheduling veteran appointments from the EWL. She also routinely checked the pending consults to make sure they were being scheduled or being placed on the EWL.

MSA1 continued assisting entering names onto the EWL and scheduling consults as well as performing her regular duties. MSA1 stated scheduling was one of the Wildly Important Goals (WIG). In January 2013, VAMC senior leader 1 established a goal to improve access to Primary Care. The goal was to see at least 40 percent of new patients within 14 days of the date their appointment was created. To comply with the WIG, MSA1 said she was not allowed to schedule a veteran off the EWL if she could not find an appointment for him within two weeks. She would leave veterans on the EWL until an appointment could be found that was within two weeks. These instructions were given to her by program analyst 2. The print screens did not contain the contact date on which the veteran called requesting an appointment, so MSA1 used the day prior to the date she physically added the veteran to the EWL as the contact date. After she entered the name onto the EWL, she would shred the print screen and move to the next name.

In June 2013, service chief 1 obtained approval for overtime for MSAs, nurses, and other VA employees with scheduling experience to schedule veterans off the EWL. Clinic supervisor 1 stated during interviews with the VA OIG that, although employees were working overtime to schedule patients off the EWL, she still assumed the responsibility of entering names onto the EWL. Clinic supervisor 1 was overwhelmed with multiple duties (training MSAs in scheduling procedures, entering and scheduling veterans on the EWL, supervising MSAs) placed on her by service chief 1 and service chief 3. For over a year, approximately during the period November 2012 to December 2013, she expressed her concerns to her supervisors.

In the later part of 2013, approximately around the time OHI came to PVAHCS, clinic supervisor 1 sent a former assistant chief an email requesting a meeting concerning how overwhelmed she was with her duties. The meeting kept getting pushed back. Clinic supervisor 1 felt leadership failed her by taking employees away and adding more responsibilities on her shoulders when they knew she was already overwhelmed. When clinic supervisor 1 would conduct training for MSAs, they would fall behind with the EWL. During the email review conducted in furtherance of this investigation, an email from clinic supervisor 1 regarding the issue of her being overwhelmed with her duties was identified. The email was sent to program analyst 2 and cc'ed to the former assistant service chief on October 4, 2013.

The email stated, "This is something that needs to be discussed on how to handle. At this time PACT is down several MSA's, this was a full time job for someone who I

can no longer afford to keep in that position without hurting PACT even more than it is already hurting. In addition, I have no one to follow up on the requests to schedule appointments. The way this was being managed was with one person full time plus multiple MSA's working OT [overtime] to assist, and then the Helpline was assisting as well by making appointments as they called in. Without additional support I am lost on how to manage this. Your assistance with figuring out this overwhelming process would be greatly appreciated, I was able to have the process managed when I could put someone on it full time, afford OT, and have the assistance from Helpline for scheduling but it seems all those options are no longer available."

On October 15, 2013, in an email from administrative employee 3 to program analyst 2, clinic supervisor 1, and the former assistant service chief, administrative employee 3 wrote, "[Former assistant service chief], We were schedule (sic) to have a meeting last week before [program analyst 2] went on vacation. The meeting has been scheduled October 23, 2013 @12p. The EWL process and plan were to be discussed."

On October 30, 2013, in an email from clinic supervisor 1 to program analyst 2, administrative employee 3, and the former assistant service chief, in response to why no new patients had been scheduled for December and January, clinic supervisor 1 wrote, "I have volunteers that are working on filing, this is a very difficult long process of trying to reach patients. At this time I have not gotten into December and January. I have not been doing OT for the new patients because I thought we were going to have a meeting to discuss how to best plan this process."

Program analyst 2 said there was a one-month period at the end of 2013 where no one worked on the EWL or scheduled Appointment Consults. She stated they sat in a drawer in Data Management because no one was available to work on them. HAS lost approximately 23 MSAs sometime in September or October 2013 and no one had time to schedule patients even though there were open times available for appointments. She stated she told the former assistant service chief they were falling behind and that getting people to help on Saturday with overtime pay was not enough. As of April 2014, clinic supervisor 1 stated veterans were still waiting on the EWL for three to four months before they received a call to be scheduled. Service chief 3 said clinic supervisor 1 printed the Appointment Consults from the ED for new patient assignments and would give paper printouts to MSAs to schedule. Service chief 3 admitted she was aware that the printouts were being held and not entered for up to three weeks.

In their interviews with VA OIG and FBI special agents, service chief 1, service chief 3, and program analyst 2 all acknowledged they were aware that clinic supervisor 1 was overwhelmed with the multiple duties assigned to her. Service chief 3 and program analyst 2 were aware that screen shots were not being picked up on a daily basis and that there were substantial delays in names being added onto the EWL.

On May 14, 2015 and June 11, 2015, service chief 1 was interviewed. He stated that the providers bear most of the blame for the backlog of new patients not being scheduled. He said the providers would block appointment slots in order to prevent MSAs from scheduling patients. Some providers refused to see new patients. He said he spoke with VAMC senior leader 4 and service chief 2 sometime during late 2013 or early 2014, but they refused to make the providers see more new patients. He stated he was not aware that program analyst 2 and the former assistant service chief had placed the responsibility of adding veterans onto the EWL completely on clinic supervisor 1. He stated he did not know the screen shots were still being printed in Data Management as late as March 24, 2014. He stated he was under the impression this practice had ended after the December 2013 OHI visit and that the screen shots were being emailed. He stated he believed they had transitioned to using email because of the OIG's concern regarding security of records containing Personally Identifiable Information. He stated VAMC senior leader 2 was briefed on every detail concerning the EWL in weekly meetings, daily morning reports, as well as one-on-one meetings. He stated he told VAMC senior leader 2 repeatedly that they desperately needed to hire more employees.

Service chief 1, former service chief 1, and the former assistant service chief stated during interviews with VA OIG special agents, that VAMC senior leader 2 would continuously return requests to fill vacant MSA positions requesting additional justification for every vacant position.

On June 9, 2015, VAMC senior leader 2 was interviewed. He stated his focus was resource management and he was not focused on the EWL. He stated the Primary Care Management Team, which included service chief 1, was responsible for the EWL. He did not provide any further information and stated he had no knowledge of print screens or delays in inputting names onto the EWL. He stated that he did not remember many details regarding these issues. (**Note**: There is no evidence to contradict this statement.) Regarding the accusation that he delayed the filling of needed MSA positions, he stated that he was chair of the Position Management Committee that reviewed requests for any new position at PVAHCS. He stated that all submitted requests had to be well-justified. If they were not, the request was returned for additional information.

Interviews Related to the Computer Program Failure That Underreported EWL Data to VA Central Office

On September 7, 2014, two employees of VA Information Technology (IT) Product Support located in Danville, IL, were interviewed by a VA OIG special agent. The interview, conducted via telephone, concerned a computer program failure that underreported EWL data transmitted from PVAHCS to the VA Austin Automation Center (AAC). VAMCs nationwide regularly transmit EWL data to AAC. Those data are viewable by certain VA officials who have access to that system. Because of the complexity of the issue, VA IT product support employee 1 gave an overview of events and then explained each document she provided. VA IT product support

employee 1 and VA IT product support employee 2 both acknowledged they had no personal relationships with personnel at PVAHCS.

On April 30, 2014, VA IT product support employee 1 received an email from PVAHCS Office of Information and Technology (OI&T) identifying a wait list transmission problem. On May 1, 2014, VA IT product support employee 1 identified the error in the error trap. An error trap is an application within the VistA computer system that is used to capture details of errors generated within VistA programs. Specifically, she found a negative value (-1) was in the "WL specific clinic" field of one of the EWL records transmitted from PVAHCS to AAC. The error created a partial appointment entry which in turn stopped the transmission of 1,046 EWL entries created by PVAHCS and sent to the AAC from May 21, 2013 (date of the partial entry) to when VA IT product support employee 1 removed the error from the error trap on May 1, 2014.

VistA is programmed to automatically send transmissions of EWL entries (from PVAHCS) twice a month to AAC, which in this case did not happen between the dates specified. VA IT product support employee 1 could not say who or how the partial entry was created. It could have been human error or system error. VA IT product support employee 1 stated it was unlikely a person at PVAHCS intentionally changed the "WL specific field" to -1 to cause a stop in transmission because they would need extensive knowledge of the system to understand what the end result of such an action would be. VA IT product support employee 1 stated that although these EWL entries were not transmitted during this time period, PVAHCS still maintained the EWL entry data within the PVAHCS VistA system. After the error was removed, the original data for each EWL entry was re-transmitted to AAC. VA IT product support employee 1 and VA IT product support employee 2 stated partial records/entries have happened, but neither is aware of this specific event happening before. They referred to it as a "program failure."

Interviews Related to the NEAR List

The NEAR list issue was addressed in the OAE August 26, 2014 report, *Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System* (Report No. 14-02603-267). Interviews and email reviews conducted by VA OIG and FBI special agents revealed that PVAHCS officials were not aware of the NEAR list and did not use the NEAR list to schedule patient appointments or place them on the EWL. When a new patient wanted care, they first went to the Eligibility and Enrollment (E&E) Department, which collected their information and determined if they were eligible. If they were eligible for care, then the veteran would be given a card with the PVAHCS Helpline phone number and told to call that number to schedule an appointment. A feature in the E&E software used to enroll the veteran prompted a question asking whether or not the veteran wanted to schedule an appointment. If the veteran replied "yes" in response, the E&E staff member would enter that into the program. That would result in the veteran's data being placed on the NEAR list. However, at that time, the PVAHCS practice was to

require the veteran to call the Helpline to make an appointment. That call would start the appointment request process, not the data recorded by E&E.

In an email dated April 22, 2014, VAMC senior leader 2 wrote, "As I discussed last night with [VAMC senior leader 1], [program analyst 2] reported yesterday that she knew about the NEAR list and had briefly reviewed it with the VISN but failed to continue to run it and utilize it. They're contacting the patients on the NEAR list who haven't already been seen, don't have appointments and aren't on the EWL." On May 2, 2014, program analyst 2 responded in an email, "I did not fail to continue to run it. I looked at it a few times when I first got here and spoke to [former assistant service chief] about it. When the VISN team came, [a VA employee] asked me to show it to her. She was focused on looking for her husband on the report as he had just registered at the Southeast Community-Based Outpatient Clinic (CBOC), I believe; so we looked at it on the screen and did not find her husband's name but did see that appointments were showing made for some patients and we discussed patients have to decide when they want to get care from us. I also recall that it came up after the VISN Team left and I told [former assistant service chief] that it had come up in conversation with them and [former assistant service chief] said she was going to talk to Eligibility about it."

On May 14, 2014, VA OIG special agents interviewed service supervisor 1 regarding the NEAR list. He stated that during the end of April 2014, service chief 1 and an assistant service chief met with him after they had attended a meeting with VA OIG auditors. He stated the assistant service chief asked him to find out what a NEAR list was because VA OIG auditors had asked about the report. He stated that, at that time, none of them was aware of the NEAR list.

He stated he subsequently found out that the NEAR list was a program within the VistA computer system. He stated he gained access to the report and printed out a copy of the NEAR list for the first time, on approximately April 24, 2014. He stated he was confident that nobody that had been discussing the NEAR list, including himself. He stated he had never printed out a NEAR list prior to April 24, 2014. He stated when he first reviewed the NEAR list and noticed that a veteran had been waiting for 477 days for an appointment, he was shocked. His first thought was, "I really hope this person has not been waiting this long." After service chief 1 and the assistant service chief reviewed the NEAR list, they asked him to prepare an action plan and told him, "we need to fix this, get me an action plan, and I want it today." He stated he provided a copy of the NEAR list to OAE auditors around May 1, 2014, per their request.

On August 20, 2014, VA OIG and FBI special agents interviewed VAMC senior leader 4. He acknowledged that the NEAR list would create a time stamp of when a patient enrolled and requested an appointment, but PVAHCS did not know about the NEAR list. He stated that HAS should have used the NEAR list. He stated his understanding was that the amount of time that a patient waited on the NEAR list was not counted towards the PVAHCS appointment wait time calculation.

On June 11, 2015, VA OIG special agents interviewed service chief 1. He stated that he should have made sure that the NEAR list was used because he was familiar with the directive. He stated, "Was I neglectful in not knowing the NEAR? Yes. As much as I read that stupid directive, should I have made sure it was done? Yes. But there's only so much I can get in a given day." He stated that the amount of time that a patient waited on the NEAR list was not counted towards the PVAHCS appointment wait time calculation.

PVAHCS completed the Scheduling Directive Certification in 2012 and the Scheduling Process Checklist in 2013 indicating that schedulers were reviewing the NEAR list daily to determine if newly enrolled patients had requested care. These certifications are noted in item 30 of the 2012 certification and in item 14 of the 2013 checklist. See the "Interviews related to the PVAHCS scheduling certifications" section of this summary for more details on the Scheduling Process Checklists.

Interviews Related to the Alleged Manipulation of Desired Dates

According to VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedure,* it is VHA's commitment to provide clinically appropriate quality care for eligible veterans when they want and need it. This requires the ability to create appointments that meet the patient's needs with no undue waits or delays. The desired appointment date is the date on which the patient or provider wants the patient to be seen. Schedulers are responsible for recording the desired date correctly. The goal is to schedule an appointment on, or as close to, the desired date as possible.

VA Policy dictates that for new patients:

1. The scheduler needs to ask the patient, "What is the first day you would like to be seen?" The date the patient provides is the desired date.

2. The desired date is defined by the patient without regard to schedule capacity. Once the desired date has been established, it must not be altered to reflect an appointment date the patient acquiesces to accept for lack of appointment availability on the desired date.

3. The third step is to offer and schedule an appointment on or as close to the desired date as possible.

If there is a discrepancy between the patient and provider desired date, the scheduler must contact the provider for a decision on the return appointment time frame. The desired date of care is established either by the veteran (the date the veteran wants to be seen) or the provider (the date the provider wants to see the patient, i.e. in six months from the last visit). VHA measures waiting times by comparing the desired appointment dates to the actual appointment dates. The reliability of reported wait time performance measures is dependent on the consistency with which schedulers record the desired date in the scheduling system. The majority of appointment scheduling at PVAHCS was done by MSAs although some was done by RNs.

VA OIG and FBI special agents interviewed multiple employees in reference to potential manipulation of desired dates. Our investigation identified 13 schedulers (listed below) at PVAHCS who knowingly altered desired date data. Their actions resulted in reduced or zero wait time numbers being associated with those appointments. Schedulers regularly reviewed reports, known as Clinic Appointment Availability Reports (CAAR) that detailed all appointments scheduled beyond 14 days of the desired date. Managers stated that they wanted only legitimate mistakes listed on the CAAR report corrected. However, some schedulers believed that they were required to retroactively change the desired dates so that they could meet the 14-day goal regardless of the facts. They would overwrite/cancel existing appointments and then reschedule them for the same day and time. This reset the desired date to a date within 14 days of the appointment.

Schedulers stated in interviews that they did not receive proper scheduling training. Most learned on the job by observing other schedulers or from working at other VA facilities across the country. There were widespread misperceptions regarding appropriate scheduling practices among staff. No scheduler was able to say that service chief 1 directly provided any instruction to inappropriately "zero out" wait times. None of the supervisors who were interviewed stated that service chief 1 or other higher officials told them to instruct their employees to engage in inappropriate scheduling practices.

Thirteen schedulers provided testimony indicating that they inappropriately altered desired dates in order to reduce the wait times. They all indicated that they were instructed to do this by supervisors. Six supervisors were implicated, one of whom is deceased. The remaining five supervisors were interviewed and denied intentionally providing instructions to staff to inappropriately alter desired dates. A summary of the interviews of the 13 schedulers and the five supervisors is listed below. The 13 schedulers stated as follows:

- On May 14, 2014, a CBOC RN was interviewed by VA OIG special agents. She stated clinic senior leader 1 told her in 2012 during staff meetings to have 100 percent compliance in the desired date area. She stated that clinic senior leader 1 told her to make the desired date the appointment date to ensure the wait times were zero. She stated she complied with these instructions starting in 2012.
- On June 17, 2014, MSA5 was interviewed by VA OIG and FBI special agents. She stated that she had been instructed to use the CAAR to find appointments that were scheduled out more than 14 days from the desired dates. She stated that clinic supervisor1 and lead MSA2 instructed her to change the desired date in order to reduce the reported wait times. She stated she complied with these instructions.
- On May 15, 2014, MSA6 was interviewed by VA OIG special agents. He stated that MSA7 directed him to "fix" reports. The CAAR report is printed daily and according to MSA7 there could be no more than a two-day wait time. If it was more than two days, then he believed that he had to fix it by canceling the

appointment and rescheduling the appointment on the same day. He stated he complied with these instructions.

- On June 3, 2014, MSA7 was interviewed by VA OIG special agents. He stated that in early 2012, former service chief 1 instructed him via a telephone call to overwrite appointments and make the first available appointment the desired date. He stated that on May 12, 2014, clinic supervisor 1 instructed him to do the same thing. He stated he complied with these instructions.
- On May 15 and June 17, 2014, MSA2 was interviewed by VA OIG and FBI special agents. She stated that her former supervisor, clinic supervisor 2, told her at the end of 2013 that her name was on a "hit list" from service chief 1. She stated her name was on a document of other schedulers who had scheduled appointments with wait times of over 14 days. She stated her former supervisor told her she needed to change all desired dates so that they were within three to five days of the appointment date. She stated she complied with these instructions. She said she would enter the scheduling system, cancel the appointment, and then reschedule the appointment for the same day with a different desired date.
- On June 19, 2014, MSA8 was interviewed by VA OIG and FBI special agents. She stated that in approximately June 2013 her supervisor, clinic supervisor 2, instructed her to change patient wait times by overwriting existing appointments and thus resetting the desired date. She stated she complied with these instructions.
- On June 16, 2014, a current VA employee/former MSA was interviewed by VA OIG and FBI special agents. She stated that she began her career in 2008 as an MSA at another VA facility. At that facility, her supervisors insisted that they have zero-day wait times. She stated that when she scheduled patients at her prior facility, she would make the appointment date the desired date. She stated she was an MSA at one of the Phoenix clinics from August 2010 to December 2013. She stated that clinic supervisor 2 was her supervisor and he told her she was scheduling incorrectly and "cheating." She stated he taught her the correct way to schedule was to ask the veteran what day they wanted to be scheduled and that day became the desired date. Beginning in December 2013, she floated as an MSA in four clinics. She stated clinic supervisor 1 was her supervisor but that lead MSA2 told her what to do. She stated that lead MSA2 subsequently instructed her to schedule the desired date between 10 and 14 days from the appointment date. She said she feared she would get written up if she did not comply. When interviewed, she stated that she would falsely make the desired date coincide within 14 days of the appointment date. She stated she had to pull the CAAR report daily and adjust the desired date for any appointment over 14 days.
- On May 8 and May 20, 2014, MSA9 was interviewed by VA OIG special agents. She stated that she used "Next Available" as the desired date, which made the wait time very short or even zero. She said she was told to do it that way or face discipline by a former clinic supervisor (deceased). She stated that clinic senior

leader 2 had the MSAs print daily CAAR reports and the MSAs were told to keep the wait times to less than 14 days unless there were a valid reason to be over, such as no availability. She stated she believed this meant if a scheduled appointment is over 14 days, you fixed it by going into the system, canceling the appointment, and rescheduling the same day with a new desired date. She said it was easier for her to bring up the appointment date and make it the desired date, which would make the wait time zero.

- On May 8, 2014, MSA10 was interviewed by VA OIG auditors. He stated that in approximately 2011, a former clinic supervisor (deceased) told him the desired date and appointment date had to be within two days. He stated the deceased former clinic supervisor told the MSAs it was coming from upper management. He stated he would run a daily CAAR report to make sure the wait times were no more than two days. If it were over two days, he would back out of the system and make the appointment date the desired date. He stated the MSAs thought it was cheating because it looked like a veteran could be seen whenever he/she wanted.
- On June 17, 2014, MSA11 was interviewed by VA OIG and FBI special agents. She stated that the clinic was expected to have zero-day wait times. She stated these orders came from "downtown"—specifically service chief 1 to clinic senior leader 2. She stated that clinic senior leader 2 instructed her to zero out the wait times. She stated her perception was that if the corrections were not made she would be reprimanded. After an appointment was made, she would exit the system and make the appointment date the desired date. She stated she printed the CAAR report every morning and corrected it. If the CAAR report had a wait time of over three days, she would go into the computer and zero out the wait time by entering the system, canceling the appointment, and rescheduling for the same date.
- On May 14, 2014, MSA12 was interviewed by VA OIG special agents. He stated that he used to schedule appointments by entering "T" or today as the desired date and then schedule the appointment. Subsequently, he would just make the date of the appointment the desired date. This would reduce the wait time to zero. He stated that clinic senior leader 2 required each PACT team to print its CAAR reports every morning. If the report showed an unacceptable wait time, he would go back in, cancel the appointment, reschedule it, and that action would zero out the wait time.
- On May 14, 2014, MSA13 was interviewed by VA OIG special agents. He stated that clinic senior leader 2 provided him a copy of the VHA directive on scheduling. He stated that she expected the MSAs to schedule veterans in a reasonable amount of time. He stated he was aware the Pentad wanted veterans seen within 14 days. He stated that clinic senior leader 2 told him to correct the dates if they were more than 14 days. This was done by rescheduling the appointments and changing the desired date. He stated he complied with these instructions. Later, when he stopped printing CAAR reports and changing desired

dates, he said he received a verbal warning from clinic senior leader 2 and nothing further.

- On May 14, 2014, MSA14 was interviewed by VA OIG special agents. She stated that PVAHCS management wanted wait times under three days when looking at CAAR reports. If the CAAR report was over three days, she was supposed to reschedule the appointment and change the desired date. She stated she complied with these instructions, which came from clinic senior leader 2.

The five supervisors stated as follows:

- On May 13 and July 14, 2014, clinic senior leader 2 was interviewed by VA OIG and FBI special agents. She denied directing schedulers to inappropriately alter the desired date. She stated that program analyst 2 provided her with instruction regarding the handling of the desired date. She stated that in approximately February or March 2013, via a conference call, program analyst 2 clarified instructions to the Southeast CBOC staff to not use "Today" as the desired date. She stated that approximately two weeks later, program analyst 2 met personally with all the MSAs one-on-one at the Southeast CBOC to provide individual instruction concerning desired date. She stated she was not with program analyst 2 when she spoke to the MSAs, but subsequent to these meetings, there was further confusion regarding what date to use for the desired date. She stated that in July 2013, program analyst 2 began emailing her a report that is referred to as the "MUMPS Report."[2] The report is similar to the daily CAAR report for individual schedulers, but instead provides a list of all appointments scheduled beyond 14 days of the veteran's desired date for all schedulers. She stated she was to speak with the MSAs to correct any mistakes. The MSAs then had to pull a daily CAAR report and check any appointments outside 14 days to correct any errors. Shortly thereafter, MSA15 complained to her about changing the desired dates to meet the metrics. She stated she called program analyst 2 regarding this matter who told her if the dates were correct to leave them alone. She stated she instructed the MSAs to print the CAAR report, circle any wait times greater than 14 days, and then say whether they were scheduled correctly or not. She stated she clarified this point to her MSAs in an October 4, 2013 email saying, "Please note not all appointments with a greater than 14 day wait time is (sic) made in error. The true wait time must remain untouched, just annotate that it is correct."
- On May 13 and June 19, 2014, clinic supervisor 2 was interviewed by VA OIG and FBI special agents. He denied telling anyone to manipulate patient wait times. He stated there were multiple ways to get around the 14-day metric, but he did not promote using those techniques. Clinic supervisor 2 said the CAAR report was implemented in the Northwest CBOC in May 2013, and it was used to review scheduling errors and ensure the desired date was entered correctly. He

[2] 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.

stated he taught his staff the desired date was the date the veteran wanted to be seen.

- On August 6, 2014, clinic senior leader 1 was interviewed by VA OIG and FBI special agents. He stated he never saw any instances of any staff "gaming the system." He was asked multiple times if he directed others to manipulate the desired date metric, but did not provide a clear answer to that specific question. He stated that he did not fully understand the scheduling package. He stated he had a conversation with service chief 2 in approximately February 2013 regarding the proper use of the desired date. Clinic senior leader 1 stated that, subsequent to this conversation, he requested formal training for the employees of the Southeast Clinic. He stated that, in February 2013, service chief 1 sent program analyst 2 to provide the requested scheduling training.

- On May 2 and May 15, 2014, clinic supervisor 1 was interviewed by a VA OIG special agent and a VA OIG auditor. She stated that she never intentionally falsified desired dates nor did she provide instructions to any MSAs to intentionally falsify desired dates. However, when describing her understanding of the desired date she conveyed that she often saw it as the day the veteran agreed to be seen. (**Note**: This is not consistent with VA policy.) Clinic supervisor 1 stated that if a veteran said he wanted to come in tomorrow, but then refused appointments that were available for the next several days after tomorrow until accepting a suitable one 25 days from tomorrow, she would view the desired date as the appointment date. She stated that she felt that reporting a 25-day wait time in this instance was not an honest reflection of the service and capacity that PVAHCS providers were providing.

  She stated that this mistaken understanding carried over to the way she reviewed, and instructed MSAs to review, the CAAR report. The MSAs would be forced to run a daily CAAR report and correct any appointments outside 14 days of the desired date. She explained that the way the VA scheduling package worked, it required the scheduler to first input the desired date into one screen and then move on to another to schedule the actual appointment. She stated that because schedulers were so busy, they would often forget to go back to the desired date entry and change it to the appointment date in the type of scheduling scenario explained above. To remedy this she would have the MSAs review the CAAR report on a daily basis with instructions to change the desire date to the appointment date for any veteran that had refused multiple appointments. She said, "…you don't want to falsely make the provider look good, and you don't want to falsely make the provider look bad. You want to report the true data." She said she thought she was instructing MSAs to do the right thing in this type of scenario. If there had not been any available appointments between the desired date and the appointment date, then she would instruct MSAs to leave the entry alone, regardless of the length of the wait time. She stated she felt that it was important to accurately reflect the true wait time. If a veteran had a desired date that was tomorrow and there were no appointments available for 25 days, then she felt recording that was important so that PVAHCS could get more resources.

- On June 19, 2014, lead MSA2 was interviewed by VA OIG and FBI special agents. He stated that he was operating in the same way and with the same understanding as clinic supervisor 1 (detailed above). He stated that from October 2013 to April 2014, he instructed his MSAs to review the CAAR reports daily to check and confirm everything was accurate. They were to identify all appointments where the wait time was over 14 days and where there were available appointments between the desired date and the appointment date. If the wait time was over 14 days and there were no available appointments, he would tell his MSAs to leave it as is and just initial next to the entry on the CAAR report indicating that they had checked it. If there were available appointments, he told his MSAs to change the desired date to the appointment date resulting in a zero-day wait time. He stated, "So that's when I was telling them well I think you're supposed to just go ahead and change that desire date to the actual date, zero it out… So then they were doing that, but it wasn't until just a couple of months ago that I found out no, you should just go ahead and leave it, let it go on to wherever it goes…" He stated that, like clinic supervisor 1, he thought he was doing the right thing. He said, "It's not about changing the 14 because it's a 14 and we want it to be smaller, it's about recognizing whether or not that was scheduled correctly." He stated that in April 2014, he spoke to clinic supervisor 1 and came to understand that these practices were wrong and that he should not have been having his MSAs change the desired date.

The August 26, 2014 VA OIG, *Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System* (Report No. 14-02603-267), indicated that PVAHCS did not comply with VHA policy concerning training. Scheduling staff must complete required training, consisting of four courses, prior to obtaining access to VistA scheduling ability. Training records that were analyzed by OAE determined only 53 percent of the schedulers had completed all required training as of May 22, 2014.

Investigation Related to the Alleged Manipulation of Desired Dates for Specialty Clinics

On November 3, 2012, former service chief 2 sent an email to the Medicine Department, VAMC senior leader 4, and service chief 1. This email was in reference to altering desired dates to meet the 14-day scheduling metric. The email instructed the specialty provider to have the ultimate say in determining what the desired date is. The specialty provider was to always specify an "EXACT DATE" they would like to see the patient. The HAS clerk would then try to find a clinic appointment within two weeks of the exact date. If the appointment could not be made within two weeks of the exact date, the HAS clerk was to inform the specialty provider and the specialty provider would then provide a new exact date. The email further explained, "But we have been getting ourselves into trouble with the access numbers because we have not always followed the correct method of picking desired dates, which is entirely at the discretion of the receiving provider."

On November 4, 2012, service chief 1 sent an email to several VAMC staff, including VAMC senior leader 4, former service chief 2 and VA physician 3, in which he recapped his meeting with former service chief 2 and VA physician 3. The recap included the following, "1. Discussed the Desired Date issue and provided education related to this. The clinician will indicate on the consult the specific date they wish the patient's appointment to be scheduled rather than providing a range (i.e. "2 months from now"). [Former service chief 2/VA physician 3] agreed to share this info with your clinical staff for change and we will provide guidance to the HAS staff as well."

On November 6, 2012, former service chief 3 sent a follow-up email to other specialty providers in which he repeated the instructions of having the specialty providers pick an exact date for a follow-up appointment. If the appointment could not be scheduled within two weeks of that date, a new exact date was to be selected as the desired date. Former service chief 3 concluded his email as follows, "At this point, there can be no argument about the merits of this policy. The metric has to be met and personal opinions about the value of it are not relevant to the forces that control."

On August 15, 2014, former service chief 2 was interviewed by VA OIG special agents concerning an email he sent to Medicine Department staff instructing them to change desired dates to meet the 14-day requirement. This email was sent subsequent to a meeting with service chief 1 and relayed instructions that service chief 1 had provided to him. Former service chief 2 stated that the "Front Office" was aware of access delays. He stated that, in the first half of 2013, patient accessibility seemed to suddenly improve and the wait times markedly diminished. He said some of the specialty clinics were still "slacking." He stated that three clinic chiefs (clinic chief 1, clinic chief 2, and clinic chief 3) had issues with HAS and patient access. He stated that VAMC senior leader 4 told everyone not to "game the system" and that the focus was on seeing the patients.

He stated he was confronted multiple times by service chief 1 for trying to work with HAS employees about improving access. He stated that service chief 1 told him that he needed to go through him (service chief 1) if he wanted anything from HAS. He stated he remembered meeting with service chief 1 and VA physician 3 the day before the email, on November 2, 2012. He stated that service chief 1 had a couple of HAS employees present and VA physician 3 had a few people present as well. He stated that service chief 1 was being "extremely difficult" and they sort of "hammered out some half agreement that didn't hold." He stated that he remembered thinking this was "a little screwy," but that going along with service chief 1 would be the path of least resistance. He stated, "If he says those are the rules, this is his area of expertise." He stated he believed that service chief 1 had a more detailed understanding of the rules and regulations for scheduling. He stated that service chief 1 pulled out a "big book or manual" and pointed to a certain spot saying it is right in the manual. He said it never crossed his mind that this was inappropriate.

He stated that if he had thought this was gaming at the time, the last thing he would have done was write an email and send it to the whole Medical Services department. He stated he thought that service chief 1 was clarifying the proper way they should be scheduling. He said the Medical Services staff was struggling to understand the desired date and create date. These were not medical issues; they were administrative so he didn't really think too much about them.

On September 2, 2014, former service chief 3 was interviewed by VA OIG special agents. He stated he remembered receiving the email from former service chief 2. He said his clinic was not meeting the 14-day metric. He stated he remembered his email to his staff regarding his instructions to choose an exact day within the 14 days to meet the metric. He said his clinic never had an MSA; they had their own schedulers. He stated that he was a "poor administrator" and didn't focus on the metrics. He considered the desired date and 14-day metric an "administrative hassle" the providers had to deal with.

On August 28, 2014, clinic chief 2 was interviewed by VA OIG special agents. She stated that her clinic was mainly procedural, so former service chief 2's email only applied to the clinical side of the department. She stated she told former service chief 2 she could not follow his instructions (from the email) with her procedures. She said she didn't really deal with administrative issues and did not deal with service chief 1.

On August 29, 2014, clinic chief 1 was interviewed by VA OIG special agents. She stated her clinic currently did not have a long patient wait time. She stated she sent an email to her staff instructing them to choose an exact date within 14 days, per former service chief 2's email. She stated that bonuses were tied in with performance and meeting the metric. She stated that appointments had to be within 14 days of MSA contact with the patient. She stated that former service chief 2 gave her instructions on how to schedule patients within 14 days. She stated that former service chief 2 continuously put pressure on her to meet the metric because her clinic was not focused on achieving this goal. She stated she was more concerned with substantive patient care issues.

On August 20, 2014, VAMC senior leader 4 was interviewed by VA OIG and FBI special agents. He read the email written by former service chief 2, in which he was copied. He said he doesn't think the email conveys a purposeful manipulation. He stated, "I read this really more that they were trying to make sure that the desire date was being captured and the time stamp was being done appropriately and that we weren't basically causing the numbers to look worse by not capturing the right desire date." He was shown the email written by former service chief 3 to his (former service chief 3's) staff in which VAMC senior leader 4 was copied. VAMC senior leader 4 stated that the email conveyed former service chief 3's opinion and that he never directed former service chief 3 to manipulate dates. He was asked why, since he was copied on the email, he never responded to say that changing desired dates to meet the 14-day metric was wrong. He said, "I probably should have replied to that to clarify and if I didn't then that was a mistake on my part."

On May 14, 2015, service chief 1 was interviewed by VA OIG special agents concerning his meeting with former service chief 2. He said he vaguely remembered the meeting because the HAS clerks were having a problem understanding when to schedule patients from specialty clinics. He said he wanted the physicians to be more specific on when they wanted to see the patient again. The email was read to service chief 1, and he stated the instructions were incorrect and the providers should not be changing desired dates. He said he did tell the providers to give a specific date but did not instruct HAS clerks to have the providers change the date if the patient could not be seen within 14 days of the original date.

Interviews Related to the Program Analyst 1 Ethics Consult

On July 3, 2013, an email was sent to all PVAHCS personnel by administrative assistant 2, on behalf of VAMC senior leader 1. The purpose of the email was to update staff regarding VAMC senior leader 1's plans to implement changes to the facility-wide Wildly Important Goal (WIG). This new WIG, implemented by VAMC senior leader 1 in the last quarter of FY 2013, was to increase the percentage of new patients to be seen in Primary Care within 14 days of the creation of their appointment.

On July 3, 2013, program analyst 1 sent an email response to administrative assistant 2 indicating that he thought the way that wait times were being reported were not accurate or ethical. An Ethics Consult was conducted in response to his email. We conducted interviews of individuals involved in this Ethics Consult. We found that several recommendations were made as a result of this Ethics Consult. Specifically, the team recommended that published documents be provided to all PVAHCS staff in order to properly communicate the trends/successes in reducing patient wait times as well as the current number of patients waiting on the EWL. The team also recommended HAS develop a clear process "package" for educating veterans regarding enrollment and accessing health care during the wait time until their new patient appointment. No members of the Pentad were present at the meeting. We found that these recommendations were not fully implemented by PVAHCS.

Interviews Related to the Alleged Manipulation of the Third Next Available Metric

While conducting interviews regarding the Specialty Clinic patient backlogs, specifically in Urology, a former Urology MSA reported the suspected manipulation of the Third Next Availability metric. We conducted numerous interviews regarding this issue. We found no evidence that any providers were manipulating this metric.

Interviews Related to the VISN 18 Site Team Visit to PVAHCS

In May of 2013, VISN senior leader 1 sent a team to several medical centers in her VISN in order to address various scheduling metric related issues. PVAHCS was one of the facilities visited. We conducted interviews regarding this site visit. Interviews of the VISN PACT team indicated that PVAHCS was not in compliance with VHA

Scheduling Directive 2010-027, as there was not a fully implemented EWL in place, no processes in place to ensure scheduling accuracy, and there was no implemented use of the Recall Reminder System. The VISN team believed the most significant issue was the lack of training on how to properly schedule according to Scheduling Directive 2010-027. As a result, the VISN PACT team required responses to monthly action suspense updates from PVAHCS to assist in increasing compliance with the Scheduling Directive. These required responses started in August 2013. Interviews revealed PVAHCS was initially compliant with its responses to VISN suspense updates, but became resistant to VISN oversight around October 2013. The VISN PACT team leader went to VISN senior leader 1 regarding PVAHCS' resistance, but she received no support in enforcing compliance. Because PVAHCS' compliance with this requirement began to lapse, the VISN required PVAHCS to continue providing responses to the VISN action suspense updates through April 2014.

Investigation Related to PVAHCS Scheduling Certifications

VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures*, issued on June 9, 2010, required facility directors to provide annual certifications of full compliance with the content of the directive. The initial certification was due six months after the issuance of the directive. On May 16, 2013, the Deputy Under Secretary for Health for Operations and Management issued a memo pertaining to VHA scheduling processes and procedures. Pursuant to that memo, the facility requirement to certify compliance with Scheduling Directive 2010-027 was waived for FY 2013. Instead, VAMC directors were asked to complete a Scheduling Process Checklist by June 14, 2013, so that the Office of Systems Redesign could assess VHA's progress in aligning with the Scheduling Directive. Facilities that were not in full compliance with the Scheduling Directive were asked to provide an action plan that would bring the facility into compliance with the Scheduling Directive. According to the directive, the director of VHA Systems Redesign, within the Office of the Deputy Under Secretary for Health for Operations and Management, is responsible for oversight of the implementation of requirements of this directive. The VISN director is responsible for the oversight of the facilities in enrollment, scheduling, and wait lists for eligible veterans. Moreover, the facility director, or designee, is responsible for ensuring compliance by the schedulers and administration.

A former systems redesign officer was interviewed by a VA OIG special agent. He indicated that the Scheduling Directive was issued through the chain of command from VACO to VISN and distributed to the facilities. He stated the VISN 18 team working on the directive consisted of himself, service chief 1, and an administrative supervisor. (**Note**: Service chief 1 and the administrative supervisor worked for the VISN at that time.) He stated that the first suspense notice from VISN 18 was sent to the facilities in December 2010. A week after the directive was distributed, facilities responded to the VISN with initial certifications of compliance. The certification was done internally via email because a SharePoint site had not been established yet. He stated that VISN senior leader 1 provided a memo to the VACO, Office of Systems Redesign (OSR), dated December 9, 2010, identifying which facilities were in

compliance and which were not. PVAHCS was listed as "Compliant." Subsequently, OSR created a SharePoint site titled "Mandatory Certification of Compliance Directive VHA 2010-027." Facilities were instructed to submit their certification response to the line items via SharePoint. Once facilities certified compliance on the OSR SharePoint website, they were required to notify the VISN. One of the OSR team members would confirm that their information was input onto the SharePoint site. He stated he did not know who the Phoenix point of contact was for the Scheduling Directive. He stated the VISN 18 team did not double check whether the facilities were in compliance or not, since they did not have any reason to believe the facilities would submit false information.

VISN senior leader 2 was interviewed by VA OIG special agents and stated that VISN 18 had scattered noncompliance. Phoenix was technically in noncompliance until 2013 because the EWL was not implemented. The VISN and facilities did not have a good understanding of the Scheduling Directive and what had to be implemented. As a result, there was a disconnect between the VISN and its facilities regarding the oversight that was required and what the facilities were responsible for. He stated that they fixed the issues as they developed. He stated that facilities were never fully compliant with the directive because there were so many needed changes. He said that even though he knew Phoenix was never fully in compliance with the directive, he did not raise any questions as to why they were certifying that they were. He said he attributed the VISN's lack of oversight of the facilities' compliance with the Scheduling Directive to the fact that the directive did not provide clear instructions.

Completed PVAHCS Scheduling Certifications and Checklist were obtained by a VA OIG special agent from a VACO service chief for FYs 2010, 2011, 2012 and 2013. Review of these documents disclosed that for each year, PVAHCS certified that schedulers in all clinics checked the NEAR list and EWL on a daily basis. For FYs 2010, 2011, and 2012, PVAHCS certified that schedulers were trained and effectively supervised to ensure correct entry of the desired date for an appointment. The FYs 2010, 2011, and 2012 Scheduling Certifications did not notate who certified the information. In FY 2013, a former assistant service chief submitted the information for the PVAHCS Scheduling Checklist. PVAHCS Scheduling Certifications for FYs 2010, 2011, and 2012 contained a total of 38 questions covering the following topics: desired date, scheduling processes, canceling appointments, and the NEAR list. PVAHCS responded "Yes" to 36 of the questions and "Partial" to two of the questions. The two questions with a Partial response covered scheduling backlogs being eliminated and the Recall/Reminder Software. The PVAHCS Scheduling Process Checklist for FY 2013 contained a total of 19 questions covering the following topics: desired date, scheduling processes, canceling appointments, and the NEAR list. PVAHCS had varying responses and did not respond to the full checklist.

Interviews of VISN Senior Leader 1

On May 28 and September 18, 2014, VA OIG and FBI special agents conducted interviews of VISN senior leader 1 regarding appointment scheduling practices at both the Tucson and Phoenix VAMC. VISN senior leader 1 had been an employee of the VA for over 37 years and had been a Senior Executive Service employee for 14 years. VISN senior leader 1 was appointed as the VISN 18 Director in 2008, and retired from that position in May 2014. As the VISN 18 Director, she was responsible for overseeing the performance of the VAMCs in her network and their respective directors.

She stated that regarding wait times and access to care, since she arrived at VISN 18, she told her directors that she is "not interested in the numbers." She stated that she was interested in making sure veterans got care. She stated she told directors that if she saw progress in their wait times, it was "more important than them meeting their performance measure." "The performance measure is not the important thing," she added. She stated that VISN 18 has had a "serious issue with wait times for a very long time." Access to care had always been the "Achilles heel" of VISN 18, and PVAHCS in particular due to their growing veteran population, their facility being land locked, and construction projects being delayed or on hold. She stated she has always said, "I don't care about the numbers, I care about access." "That's been a consistent message of the network."

She said she didn't believe [now] former VAMC senior leader 1 was "gaming the system" to make the access numbers look better. She stated that during VAMC senior leader 1's performance evaluation, she would review VAMC senior leader 1's self-assessment, and run numbers from the VA national computer system. She stated the national computer system numbers generally supported what VAMC senior leader 1 was reporting on her self-assessment. She stated that in FY 2013, VAMC senior leader 1 implemented use of the EWL at the Phoenix VAMC to improve wait times and access to care.

With regard to performance plans and metrics, VISN senior leader 1 explained that none of the facilities were all green on their metrics. She stated there are many parts to the SES performance plans, which included five elements. Metrics can affect two of the five elements, "Results Driven" and "Business Acumen." She explained that in the Results Driven element, which represented 40 percent of a director's overall performance plan, a director could have metrics in the red (below the metric target) and still successfully meet overall performance standards. Just because a metric was red did not mean that VISN senior leader 1 would not give a director credit for improvement. For example, if the measure was 47 percent access to care within 14 days and the facility had a 22 percent score at the beginning of the year and a 40 percent score by the end of the year, she stated she would give the director credit for the improvement.

She stated she would also give a "minus mark" to directors if their measures got worse, even if they were still in the green (above the metric target). She said she did

not give a lot of minus marks in that kind of a setting, particularly if there were a clear reason like a loss of providers. She stated she allowed the directors to explain to her what they were doing about an issue and how they were implementing recovery from a lower metric level. In the performance documents, there were some documents that were turned in that had narratives that described the work that a director did to improve particular issues.

Regarding performance appraisals, she explained that just because the measure was red, it did not mean she would give the director a "bad mark." Also, just because the measure was green, did not mean she would give the director "out-of-sight kind of marks." She stated there were many other aspects involved in the metrics (e.g., what was the employee or patient satisfaction rate, are there improvements going on, has the director implemented new methods to do different things). She stated she typically gave directors "Highly Successful" and "Outstanding" ratings if the director was getting more green metrics or showing more improvement.

Other Possible Administrative Issues Identified

On June 11, 2015, service chief 1 was interviewed by VA OIG special agents. He provided 431 pages of documents for the agents' review. He had been on administrative leave since May 2, 2014 and prohibited from accessing PVAHCS grounds. While reviewing copies of these documents, it was discovered that three pages of the 431 pages contained veteran Personally Identifiable Information and Personal Health Information. Specifically, the report listed veteran names, addresses, dates of birth, Social Security numbers, telephone numbers, and the names and clinic locations of the veterans' treating physicians. The pages were titled "Cross Walk Report." On June 22, 2015, service chief 1 provided the original three pages of the Cross Walk Report to OIG agents.

Additional Information

OHI issued a report on October 15,2015, *Healthcare Inspection: Access to Urology Service, Phoenix VA Health Care System, Phoenix, Arizona* (Report No. 14-00875-03), in which it was determined that leaders did not have a plan to provide urology services during significant unexpected provider shortages in Urology Services. This issue was first raised in the OAE report; *Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System*, from August 26, 2014 (Report No. 14-02603-267), and subsequent work was completed by OHI.

4. Conclusion

The joint VA OIG and FBI investigation found no evidence that there was any intentional, coordinated scheme by management to create a secret wait list, delay patient appointments, or manipulate wait time metrics. Specifically regarding the EWL allegations, we found that implementation of the mandated EWL program was done very poorly at PVAHCS, resulting in many veterans experiencing extended wait times for Primary Care appointments. We found no evidence of any scheme initiated by VA management officials to willfully delay

appointments or mischaracterize wait times. We found no secret lists used by anyone at the facility to hide patients waiting for care.

Specifically regarding the metric manipulation allegations, we did find some manipulation of appointment data done by low-level VA scheduling staff from approximately autumn 2012 until the initiation of our investigation in May 2014. There were numerous reasons why staff took these actions. They included: (1) a metric that was not intuitive and often not fully understood by managers and staff, (2) a lack of effective training regarding the recording of this metric, (3) miscommunication between lower-level managers and schedulers, and (4) the existence of inappropriate practices regarding this metric that were widespread throughout the VA system for a long period of time. Testimony from subordinates and supervisors alike clearly indicated that manipulation of wait times occurred. Our investigative results did not find evidence that this was a scheme orchestrated by the senior managers (Pentad).

Additionally, the manipulation that did occur involved metrics only. We found no link between the desired date metric manipulation that did occur and the delays associated with the poor implementation of the EWL. At PVAHCS, these were two separate issues. We also found that wait time metrics played a minimal role in the annual performance appraisals and bonuses received by PVAHCS management.

We found that VISN 18 and its facilities did not have a good understanding of VHA Directive 2010-027 and what had to be implemented. As a result, the facilities within VISN 18 were never fully compliant with the directive.

We found no evidence that any providers were manipulating the Third Next Availability metric.

We found that several recommendations were made as a result of the Ethics Consult. Specifically, the team recommended that published documents be provided to all PVAHCS staff in order to properly communicate the trends/successes in reducing patient wait times as well as the current number of patients waiting on the EWL. The team also recommended HAS develop a clear process package for educating veterans regarding enrollment and accessing health care during the wait time until their new patient appointment. We found that these recommendations were not fully implemented by PVAHCS.

VA OIG referred the Report of Investigation to VA's Office of Accountability Review on November 3, 2016.

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For more information about this summary, please contact the Office of Inspector General at (202) 461-4720.