

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



**VA Medical Center in Beckley,
West Virginia
May 8, 2017**

1. Summary of Why the Investigation Was Initiated

The Department of Veterans Affairs (VA) Office of Inspector General (OIG) initiated an investigation in 2014 based on a referral received from the U.S. Office of Special Counsel, which detailed a complaint made by confidential source CS-58 (CS-58) and program support assistant (PSA) 1. The referral, which OIG received in 2014, included these allegations:

1. CS-58 and PSA1 alleged that VAMC Beckley staff did not follow proper scheduling protocols, which resulted in the manipulation of wait time data.
2. CS-58 and PSA1 alleged that the agencywide bonus system motivated VAMC Beckley management to direct the use of improper scheduling practices.
3. CS-58 and PSA1 alleged that management improperly removed patients from the New Enrollee Appointment Request (NEAR) Call List in advance of a Veterans Health Administration (VHA) audit.
4. CS-58 and PSA1 alleged that administrators mismanaged the eligibility determination process and that VAMC Beckley staff made many inaccurate eligibility determinations.

Following receipt of these complaints, VA OIG conducted a total of 127 interviews. VA OIG also obtained a total of 383,177 emails involving nine VAMC Beckley employees. A keyword search was conducted for 133 terms, which narrowed this population to 42,897 emails. Each of these emails was reviewed individually for information related to these allegations. During the course of the review, VA OIG found emails that suggested certain VAMC Beckley employees might have engaged in inappropriate practices. Listed below are several more allegations obtained from this email search and gleaned from additional interviews:

1. PSA1 alleged that many VAMC Beckley employees scheduled appointments without obtaining input from the patient.
2. Social worker 1 alleged that former physician 1 prohibited medical support assistant (MSA) 1 from both scheduling patients past 1:00 p.m. and accepting walk-in patients.
3. Supervisory employee 1 alleged that a program analyst asked her and MSA2 to remove approximately 30 patients from the appointment schedule in the Veterans Health Information Systems and Technology Architecture (VistA) and to place new patients in their vacated slots.
4. VA OIG identified emails in which senior leader 1 and service chief 1 stated that

physician 1 was manipulating the patient's desired date and "gaming the system."

5. VA OIG identified an email in which senior leader 2 alleged that providers were instructing schedulers not to fill, in their schedule, openings that were created by cancellations.
6. VA OIG identified an email in which service chief 1 said that former physician 2 directed MSA4 not to schedule appointments out beyond 10 calendar days.
7. VA OIG found an October 22, 2009 email from administrative employee 1 to senior leader 3 in which the administrative employee 1 stated, "That pt that is out there 18,199 days I would not worry about him. He'll be dead by then."
8. VA OIG found emails suggesting that former physician 3 used inappropriate scheduling practices.
9. VA OIG found an email in which physician 2 and former physician 3 discussed having a "7-day therapy rule" that would require patients to receive treatment for 7 consecutive days, which would result in a larger reimbursement for the facility.
10. PSA1 alleged that schedulers were directed to place consultation documents in a drawer and to delay the processing of this paperwork.
11. Nurse practitioner 1, Primary Care Clinic, alleged that physician 3, Urology Clinic, regularly discontinued consultations by indicating that further testing should be completed before he would agree to see the patient.
12. PSA1 alleged that schedulers were prohibited from using the Electronic Wait List (EWL).
13. Program Support Clerk (PSC) 1, Compensation and Pension Clinic, alleged that, from approximately 2009 to 2012, VAMC Beckley employees working in Home-Based Primary Care (HBPC) maintained a Microsoft Excel spreadsheet that listed patients waiting for care.
14. Multiple employees said they knew about unofficial wait lists that were at one time maintained by VAMC Beckley employees.
15. VA OIG found an email in which service chief 3 stated that Mental Health Clinic patients would be placed on a list.
16. Confidential source CS-57 (CS-57) alleged that specialist 1 and nurse practitioner 2, both of the Mental Health Clinic, were regularly canceling large numbers of patient appointments so they could participate in union activities—which led to patient care issues.
17. CS-57 alleged that VAMC Beckley management held a meeting just before VA OIG arrived at VAMC Beckley in July 2014 to discuss scheduling practices and to instruct schedulers on the best way to respond to questioning by VA OIG agents.
18. Supervisory medical administration specialist (SMAS) 1, Patient Health Benefits Section, alleged that PSA2, Rural Health Initiative, and PSA1 knowingly submitted false information on applications for VA health care for approximately four veterans to ensure that the Health Eligibility Center (HEC) would find these veterans eligible. She said she

believed PSA2 and PSA1 did this because they were concerned that the Rural Health Initiative would be discontinued if they did not enroll enough veterans.

19. A CS alleged that his or her spouse received an anonymous letter stating that they engaged in an extramarital affair. The CS alleged that this letter was sent in an effort to retaliate against them for reporting their concerns about inappropriate practices at VAMC Beckley.
20. MSA5, Non-VA Care Coordination (NVCC), alleged that veterans experienced a delay in care when scheduled through the Veterans Choice Program. Other VAMC Beckley employees also expressed concern about the scheduling process for this non-VA care program.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** VA OIG interviewed 127 current and former VA employees.
- **Records Reviewed:** VA OIG reviewed performance appraisals, contribution award documentation, and spreadsheets. We conducted a keyword search of more than 380,000 VA emails and then conducted a more indepth review of over 40,000 of those emails.

Actual summary of evidence obtained during the investigation is provided in the Appendix.

3. Conclusion

- This investigation substantiated that improper scheduling practices had been used by employees at VAMC Beckley. Specifically, some schedulers indicated they had been instructed to use the appointment date as the desired date, which resulted in zero-day wait times. Former service chief 1 and SMAS1 were identified by some employees as having given such instruction. However, VAMC Beckley employees largely did not recognize these practices as manipulation and instead described them as standard practices employees learned during their on-the-job scheduling training. (Issue 1. For additional information, see Appendix, page 8.)
- This investigation disclosed that for the time frame covering FYs 2010 through 2015, service chief 1 and the four members of VAMC Beckley's executive leadership team received bonuses and that patient access and wait times were mentioned in many of the evaluations; however, wait time metrics did not constitute a significant percentage of the overall criteria used in the evaluations. (Issue 2. For additional information, see Appendix, page 25.)
- We substantiated through interviews of numerous VAMC Beckley employees that the NEAR Call List had not been actively managed for several years. However, VAMC Beckley employees denied having any knowledge of the improper removal of patients from the NEAR Call List. However, this investigation was unable to conclusively substantiate that patients were improperly removed from the NEAR Call List. (Issue 3. For additional information, see Appendix, page 31.)

- This investigation substantiated that some VAMC Beckley staff appeared to apply outdated eligibility rules to applications that may have resulted in a veteran initially being determined ineligible. However, typically, all applications submitted by medical center employees feed into the HEC's Enrollment System, which makes the final enrollment determination. CS-58 and PSA1 stated that they knew of a backlog of 2,500 to 4,000 veterans who were waiting for eligibility determinations. CS-58 and PSA1 alleged that a computer "glitch" was responsible for these applications not being transferred to the HEC. CS-58 and PSA1 further stated that the families of five deceased veterans were contacted by VAMC Beckley employees who were attempting to schedule appointments for these veterans. Many VAMC Beckley employees were questioned about these allegations and multiple employees said they had heard rumors about the mismanagement of the eligibility determination process but they denied having any direct knowledge of this situation. An OIG report titled *Review of Alleged Mismanagement at the Health Eligibility Center* (September 2, 2015) confirmed that the HEC had a backlog of approximately 11,000 unprocessed health care applications. The OIG report also confirmed that the HEC had approximately 867,000 pending records as of September 30, 2014. However, we were unable to reliably determine how many of these records were associated with actual applications for enrollment. According to this report, about 307,000 of the roughly 867,000 pending records were for individuals who had been reported as deceased by the Social Security Administration. (Issue 4. For additional information, see Appendix, page 38.)
- Through interviews of VAMC Beckley employees, this investigation substantiated that it was a common practice for schedulers to make a return appointment without obtaining input from the patient. However, multiple employees remarked that more recent scheduling guidance had indicated that this is a prohibited practice. It appeared that many schedulers have stopped using this practice since receiving this recent guidance. (Issue 5. For additional information, see Appendix, page 44.)
- During an interview, MSA1 denied that former physician 1 prohibited her from scheduling patients past 1:00 p.m. However, MSA1 said that even though former physician 1's schedule had 10 available appointment slots, he would often tell her to only schedule six patients. As well, MSA1 recalled instances when former physician 1's nurse, nurse 1, would deny requests for appointments from walk-in patients. For her part, nurse 1 stated that former physician 1 saw patients on a walk-in basis while employees stated that former physician 1 was limiting his appointment schedule because he needed to complete other work-related tasks. (Issue 6. For additional information, see Appendix, page 46.)
- We determined that no patients appeared to have been rescheduled because of a specific request made by the program analyst. Interviews determined that supervisory employee 1 and MSA2 had refused to comply with the program analyst's request to remove approximately 30 patients from the appointment schedule in VistA and place new patients in the vacated slots. (Issue 7. For additional information, see Appendix, page 48)

- We did not substantiate the allegation that physician 1 was manipulating the patient's desired date and gaming the system. Service chief 1 said he thought physician 1 was assigning desired dates based on clinic availability but did not recall addressing the issue with physician 1. Senior leader 1 shared service chief 1's concerns but he also stated that he did not address the matter with physician 1. MSA3, who was responsible for scheduling physician 1's patients at the time, stated that she knew nothing about physician 1's alleged inappropriate practices. Physician 1 stated that he always chose the patient's return date based on the patient's needs, not on clinic availability. (Issue 8. For additional information, see Appendix, page 51.)
- We found that a VA employee in the Dental Clinic reported she was instructed to leave open the appointment slot when a patient canceled on the same day. Another scheduler stated that some physicians who overbooked their schedule would ask schedulers not to fill an appointment slot if a patient canceled. Additional interviews disclosed that same-day cancellations were difficult to fill. Senior leader 2 stated that he had sent an email to address the issue of filling canceled appointments. (Issue 9. For additional information, see Appendix, page 52.)
- We did not find any evidence that former physician 2 directed MSA4 not to schedule appointments for patients beyond 10 calendar days, except for an email in which service chief 1 said that former physician 2 had done so. When interviewed, service chief 1 stated that he could not recall the circumstances surrounding these statements. Meanwhile, MSA4 indicated that he did not recall receiving such direction from former physician 2. (Issue 10. For additional information, see Appendix, page 53.)
- The investigation disclosed that an email in which administrative employee 1 stated, "That pt that is out there 18,199 days I would not worry about him. He'll be dead by then" was meant to reference a scheduling error. We determined that the veteran referenced in the email was examined by former physician 3 in the Physical Medicine and Rehabilitation Clinic 7 days after the email had been sent. (Issue 11. For additional information, see Appendix, page 55.)
- Interviews conducted during this investigation suggested that former physician 3 likely followed inappropriate scheduling practices at one time, and that VAMC Beckley management addressed these issues with him. Some VAMC Beckley employees said former physician 3 had stopped these practices but others disagreed. (Issue 12. For additional information, see Appendix, page 55.)
- We determined that a "7-day therapy rule" was never implemented. (Issue 13. For additional information, see Appendix, page 59.)
- Our investigation identified one employee who said that a former VAMC Beckley employee had placed consultation documents in a drawer some 15 years ago, resulting in a delay of the processing of this paperwork. Additional interviews confirmed that several VAMC Beckley employees had also been placing open consultation documents in a drawer more recently. The same employees indicated that they didn't do it to hide

consultations and that this practice did not delay the processing of these consultations. These employees explained that this practice was adopted to make sure physicians could review each consultation before an appointment was scheduled. (Issue 14. For additional information, see Appendix, page 61.)

- We found that physician 3 discontinued consultations by simply noting that further testing was required. Service chief 1 stated that he had received complaints about physician 3's actions; however, evidently, physician 3 was "making a medical call" that did not appear to be in conflict with VA regulations. (Issue 15. For additional information, see Appendix, page 64.)
- Several employees reported during interviews that they were prohibited from using the EWL while others said they were told the EWL was available to use when necessary. Senior leader 1 stated during an interview that, around 2004, guidance issued by former director 1 advised not to use the EWL. Both former director 2 and a VISN senior leader indicated during separate interviews that they were not aware of VAMC Beckley management directing schedulers not to use the EWL. The investigation also found a May 2013 email, from senior leader 1 to service chief 2 (VAMC Fayetteville), in which he shared his belief that VISN 6 needed to address the misperception that the use of the EWL was prohibited. (Issue 16. For additional information, see Appendix, page 65.)
- Our investigators substantiated the allegation that HBPC maintained a spreadsheet that contained the names of patients waiting for care. VAMC Beckley employees confirmed during interviews that such a spreadsheet was maintained on the HBPC shared computer drive. Administrative employee 2 stated during an interview that HBPC started using the EWL in 2012. Administrative employee 2 further stated that she deleted the spreadsheet on the access drive when HBPC started using the EWL. Former director 2 said during an interview that she thought that around 2009 or 2010, policy declared the EWL unavailable to the HBPC Clinic. (Issue 17. For additional information, see Appendix, page 68.)
- With respect to the allegation that VAMC Beckley had at one time maintained unofficial wait lists—a claim that was raised by several employees at the facility—our investigation uncovered two potential incidents that had occurred a number of years ago and appeared to have been resolved by VAMC Beckley management. (Issue 18. For additional information, see Appendix, page 71.)
- The investigation disclosed that when social worker 2, Mental Health Clinic, was transferring to another position at VAMC Beckley, social worker 2's patients needed to be transferred to a new provider. Social worker 2 provided a handwritten list of her patients to service chief 3 for the sole purpose of identifying those patients. (Issue 19. For additional information, see Appendix, page 71.)
- We found that some VAMC Beckley employees felt that the cancellation of appointments for the purpose of participating in union activities was affecting patient care. Other VAMC Beckley employees stated that these cancellations were not in conflict with VA

regulations. In addition, some employees said patients were given timely notification of the need to cancel the appointments and were often rescheduled into earlier appointment slots. (Issue 20. For additional information, see Appendix, page 72.)

- We did not substantiate the allegation that a meeting had been organized by VAMC Beckley management for the purpose of instructing schedulers on the best way to respond to questioning by VA OIG agents. (Issue 21. For additional information, see Appendix, page 79.)
- The investigation did not substantiate the allegation that PSA1 and PSA2 submitted false documentation to qualify veterans for health care. (Issue 22. For additional information, see Appendix, page 81.)
- We were unable to identify the author of the anonymous letter sent to the CS's spouse. (Issue 23. For additional information, see Appendix, page 83.)
- We found that concerns regarding alleged scheduling delays in the Choice Program may have stemmed from communication issues between veterans and the third-party provider. This provider, HealthNet, was responsible for scheduling those appointments. Interviews conducted by VA OIG agents suggested that this issue was not specific to VAMC Beckley. Reportedly, veterans scheduled through Choice were being monitored and efforts were being made to improve this process. (Issue 24. For additional information, see Appendix, page 84.)

VA OIG referred the Report of Investigation to VA's Office of Accountability Review on December 21, 2016.



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For more information about this summary, please contact the
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Appendix

Summary of the Evidence Obtained From the Investigation

Issue 1: Investigation of the Allegation That VAMC Beckley Did Not Follow Proper Scheduling Protocols, Which Resulted in the Manipulation of Wait-Time Data

Interviews Conducted

- On July 10, 2014, CS-58 stated that between 2009 and 2011, schedulers received direction from management to “zero out” patient wait times. CS-58 said that after his or her office scheduled an appointment for a patient, he or she would often receive telephone calls from specialist 3 and SMAS1 stating “...your wait time is this many days... fix it,” and “Look at this person, it’s over 14 days. You need to fix it.” CS-58 said that former service chief 1 and SMAS1 were directing him or her to make the patient’s desired date match the selected appointment date. In these instances, the changes requested by former service chief 1 and SMAS1 resulted in Wait Time Two¹ reflecting a zero-day wait for the patient. CS-58 said that in approximately 2010 or 2011, “...there was all this buzz about patients waiting for care.” Around that time, CS-58 said schedulers were told by “the lead clerk and coordinator” (not further identified [NFI]) that if a patient would not provide a desired date, the scheduler should get into the system to locate the next available date. CS-58 stated that if the patient agreed to be scheduled on that next available appointment date, schedulers were directed to exit and re-enter the system. Upon re-entering VistA, the desired date would be entered as the selected appointment date, resulting in a zero-day wait time. CS-58 believed this direction was being provided to make patient wait times at VAMC Beckley appear lower than they actually were. CS-58 said there was a “Next Available” prompt displayed when making an appointment for a patient. The prompt asks if the scheduler would like to select the next available appointment slot. CS-58 said that even if the patient specifically requested the next available appointment, schedulers were instructed to always enter “No” at this prompt. CS-58 stated that if the scheduler entered “Yes” at the Next Available prompt, the desired date would automatically be documented as the appointment creation date. CS-58 suggested that management did not want the desired date to be documented as the appointment creation date because that would result in the system recording a higher patient wait time.
- On July 10, 2014, PSA1 stated that during his on-the-job scheduling training in 2011 or 2012, he realized that some of the instructions he had received from VAMC Beckley schedulers (NFI) were in conflict with the scheduling directive². PSA1 stated that he would hear proper instruction given to schedulers in public but “behind the scenes they’re trying to show you a different way to do it without blatantly saying ‘I want you to skew these numbers.’ ” He said he believed that two MSAs in the Primary Care Clinic, MSA6

¹ Wait Time Two reflects the number of days between the desired date and the selected appointment date.

² VHA Directive 2010-027, *Outpatient Scheduling Processes and Procedures*.

and MSA3, had improperly entered zero-day wait times for patients. He said he would become suspicious if he saw a patient with a zero-day wait time for an appointment scheduled months in the future. He added that he would also become suspicious whenever he saw a pattern of “all zero wait times.” He said that since these schedulers were speaking with patients about the appointment by telephone, there was no way of knowing exactly what was said. As a result, it was very difficult to prove that a scheduler was entering a false desired date. He stated that he believed that schedulers were often entering the next available date as the desired date. He said that when scheduling patients, he was instructed to ask veterans when they would like to be seen and then attempt to find an appointment for that time in VistA. If there was no availability at that time, he explained he was told to offer the next available appointment to the patient. If the patient agreed to take this appointment, he said he was instructed to then log out of VistA. Upon re-entering VistA, he would then enter the selected appointment date as the desired date. He said he had to log out and back again into the system to enter the desired date as the selected appointment date. He stated that he was concerned that this practice was used to alter the desired date and ultimately make patient wait times appear lower. He said he initially used these improper scheduling practices as he had been instructed. When he later understood that these practices were in conflict with the scheduling directive, he said he began using proper scheduling practices. He explained that even if the patient specifically requested the next available appointment, he was directed by the program analyst, SMAS1, former service chief 1, and various other schedulers (NFI) to always enter “No” at the Next Available prompt. He stated that he was instructed to never use this prompt adding that he believed this instruction was given in order to “skew numbers” and to make patient wait times appear lower than they actually were. He said he recalled a meeting held around 2010 or 2011 during which former director 2 addressed all VAMC Beckley schedulers. He recalled that former director 2 asked the schedulers if VAMC Beckley managers ever directed them to use improper scheduling practices. He said the schedulers did not openly share their knowledge of improper practices used because VAMC Beckley managers were also at this meeting. He also stated that he thought that former director 2 was encouraging schedulers to use proper scheduling practices.

- On July 15, 2014, MSA7, Mental Health Clinic, said she received scheduling training from supervisory employee 1 who had told her to enter “Yes” at the Next Available prompt, which would make the next available appointment date visible in VistA. She explained that if a patient asked for the next available appointment, she would offer the next available date to the patient. Once the patient selected an appointment, she was instructed to exit and re-enter VistA. Upon re-entering VistA, she was instructed to enter “No” at the “Next Available” prompt and then enter the selected appointment date as the desired date. (**Note:** In an effort to eliminate redundancy, this practice is referred to as “Entering, Exiting, and Re-Entering VistA” throughout the remainder of this summary.) She said she did not know the reason supervisory employee 1 had instructed her to use this practice, and she was never told this practice resulted in the patient’s wait time being documented as zero days. When asked if, despite the patient’s request, she would always enter the next available date as the desired date, she said, “No, not always.” She explained there were instances when patients wanted to schedule an appointment on the same date of another appointment they already had at VAMC Beckley. In this case, she

said she would use the date the patients provided as the desired date.

- On July 15, 2014, MSA8, Primary Care Clinic, said that on approximately seven occasions, she had entered the selected appointment date as the desired date. She said she and other schedulers had been counseled by management for matters related to when the desired date did not match the selected appointment date. She, for example, had received counseling from the program analyst. She said she was directed to use this practice in her initial scheduling training and she believed that this guidance came from (1) senior leader 1; (2) VA Central Office (VACO), and (3) other VAMC Beckley supervisors (NFI). When asked to elaborate, she stated, “I guess I’ve been doing it wrong. I think we’re supposed to put...the desired date would be the date the patient wants to come in” even if this date was unavailable. She said that on July 11, 2014, she participated in a meeting during which the Veterans Integrated Service Network (VISN) senior leader directed schedulers not to use the desired date anymore. She said she was directed to use the practice of Entering, Exiting, and Re-Entering VistA. She said that even if the patient specifically requested the next available appointment, she was directed by supervisors to always enter “No” at the Next Available prompt after re-entering VistA. She did not indicate the reason for using this practice but said she thought SMAS1 might have provided this guidance to her. She stated that she recalled meetings as recently as 2013 at which supervisors provided schedulers with this guidance.
- On July 15, 2014, PSC1, Compensation and Pension Clinic, said that from 2006 to 2013, he received instruction from former service chief 1 concerning patient scheduling. He stated that former service chief 1 directed him to use the practice of Entering, Exiting, and Re-Entering VistA. He stated that in October 2013, MSA9, Audiology Clinic, told him that she felt this was an inappropriate practice, and that after this conversation, he had stopped using this practice. He said he recalled that, in approximately 2006, he was instructed by MSA10, Compensation and Pension Clinic, to always enter “No” at the Next Available prompt in VistA. He still used this practice at the time of this interview. He said that if schedulers entered “Yes” at the Next Available prompt, they would be counseled by VAMC Beckley management. He stated that in 2006 or 2007, he had accidentally entered “Yes” at the Next Available prompt and that soon after he had received a call from someone in management, possibly former service chief 1, who had told him not to do this again. He said he did not understand why this practice was being enforced but that it might be to manipulate wait-time data. He added that he did not have any direct evidence to support this statement.
- On July 15, 2014, MSA6, Primary Care Clinic, described a practice that she occasionally used when scheduling a patient who, instead of providing a desired date, would say, “I don’t care when you put me in. Just, you know, whenever you have an opening.” She said that in this scenario, she would enter VistA to view the next available appointment date. She said that she and the patient then “can come up with that desired date as to what’s good for him.” She would exit and then re-enter the system. Upon re-entering the system, she would enter the selected appointment date as the desired date. She explained that when a veteran requested an appointment for a specific date, she entered that date as the desired date.

- On July 15, 2014, MSA11, Primary Care Clinic, said he was instructed to always enter “No” at the Next Available prompt. He said he thought this instruction was given to him because, otherwise, the scheduler would be unable to enter the desired date and the system would automatically schedule the patient in the next available appointment slot. He said he never selected “Yes” at the Next Available prompt, noting that the consequences of making that selection of “Yes” were not entirely clear to him.
- On July 15, 2014, MSA3, Primary Care Clinic, said when asked if she had ever been directed by VAMC Beckley management to use inappropriate scheduling practices, “No, in fact, I’ve been warned never to do that” by PSC2, service chief 1, and SMAS2. MSA3 said each of them told her to always follow the instruction outlined in the scheduling directive.
- On July 16, 2014, MSA12, Mental Health Clinic, stated that she was directed by management (NFI) to always enter “No” at the Next Available prompt. She explained that a part of the scheduling process was to obtain a desired date from the patient. She said that if a scheduler entered “Yes” at this prompt, the scheduler was then unable to enter a desired date for the patient.
- On July 17, 2014, the practice of Entering, Exiting, and Re-Entering VistA was explained to supervisory employee 1, who did not admit to using this practice. She stated that “the only reason we would back out is say if we made a mistake inputting something” or “we’re going to redo the appointment with the desired date,” adding, “As far as like backing out and then going and scheduling the appointment, no. You schedule it based on the desired date of the patient or the order.”
- On July 21, 2014, MSA10, Compensation and Pension Clinic, was asked how she identified the desired date, to which she replied, “I don’t do desired date. I go by what the veteran says and to get him in as soon as possible.” She said she entered “T” in VistA, which designated today’s date, which enabled her to view the next available appointment on the schedule. She said “99.9% of the time” she would begin her conversation with the patients by offering them the next available appointment. She was asked whether after the patient had selected an appointment, she would exit and re-enter VistA to substitute the “T” she had entered to the selected appointment date, she replied, “I guess I have to, yeah, but I don’t go all the way out of VistA.” She said that, in approximately 2006, she was instructed to use this practice but she could not recall by whom.
- On July 22, 2014, the practice of Entering, Exiting, and Re-Entering VistA was explained to MSA13, Specialty Clinics. She first stated, “I don’t think anybody’s ever taught me that, that we go in and come back out.” She explained that the desired date was very often different from the next available appointment date. She said if those dates matched, it was because the patient requested a date that the clinic had available. She later stated that she would often enter VistA, view the next available appointment date, and then exit the system. However, she said “... that was when I first started ... so I was just learning.” She said she did this after she observed other schedulers (NFI) using this practice and she learned that “they was just seeing what the next opening was.” She said

this was not a practice she used each time she scheduled and there were times when she would not back out of VistA. She said she did not use this practice anymore because “I’ve been told not to do it that way” (NFI). She said she had not used this practice to manipulate the desired date or the patient’s wait time. She also stated that “the bosses don’t tell us to fudge anything” with respect to the desired date and patient wait times.

- On July 23, 2014, MSA14, Primary Care Clinic, stated that he received direction via email several years ago to always enter “No” at the Next Available prompt because this allowed the scheduler to enter the desired date. He added that he believed he was told that entering “Yes” at the Next Available prompt “messed up matrixes or something.”

When reinterviewed on March 31, 2015, MSA14 stated that SMAS1 had told him to always enter “No” at the Next Available prompt because entering “Yes” at this prompt “...was messing with some form of number.” However, he said if the patient wanted to be seen *today*, SMAS1 never discouraged him from entering *today* as the desired date.

When reinterviewed on September 16, 2015, MSA14 stated that when scheduling an appointment, a provider would occasionally ask that a patient return on the next available appointment date. If the patient did not provide a desired date, he would use the next available date as the desired date. However, he said he had never been instructed to use the next available date as the desired date when a patient requested a specific date. He said he always attempted to obtain a date from the patient because “the patient overrides the provider.” He stated that he could not recall a time when he was told never to use “today” as the desired date. He said if a patient came into VAMC Beckley and requested to be seen *today*, he always offered the patient some kind of service. If the clinic had no availability, he said the patient could be seen briefly by a nurse and they would discuss a time for the patient to return, if necessary. When scheduling the patient’s return appointment, he said he used the date agreed upon by the patient and the nurse as the desired date.

- On July 24, 2014, former MSA1, HBPC, stated that she had heard schedulers (NFI) discussing rumors of inappropriate scheduling practices being used at VAMC Beckley. When asked who was spreading these rumors, she replied, “it was talk amongst a lot of the clerks” (NFI) and recalled that she had heard schedulers used these practices because “it was easier to do it this way” even though they knew these practices were improper. She opined that these practices were being used “to make the books look better so that it looked like we were getting more people in quicker.” When the practice of Entering, Exiting, and Re-Entering VistA was explained to her, she said, “I know of clerks doing that” as early as 2009. She added, “I can’t give you specific names because I don’t remember.” She stated that her impression was that these clerks were using this practice to affect wait times. She stated, “... I also remember them being told by our bosses not to do that” (NFI). She said she received instruction from SMAS1 to always enter “No” at the Next Available prompt. When asked why this practice was used, she said, “I didn’t ask. I just did what I was told.”
- On March 31, 2015, MSA9, Audiology Clinic, said that when she first started scheduling, she was told never to enter “Yes” at the Next Available prompt in VistA even if the

veteran asked for the next available appointment. She said, "... I always put 'No' but ... if he wants to be seen today, where it says desired date, I put a 'T' for Today." When asked where this guidance originated, she replied, "I don't know if anybody specifically told me not to but it seems like in my training that that is the current practice."

- On March 31, 2015, service chief 4 was asked about (and provided a copy of) a March 6, 2014 email from administrative employee 1 with the subject line, "ACCESS." In this email, administrative employee 1 stated, "They killing you on this Next Avail appointments." After reviewing this email, service chief 4 said administrative employee 1 likely was referring to the Next Available appointment prompt. She added she thought administrative employee 1 was stating that schedulers were making the wrong selection when they arrived at this prompt. She further said she did not understand the Next Available prompt and did not know what schedulers were supposed to do when they arrived at this prompt. She said she believed administrative employee 1 was likely telling her there were "issues with my wait times" and that patient wait times were affected by the use of the Next Available prompt.
- On March 31, 2015, Registered Nurse (RN) 1, Outpatient Specialty Clinics, was asked about (and shown copies of) two emails that were sent to her from administrative employee 1. The first was the aforementioned message whose subject line read "ACCESS." The second message (dated May 7, 2014) stated, "Next Available orders are killing your clinics." RN1 also reviewed the email attachments sent with these messages. She said these attachments were listings of consultations from physicians asking for patients to be scheduled in the next available appointment slot. She said, "...we have 30 days to get them in from the date that the appointment was created by the clerk." She stated that the patients' names listed in the attachments appeared to be established patients who were scheduled out beyond 30 days. The purpose of these emails was to look at clinic availability and to pull patients forward when possible to get them appointments within the required 30-day time frame. She also stated that she, clinic nurses, and schedulers look at the access list on a daily basis to assist with this effort.
- On March 31, 2015, MSA4 was interviewed. The MSA4 worked as a scheduler from approximately 2012 through 2013, however was in the process of transitioning back to a scheduling position at the time of this interview. He stated that he learned in training that the desired date was selected by the patient or the provider. He explained that when he worked as a scheduler, SMAS1 directed him to use improper practices and added that SMAS1 told him that even when the patient specifically asked to be seen *today*, she did not want schedulers to use *today* as the desired date because "it messed up all the numbers." He stated that SMAS1 directed him to enter the selected appointment date as the desired date even when the patient initially requested a different date. He further stated that he received telephone calls from SMAS1 during which she directed him to change the desired date. He said he thought SMAS1 made reference to the fact that the desired date affected the wait time data. He said this happened "quite a bit." Although he could not remember by whom, he said he was instructed to follow the practice of Entering, Exiting, and Re-Entering VistA to establish the next available date as the desired date. He stated, "It's just the way I was taught. I never agreed with it. You're fixing numbers. You're cheating." He also stated that SMAS1 directed him to always

enter “No” at the Next Available prompt in VistA. He said, “...that’s another thing that I was told that I had to go back and change.” He added that he did not understand the purpose of this practice.

- On March 31, 2015, PSC3, Specialty Clinics, was asked if she had been directed by VAMC Beckley management to enter the selected appointment date as the desired date. She stated that she had not been directed to follow this practice. However, she provided multiple examples of instances of her following this practice. She said there had been instances when a veteran would ask for an appointment on a date that was not available. In this scenario, she would offer the veteran other available appointments. She said that when the veteran selected one of the available appointments, she would enter the selected appointment date as the desired date. She stated, “I don’t know if that is actually correct,” but she was making the effort “to get the veteran what they are asking for.”

When interviewed again on August 25, 2015, PSC3 said she worked for several years as a scheduler in the clinic of former physician 3. She said former physician 3 never instructed her to use the next available appointment date as the desired date instead of asking the patients when they would like to be seen.

- On April 1, 2015, PSA4, Rural Health Initiative, said she was trained by PSA2 and PSA1 to always enter “No” at the Next Available prompt in VistA. She said she did not recall the reason behind this practice.
- On May 5, 2015, the practice of Entering, Exiting, and Re-Entering VistA was described to PSC2, Primary Care Clinic. He said that in approximately 2011 or 2012, some schedulers were using this practice. He stated that these schedulers were “confused on desired date” when a patient was not requesting a specific appointment date. In some cases, these schedulers “would go in and see the next open slot and offer it to the patient.” He said former service chief 1 reprimanded former scheduler 1 for following this practice and required that former scheduler 1 complete additional training. He said a few others (NFI) were following this practice, but he knew that VAMC Beckley management dealt with the issue appropriately by requiring those schedulers to obtain additional training.
- On May 6, 2015, social worker 1 was asked about (and provided copies of) emails that were sent to her by administrative employee 1. In one email dated February 13, 2013, administrative employee 1 stated, “whatever provider is using next available appointment needs to stop.” In another email dated February 26, 2013, administrative employee 1 stated, “The next available marked in yellow needs to stop...That will hurt you every time.” Social worker 1 said she thought administrative employee 1 was referring to the Next Available prompt in VistA. She stated that she had always been directed to enter “No” at the Next Available prompt. She said she thought she had seen this instruction in the online training she received in VA’s Talent Management System (TMS). She explained that when schedulers entered “Yes” at the Next Available prompt, they were not required to enter the desired date; she believed this practice was common because management wanted schedulers to enter a desired date.

- On May 6, 2015, the practice of Entering, Exiting, and Re-Entering VistA was described to administrative employee 1. He said he had heard of this practice being followed at other facilities (NFI) but not at VAMC Beckley, adding, “You don’t do that. That’s gaming the system.” When asked about the Next Available prompt, he explained that some training staff from VISN-6 will instruct schedulers to use the prompt and others from VACO will instruct schedulers not to. He said using the prompt resulted in the wait time being calculated from the appointment creation date to the appointment date. He said he believed it was appropriate for schedulers to enter “Yes” at the Next Available prompt if the physician ordered the patient to return on the next available appointment date. He said he once had a conversation with a physician (NFI) who always requested that his patients be seen on the next available appointment date. He said the next available “might be 3 months down the road.” As a result, he had asked the physician if he could provide a more specific date. He stated that for some physicians, requesting the patient be seen on the next available date “just becomes a habit.” When asked if anyone was discouraging schedulers from using the Next Available prompt to make patient wait times appear lower than they actually were, he said, “That’s possible.” However, he stated that he did not have any direct knowledge of anyone doing this. He said VISN employee 1, VISN-6 System Redesign, suggested that schedulers should not use the Next Available prompt, adding that he might have relayed this message to schedulers at one time. However, he stated that he was still confused about this because the guidance had been inconsistent. He said he did not discourage staff from using the Next Available prompt for the purpose of making wait times appear lower than they actually were. Instead, he said he had “talked to a few physicians about ... getting out of that habit.”

Administrative employee 1 was shown a copy of an email that he and senior leader 3 received from former physician 3 and dated January 10, 2011. In the email, former physician 3 stated that he would ask his scheduler to tell him when the next available appointment was and he would enter that as the desired date. Former physician 3 stated, “I am wondering if you endorse this maneuver as it seems to subvert the process.” Administrative employee 1 said this occurred when former physician 3 was “putting in everybody for next available.” He said former physician 3’s statement had nothing to do with making wait times look better. He said, “He wouldn’t know the difference between good numbers and bad numbers as far as access.” Instead, he said this was about former physician 3 wanting to “do things his way, the quickest way.” He explained that one of his job responsibilities was to review data and provide guidance to VAMC Beckley employees. He said he had never directed schedulers to enter the next available appointment date as the desired date to make patient wait times appear lower.

- On May 6, 2015, senior leader 3 was asked about (and provided with a copy of) the email referenced above from former physician 3 to administrative employee 1 and herself. After reviewing the email, she said she did not remember that discussion. She recalled that administrative employee 1 was always working with former physician 3 because the metrics in former physician 3’s clinic often needed improvement. She recalled that former physician 3 “was really bad about writing next available appointment on patient records.” She said she was not aware of former physician 3 following any improper scheduling practices.

- On May 7, 2015, the practice of Entering, Exiting, and Re-Entering VistA was described to SMAS1, Patient Health Benefit Section. SMAS1 said, “I’ve heard of that but that’s not the correct way to do it.” When asked how she had heard about it, she said, “I worked in scheduling for a long time. Yes, I know that you can do that.” However, she stated that she had no knowledge of this practice being followed at VAMC Beckley. When asked about the Next Available prompt, she said she had always been instructed to enter “No” at this prompt. She said she believed this guidance was provided in the online TMS training. She said she was instructed to do this because the scheduler was required to enter a desired date and that using this prompt allowed a scheduler to bypass this entry. She stated that if a scheduler entered “Yes” at this prompt, the system would not bring up same-day appointments. She indicated that if the patient wanted to be seen *today*, the scheduler needed to enter the desired date as *today* so that the available appointments would be visible. She said that when she observed some schedulers entering “Yes” at the Next Available prompt, she told them to change this habit. Despite the VAMC Beckley guidance, she said she believed the scheduler should enter “Yes” at the Next Available prompt if the patient specifically requested the next available appointment. She said she did not believe management was directing this practice to affect patient wait-time data. When asked if she had directed a scheduler to change a desired date to match the next available appointment date, SMAS1 said, “I don’t recall doing that.” When asked if there would ever be a time she would direct a scheduler to change a desired date after it had been entered, she said, “No, absolutely not.” When asked why someone would allege that she directed him or her to change a desired date, she said, “Unless they’re just confused about instruction. I would never tell somebody to change a desired date to the next available.”
- On May 7, 2015, the practice of Entering, Exiting, and Re-Entering VistA was described to the program analyst. He said, “That is something we have not taught, and that is something that we have tried to correct.” He said he believed Acute Care staff, possibly RN1, might have directed this practice. He stated that he knew that supervisory employee 1 followed this practice because he had counseled her about it. He said he believed that the counseling resolved the issue. He added that he had no knowledge of anyone else following this practice. He also stated that there were some inappropriate scheduling practices followed by VAMC Beckley employees within the Physical Medicine and Rehabilitation Clinic. He said that specialist 3 and former physician 3 worked in that clinic and that specialist 3 was entering the appointment date as the desired date, which resulted in a zero-day wait time. He stated that he could not recall where this practice originated. However, he recalled having conversations with former physician 3 concerning proper scheduling practices and that former physician 3 did not agree with some of the practices discussed.

VA OIG provided the program analyst with a copy of an email that he had sent to “VHABEC PACT CLERKS” mail group on October 24, 2012. The email read, “The question I was presented with today is if we are not leading patients into a desired date by telling them our next available appointment.” He further stated in the email that he had attached a spreadsheet showing “how many patients are being scheduled with zero wait time. With many of our clinics booked out more than a month, I don’t see how this is possible.” After reviewing the email, the program analyst said there was a widespread

problem among schedulers who offered the patient the next available appointment date without first obtaining the patient's desired date. He said the schedulers told him that veterans would get upset with them when they were told that their desired date was not available and that the first available appointment was weeks away from that date. The veterans would ask why the scheduler could not simply offer the veteran the available date. He said he believed this practice started as a result of this feedback given to schedulers by veterans. When asked for names of schedulers who did this, he said, "There was a lot of them." However, he could not provide specific names.

- VA OIG provided the program analyst with a copy of an email that service chief 1 sent to him and SMAS1 on April 19, 2013. In the email, service chief 1 stated, "If I were an outside person looking in, I would have serious doubts that this clinic isn't leading patients to accept the next available appointment as their desired date...clinic wait time two is zero quite often." After reviewing the email, the program analyst recalled that he had reviewed clinic data after receiving this email. He said he did not find any indication of inappropriate scheduling practices and thought that those patients with zero-day wait times were those who were referred to, and seen in, Primary Care after first arriving to the Emergency Department with minor complaints.

As well, during the May 7, 2015 interview, the program analyst was asked about the Next Available prompt. He said he had always been instructed to enter "No" at this prompt, which is the same guidance that he provided to schedulers. He stated that this practice existed because schedulers were required to enter a desired date for the patient. When a scheduler entered "Yes" at the Next Available prompt, the computer responded with the desired date as the date the appointment was created. He said that, even if the patient asked specifically for the next available appointment, schedulers were asked to enter "No" at the Next Available prompt so that they could enter a specific desired date. He said "the clerk can still put today" as the desired date "and get the same result." He said the intent of this guidance was not to make wait times appear lower, instead, the intent was to be "much more transparent in everything that we're doing." He stated that MSA4 had to receive additional training because he continued to enter "Yes" at the Next Available prompt.

- On May 13, 2015, senior leader 2 said he recalled that former physician 3 would order all return patients to be scheduled on the Next Available appointment date with little regard for patient care. He said that because the next available was often months away, he was concerned that former physician 3 was not addressing patients' needs in a timely manner.
- On July 13, 2015, specialist 3, Physical Medicine and Rehabilitation Clinic, stated that for a time she was entering the next available appointment date as the desired date instead of obtaining a desired date from the patient. She further stated that for approximately six months in the spring of 2015, the Physical Medicine and Rehabilitation Clinic was overwhelmed and that she took on the additional responsibility of scheduling her own patients. She explained that instead of calling the patients, she would schedule them on the next available appointment date and enter the desired date as that next available appointment date. She said, "I didn't have time to call everybody. I felt like scheduling them and getting them in was more important." She denied following this practice to

affect wait times or other data. When asked why she followed this practice, she said, “That’s just the way I know how to do it.” She said former physician 3, who was the physician who worked in Physical Medicine and Rehabilitation Clinic, never directed her to follow this practice or any other inappropriate practices. She said she had always been directed to enter “No” at the Next Available prompt but could not recall who directed her to follow this practice. She acknowledged not knowing the reason behind this practice.

- On July 14, 2015, former service chief 1 stated that there was quite a bit of discussion concerning the Next Available prompt because schedulers were getting into the habit of using the prompt more than deemed appropriate. However, he stated that schedulers were given the guidance that they could enter “Yes” at the Next Available prompt if it was appropriate. He was asked if the instruction concerning the Next Available prompt was given in an attempt to affect patient wait time data. He replied, “There’s always connections to the metrics, everything that you do.”

The practice of Entering, Exiting, and Re-Entering VistA was described to former service chief 1. He said he was not familiar with the practice but offered, “If I would have known that the clerk was doing that, I would have had a very serious conversation with them.” When asked if he ever instructed schedulers to follow this practice, he responded, “I would never do that.”

- On July 15, 2015, the practice of Entering, Exiting, and Re-Entering VistA was described to RN1. She said she had no knowledge of anyone at VAMC Beckley following this practice and denied ever directing supervisory employee 1 to follow this practice. She said it was her understanding that schedulers were asking patients for their desired date.
- On July 15, 2015, the practice of Entering, Exiting, and Re-Entering VistA was described to supervisory employee 1. She said she was instructed to follow this practice in 2006 while working at VAMC Huntington; however, she could not recall the names of the individuals who gave her such instruction. She said she did follow this practice until “a couple of years ago,” and believed that these VAMC Beckley employees were following the same practice at one time: (1) former MSA2, (2) MSA15, and (3) former scheduler 2. She said that while she did understand that this practice would make the patient’s wait time equal to zero days, she was not following this practice to affect wait-time data. She added that she was following this practice because this was how she had been instructed to schedule.
- On July 15, 2015, the practice of Entering, Exiting, and Re-Entering VistA was described to service chief 1. He said he had heard of this practice because he knew it occurred at a VAMC in Alabama (NFI). However, he stated that he had no knowledge of this practice being followed at VAMC Beckley. He said the guidance concerning the Next Available prompt had changed over the years, so there was some confusion on the issue. He said the current guidance was that schedulers should not be using the Next Available prompt. He said he believed this guidance would soon change to allow the scheduler to use the prompt when necessary. He noted that this guidance was not being provided to manipulate wait-time data. He said if a scheduler entered “Yes” at the Next Available prompt, the computer would take the scheduler to the next available appointment. He

said, “I guess that could influence what I do as far as your appointment.” He said schedulers were told not to use the prompt because “you’re not accurately representing what the patient wants.” He stated that if the patient requested an appointment *today*, the scheduler could still enter *today* as the desired date. He said the scheduling directive did not discuss this prompt and the guidance on this prompt had come from VACO.

VA OIG provided service chief 1 with an email that he had sent on August 12, 2014 to senior leader 1 and VISN employee 1. In the email, service chief 1 stated, “Back when NVCC started you me and [senior leader 1] talked about DD and at that time it was put out that the appointment date and the DD for NVCC were to be the same.” During his interview, he recalled this had been a discussion about how VAMC Beckley employees would be scheduling appointments for patients who had been approved to receive non-VA care. He also recalled participating in national telephone calls during which someone (NFI) stated that these patients’ desired dates should be the same as their appointment dates. He said he had been seeking clarification from VISN employee 1 on this issue and that VISN employee 1 had never followed up with him to explain this guidance; so, VAMC Beckley continued to follow this instruction.

VA OIG provided service chief 1 with a copy of an aforementioned email (dated April 19, 2013) in which service chief 1 stated to the program analyst and SMAS1, “If I were an outside person looking in, I would have serious doubts that this clinic isn’t leading patients to accept the next available appointment as their desired date...clinic wait time two is zero quite often.” He said that he often conducted audits and would inquire about data that looked strange. He said the program analyst had reported to him no inappropriate scheduling practices among staff, after reviewing clinic data, and he “took his word for it.”

- On August 24, 2015, the practice of Entering, Exiting, and Re-Entering VistA was described to former scheduler 2. He stated that he did not recall ever following this practice. He said this could have been a practice at VAMC Beckley at one time, but he had no direct knowledge of this practice being followed. He added that he did not recall any direction from management to follow this practice. He conceded that if the patient did not initially provide a desired date, he would look for the next available appointment date and share this information with the patient.
- On August 24, 2015, the practice of Entering, Exiting, and Re-Entering VistA was described to MSA15, Oncology Clinic. He said he had never followed this practice. He further stated that he was not trained to schedule an appointment in this manner and never trained any other schedulers to follow this practice. He stated that he was not aware of this practice being followed at VAMC Beckley.
- On August 24, 2015, PSC4, Primary Care Clinic, stated that when he scheduled appointments, the patients generally would not provide a specific desired date. He explained that he would enter the system to locate the next available appointment, discuss these options with the patient, and allow the patient to choose the best appointment date. He stated that he would then exit and re-enter the system. Upon re-entering VistA, he said he entered the next available date as the desired date. When asked about the Next

Available prompt, he said that the guidance regarding this prompt had changed over time. He stated that at times, he heard instruction to use the prompt, and at other times, he had been told not to use the prompt. He said he believed that he was currently using the prompt. He noted that the different guidance he received concerning this prompt had come from his peers, not management. He stated that during the time he worked in the Physical Medicine and Rehabilitation Clinic, former physician 3 never instructed him to follow any inappropriate scheduling practices. He said former physician 3 did not direct him to disregard the patient's request by always using the next available appointment date as the desired date.

- On August 25, 2015, MSA2, Eye Clinic and General Surgery Clinic, stated that guidance regarding the Next Available prompt had changed over time. She further stated that she was initially told to always enter "No" at the Next Available prompt. She added that within the last year, the guidance changed at the time a new scheduling directive was published. She stated that SMAS2 and supervisory employee 1 had told her that she was allowed to enter "Yes" at the prompt if the patient specifically asked for the next available appointment; however, if the patient requested a specific appointment date, the scheduler should enter "No" at the Next Available prompt and then enter the desired date. She said she did not know if the instruction related to this prompt had anything to do with affecting patient wait-time data. At the time that she was told she should not use this prompt, MSA2 recalled that she would offer the next available date to the patient if the patient asked for the next available appointment. When the patient selected an available appointment date, she entered that date as the desired date.
- On August 25, 2015, MSA16, Specialty Clinics, said she had been instructed never to back out of VistA to change the desired date. She explained that she received this guidance when she started as a scheduler and that this guidance had never changed. When asked about the Next Available prompt, she said she had been directed not to use this prompt. She said if the patient specifically asked for the next available appointment, she would use this prompt. She said she did not believe this guidance was given to affect wait-time data. She recalled being told that the patient should select the desired date and that if you use that prompt, it would not require the scheduler to enter that date.
- On August 26, 2015, senior leader 1 stated that up until the month preceding this interview, VAMC Beckley management directed schedulers not to use the Next Available prompt. He explained that VISN employee 1 had provided updated guidance approximately 1 month earlier with new instructions stating that schedulers could use the Next Available prompt. He said the new guidance prompt had nothing to do with the manipulation of patient wait-time data. During the interview, VA OIG described the practice of Entering, Exiting, and Re-Entering VistA to senior leader 1. He stated that around 2011 or 2012, former MSA3 followed this practice. He said he did not know former MSA3's motivation for following this practice, which he called "gaming the system." He said that management had counseled former MSA3 and that the behavior had stopped. He stated that schedulers "have never been told to do that." He acknowledged that there was a "tremendous amount of pressure on the schedulers" concerning patient wait times but that he had always directed schedulers to "do it right." He recalled an instance in approximately 2013 or 2014 when MSA8 changed either the

create date or the desired date when she was rescheduling an appointment. He said he did not know MSA8's motivation for doing this but he believed she had been counseled about this issue.

VA OIG provided senior leader 1 with an aforementioned email (dated August 12, 2014) from service chief 1 to him and VISN employee 1. In the email, service chief 1 stated, "Back when NVCC started you me and [senior leader 1] talked about DD and at that time it was put out that the appointment date and the DD for NVCC were to be the same." Senior leader 1 stated that VISN employee 1 never provided him with any additional guidance on this issue and, as a result, VAMC Beckley followed this instruction despite the fact that he felt that this practice was improper. He emphasized that this instruction was only applicable to the scheduling of non-VA care appointments and he believed the facility was still following this instruction.

VA OIG provided senior leader 1 with an email (dated June 14, 2010) sent by a VAMC Durham employee to administrative employee 1 and later forwarded to senior leader 1. In the email, the VAMC Durham employee stated, "...we do not want a scheduler to make an appt using the Next Available option....they can use it to just locate the next appt but they should come back out and go back into the appt mgmt menu....select 'no' to the question 'Is this a next available appt' and enter the provider or patient's desired date." In a reply email, senior leader 1 told administrative employee 1, "Some of this is in direct contradiction of the don'ts we recently received." Administrative employee 1 responded, "My thought exactly." Senior leader 1 told VA OIG that this instruction from the VAMC Durham employee was "obviously wrong." However, he stated that this was at a time when instruction related to scheduling was frequently changing. He said he did not relay this instruction to schedulers because he believed it was in conflict with VA policy. He stated that after receiving this email, he had disregarded the instruction but he did not recall ever reporting this incident to anyone else.

VA OIG provided senior leader 1 with a copy of the aforementioned email from former physician 3 to senior leader 3 and administrative employee 1 (dated January 10, 2011). In the email, former physician 3 stated that he would ask his scheduler to tell him when the next available appointment was and he would enter that as the desired date. Former physician 3 stated, "I am wondering if you endorse this maneuver as it seems to subvert the process." Senior leader 1 said he believed that former physician 3 was suggesting using the next available date as the patient's desired date. He also believed that senior leader 2 had addressed this issue with former physician 3. He said he believed former physician 3's motivation was "anything that kept him off the radar." According to him, former physician 3 came up with various schemes but that schedulers had alerted Health Administration Services (HAS) management to former physician 3's improper instruction. He stated that he did not believe the schedulers followed former physician 3's improper instruction.

- On September 15, 2015, MSA5 said the desired date was determined by the patient or the provider. She said there were certain scheduling practices encouraged by VAMC Beckley management that she did not understand but she had been told "that's the way you do it." For example, she stated being instructed never to enter *today* as the desired

date. She said, "Even though today was the desired date for the patient, you were to go through...the scheduling graph, find the next available. You put that as the desired date." She recalled that she and MSA17 "got into trouble" for not using the next available date as the desired date. She said SMAS1 contacted her by telephone on at least two occasions and told her, "You need to go in there and you need to fix that...it makes the numbers on the report askew." She thought she had received one call from SMAS1 around June or July 2013 and another call a few months later. She stated that MSA17 confided that SMAS1 had also contacted her and told her to fix an appointment because she had entered *today* as the desired date. She explained that she scheduled as directed by SMAS1 but that she always entered the true desired date in the remarks field in VistA. She stated that she had also been instructed by MSA9 and MSA18 to always use the next available appointment date as the desired date. She further stated that since she started scheduling in 2012, she had been directed to enter "No" at the Next Available prompt and that this guidance had not changed. She said she did not know the reason for this practice. She said on the occasions she entered "Yes" at the prompt, she would receive a call from someone (NFI) telling her to fix this. She said that PSA2 had seen instances in which desired dates in VistA were incorrect. She stated that PSA2 told her that he had spoken with patients before transferring them to the scheduler (NFI) in the clinic where the patients requested to be seen. She stated that PSA2 said he went back in the system after the appointment was scheduled and found that the desired date was different from the date the veterans told him they would like to be seen. She also stated that she currently reviewed wait times to determine if a patient qualified for an appointment through the Choice Program. She said she had noticed at least 15 or 20 instances per week in which the official desired date entered was different from the desired date documented in the remarks section in VistA. She stated she recalled one week when she discovered approximately 40 instances in which the official desired date did not match the date documented in the remarks section. She said she noticed an improvement over time with "... stragglers here and there." She stated that since April or May 2015, the number of occurrences had decreased on average from 20 to 4 per week. She further stated that these schedulers may have been following the same practice she used to follow when she scheduled appointments. She explained that, to qualify for the Choice Program, a patient's wait time must exceed 30 days; this created confusion as she was unable to select the date to use when assessing whether the patient should qualify for the Choice Program. She said she could not identify any particular scheduler who was doing this more frequently than another but she believed that for the most part these were new employees who were making mistakes.

- On September 15, 2015, the practice of Entering, Exiting, and Re-Entering VistA was described to MSA9. She stated, "When the patient calls and asks for an appointment, that would be the desired date." She also stated, "I've told a patient when the next available date is...but that would not be the desired date." She said she believed such practice probably had been followed by other schedulers but said, "I never did it." When asked if she had ever trained anyone to follow this practice, she replied, "That would be wrong."
- On September 15, 2015, the practice of Entering, Exiting, and Re-Entering VistA was described to MSA18, Primary Care Clinic and Pain Management Clinic. He stated, "I don't back out and use the next available as the desired date. I never do that." He said he

was not aware of management directing this practice and that he had never instructed anyone to follow this practice. He stated he always started scheduling by entering *today* as the desired date and then he opened the calendar to review the clinic's availability and always asked the veterans when they would like to be seen. He said some veterans would provide a date and others would not. He stated that when a veteran provided a date, he would enter it as the desired date. He explained that if the veteran did not provide a date, he would look for openings on the calendar around the date the physician requested to see the veteran. He said he did not alter wait times because he wanted management to know if veterans were waiting for appointments. He said that senior leader 1 and service chief 1 always emphasized that honesty in scheduling was very important. He said that he had not been instructed never to use *today* as the desired date and that there were instances when this would be appropriate. He stated that he had always been instructed to enter "No" at the Next Available prompt. He said he did not understand the function of this prompt nor did he know why he was instructed never to use it.

- On September 16, 2015, MSA17, HBPC, said she worked in the Eye Clinic around 2012 or 2013. She stated that while working at the clinic, SMAS1 instructed her to enter the next available date as the desired date. She explained that on one occasion when she had entered *today* as the desired date as requested by the patient, SMAS1 had said, "It doesn't work like that...your next availability is desired date." She stated that SMAS1 emphasized to her that the desired date should never be *today*. She further stated that if a patient requested a specific date other than *today*, she would still enter that as the desired date. She stated that after receiving this instruction from SMAS1, she started offering patients the next available appointment date. She added that if the patient agreed to be seen on that date, she would enter the scheduled appointment date as the desired date. She stated that she did this even though she knew it was improper, otherwise SMAS1 would tell her to change it. She said that SMAS1 only approached her about this issue when the clinic was booked for the next 30 days. She stated that when she scheduled for other clinics with more availability, it was easier to use the desired date provided by the patient without being reprimanded. She said that at SMAS1's request, she changed at least three or four desired dates for patients in the Eye Clinic. She stated that to change a desired date, she would have to cancel and reschedule the appointment. She said she had talked with the program analyst about the guidance sent by SMAS1 and that the program analyst explained the proper way to schedule but he (program analyst) had indicated that doing it this way "makes our numbers look bad." She said she felt the program analyst was trying to justify the instruction SMAS1 provided but he never specifically told her the next available date should be entered as the desired date.

VA OIG described to her the practice of Entering, Exiting, and Re-Entering VistA. She said she had followed this practice "plenty of times" because of the guidance sent by SMAS1. She did not identify any one person who instructed her to follow this practice. She stated, "Basically that's just what everybody did." She also stated that she had been instructed never to use the Next Available prompt in VistA. She said she did not know why she was instructed never to use this prompt. She stated that she was not aware of the fact that the official desired date entered in VistA could be different from the desired date documented in the remarks section. She said that if this was happening, it was likely the result of errors made by hurried schedulers. MSA5 reportedly told her that when she

found that the official desired date differed from the desired date documented in the remarks section, she provided this information to SMAS2.

- On September 16, 2015, former director 2 (**Note:** At the time of this interview, former director 2 was the director of VAMC Beckley.) stated that her responsibilities had never included scheduling. She said she took the scheduling training but had never actually scheduled a patient. She said she met with schedulers once per quarter. In her discussions with schedulers about the training they received, she was told that they felt the training was appropriate and that it fully prepared them for their position. She said she had heard of instances when a veteran was asked several times for a desired date by a scheduler and still the veteran said that he or she wanted the next available appointment. She stated that the facility had a tool that allowed management to review the actions taken by a scheduler when making an appointment. This enable VAMC Beckley management to identify any schedulers who might not being scheduling properly. She said, “I have never found evidence where somebody has been told to make the desired date the next available appointment.” She said she had heard of instances in which veterans became confrontational toward schedulers because they would not provide a desired date. She stated, “Why would you argue with them about demanding they give you a date?” She said she did not know that schedulers were told never to use the Next Available prompt and she was unsure why this instruction has been provided. She said she believed that if a veteran asked for the next available appointment, it would be appropriate to use this prompt. However, she stated that she did not have intimate knowledge of scheduling practices. She added that she was not aware of any deliberate manipulation of wait-time data at VAMC Beckley. She said, “I haven’t had anybody in the hospital that would direct someone to do something wrong and certainly not for a performance measure.” She also said that if people were claiming that VAMC Beckley employees had manipulated wait-time data, “Obviously it hasn’t been for anyone’s benefit because we didn’t meet the exceptional measure ...for that scheduling directive.” She said, “I don’t want anybody to ever cook the books, not just about scheduling, just about anything.” She went on to say, “...if we discover somebody has willfully done something, we take the appropriate administrative action and correct the behavior.”
- On April 20, 2016, a VISN senior leader stated that he had no knowledge of improper scheduling practices being followed by schedulers at VAMC Beckley or being directed by VAMC Beckley management. When asked if he had ever directed schedulers not to use the desired date, as alleged by MSA8, he said that he did occasionally meet with groups of schedulers at various facilities but that he never provided this guidance.
- On April 22, 2016, SMAS2 was asked if he had observed instances when the official desired date entered was different from the desired date documented in the remarks section in VistA. He replied that he and PSC2 received weekly emails concerning these issues from other VAMC Beckley employees. He said these are scheduling errors and that he had no reason to believe schedulers were doing this intentionally. He said that when he or PSC2 were notified of errors, they spoke with the scheduler and directed them to fix the error in VistA.

Records Reviewed

- VA OIG reviewed correspondence that included instruction for identifying the desired date. In an email from VISN employee 1 to former service chief 1 (dated September 13, 2010), VISN employee 1 stated, “If it is a new consult and the patient does not specify, then you can use the next available date as the desired date”. VA OIG reviewed another email from PSA3 to mail group “VHABECACA” dated November 22, 2010. An attachment to this email, titled “Systems Redesign Steering Committee,” included information pertaining to a meeting held on November 5, 2010 to discuss scheduling practices. The document stated, “Per direction from the Veterans Integrated Service Network ... ‘desired date’ is defined as the next available date if the patient does not provide a definitive date.”
- VA OIG reviewed correspondence that included instruction concerning the Next Available prompt. This correspondence confirmed that this instruction changed over time. VA OIG identified an email in which VISN employee 1 stated that there was a time when entering “Yes” at the Next Available prompt would be appropriate. In this email (dated September 8, 2010) to administrative employee 1, VISN employee 1 stated, “The Next Available option is used ONLY in creating a same-day appointment for a patient who has called ‘today’ requesting to be seen ‘today,’ but may also apply when a patient or referring clinic calls wanting a patient seen ‘today.’”
- VA OIG reviewed several emails dating from 2011 to 2014 that showed instruction was given to schedulers to always enter “No” at the Next Available prompt. In an email to administrative employee 1 (dated January 12, 2012), SMAS1 stated, “One of my clerks is still scheduling next available after being instructed AGAIN that we do not ever schedule next available.” In an email to various VHA employees (dated March 24, 2014), VISN employee 1 stated, “...please work with your schedulers to ensure they are entering the Desired Date instead of the Next Available prompt.” In an email (dated May 22, 2014), a supervisory VAMC Asheville employee provided senior leader 1 with a copy of a PowerPoint presentation on scheduling training that stated, “Always, always NO for next available.”

Issue 2: Investigation of the Allegation That the Agency-Wide Bonus System Motivated VAMC Beckley Management To Direct Improper Scheduling Practices

Interviews Conducted

- During the interview of CS-58 on July 10, 2014, CS-58 suggested that low patient wait times might have resulted in VAMC Beckley staff receiving bonuses. However, CS-58 had no direct knowledge or evidence to indicate that this occurred.
- During the interview of PSA1 on July 10, 2014, he said that he believed individuals at the “VISN level or even higher” were alerted when a VA facility had high patient wait times. PSA1 alleged that this motivated VAMC Beckley management to instruct schedulers to follow improper practices. He suggested that low patient wait times might have resulted in VAMC Beckley management receiving bonuses but stated that he did not have any

direct knowledge or evidence to indicate that this occurred.

- On April 20, 2016, the VISN senior leader was interviewed regarding the allegation that VAMC Beckley management officials directed improper practices so that patient wait times would look better and that low patient wait times would result in officials receiving bonuses. He said he had heard this allegation before but that he had no knowledge of this happening. He said that wait times in VISN 6 had been very high for some time, which made him think that these facilities were honestly recording wait times. He said that wait times were one of many performance measures contained in the performance evaluations of VAMC Beckley management officials.

Records Reviewed

- VA OIG reviewed the electronic personnel file for senior leader 3. The file showed that from FY 2010 through FY 2015, she had received five monetary awards as a result of her performance evaluations and one “Contribution Award.”

VA OIG reviewed senior leader 3’s performance evaluations that spanned FY 2010 through FY 2015. The review disclosed the following:

- o Within her FY 2010 evaluation, Element One titled, “Mission Critical Measures,” mentioned the “New Patient Wait Times Access” target and the “Timeliness Compensation and Pension Exam” target. These were only two of many items within this evaluation, including “Veterans’ Satisfaction,” “Budget Execution,” and “Patient Safety.”
- o Her evaluations that covered FY 2011 and FY 2012 did not mention access or patient wait times.
- o Her FY 2013 evaluation mentioned access under Critical Element Five titled, “Results Driven.” The document stated, “While our facility did not meet the access measures for specialty care, or the PACT measures for primary care, [she] has done an exceptional job...to lead staff to consider creative interventions to improve in all of these areas.” This was only one of many items included within her evaluation. Some of the other items mentioned in this evaluation included “Flexibility,” “Conflict Management,” and “Financial Management.”
- o Her FY 2014 evaluation contained one mention of access under Critical Element Five titled, “Results Driven.” The document stated, “...supporting the [specialty] department to meet the access measures for timely care.” This was only one of many items included within this evaluation. Some of the other items mentioned in this performance evaluation included “Political Savvy,” “Technology Management,” and “Team Building.”
- o Her FY 2015 performance evaluation included multiple references to veterans’ access to care. The document included phrases such as ensuring “appropriate and timely clinical services,” “ensuring access to care in less than 30 days in primary care, specialty, and mental health care,” “timely completion of Compensation and Pension

- examinations,” “improvements in access have been achieved reducing wait times in primary care, MH and specialty care,” and “supporting the [specialty] department to meet the access measures.” There were many other items within this evaluation that were unrelated to access and wait times, such as “Communication,” “Resource Management,” and “Conflict Management.”
- VA OIG reviewed the electronic personnel file for senior leader 2. The file showed that from FY 2010 through FY 2015, senior leader 2 received three monetary awards as a result of his performance evaluations, six monetary awards received as part of “Physician Performance Pay,” and one “Contribution Award.”

VA OIG reviewed senior leader 2’s performance evaluations that spanned FY 2010 through FY 2015. The review disclosed the following:

- His FY 2010 evaluation contained multiple references to veterans’ access to care. The document mentioned phrases such as “Clinical Access” targets, “opportunities to expand quality, access, and timeliness of care,” “Compensation and Pension Exam Timeliness,” and “access and scheduling.” There were many other items within this evaluation that were unrelated to access and wait times, such as “Inpatient Satisfaction,” “Information Security,” and “Organizational Stewardship.”
- His FY 2011 evaluation did not mention access or patient wait times.
- His FY 2012 evaluation contained multiple references to veterans’ access to care. The document mentioned “improved access through virtual care modalities,” “timeliness of Compensation and Pension exams,” “Primary Care patients ... seen within 7 days of their desired date,” and “14 day wait time from desired date (specialty care).” There were many other items included within this evaluation that were unrelated to access and wait times, such as “Conflict Management,” “Financial Management,” and “Technology Management.”
- His FY 2013 evaluation contained multiple references to veterans’ access to care. The document mentions “... increase access to care,” “timely treatment of veterans,” and “Specialty care access, mental health metrics, and PACT metrics were not met.” There also were many other items included within this evaluation that were unrelated to access and wait times, such as “rapport with veterans,” “Leading People,” and “Business Acumen.”
- His FY 2014 evaluation contained multiple references to veterans’ access to care. The document included phrases such as, “[senior leader 2] ensures access,” “Increase patient driven access,” “mitigates barriers to timely appropriate care,” and it made reference to “delays in pathology services.” There were many other items within this evaluation that were unrelated to access and wait times such as “Resource Management,” “Prudent Stewardship,” and “Collaboration.”
- His FY 2015 evaluation contained multiple references to veterans’ access to care. The document mentioned “appropriate and timely clinical services,” “appropriate

access to...home and community-based services,” and “Access Management.” There were many other items contained within this evaluation that were unrelated to access and wait times, such as “Recruitment and Hiring Strategies,” “Bed Management,” and “Communication.”

VA OIG reviewed supporting documentation that pertained to senior leader 2’s “Physician Performance Pay” for the period of FY 2010 through FY 2015.

- o The supporting documentation for his FY 2010 and FY 2012 “Physician Performance Pay” did not mention access or patient wait times.
- o The supporting documentation for his FY 2011, FY 2013, and FY 2014 “Physician Performance Pay” mentioned the completion of timely Compensation and Pension exams but did not mention access or patient wait times. This was one of many items included in this documentation that were unrelated to access and wait times, such as “training,” “medical staff functions,” “Opioid prescribing,” and “customer service.”
- o The supporting documentation for his 2015 “Physician Performance Pay” mentioned the completion of timely Compensation and Pension exams and “timely and appropriate care.” There were many other items included in this documentation that were unrelated to access and wait times, such as “Infectious Disease Management” and “Business Functions.”

Senior leader 2’s “Physician Performance Pay” documents contained a narrative that described the performance objectives and the degree to which these objectives were met. It appeared that the narratives in the FY 2010 and FY 2011 “Physician Performance Pay” documents contained more information than what was visible on the documents received from service chief 7. Service chief 7 confirmed that no additional documentation was available.

- VA OIG reviewed the electronic personnel file for service chief 1. The file showed that from FY 2010 through FY 2015, service chief 1 received six monetary awards as a result of his performance evaluations and one “Contribution Award.”

VA OIG reviewed service chief 1’s performance evaluations that spanned FY 2010 through FY 2015. The review disclosed the following:

- o His FY 2010 evaluation mentioned phrases such as “Percent of unique patients on the access list waiting more than 30 days from desired date,” “Compensation and Pension exam timeliness,” and “timely and appropriate access to healthcare.” There were many other items included within this evaluation that were unrelated to access and wait times, such as “Patient Satisfaction,” “implementation of core business management principles,” and “Information Security.”
- o His FY 2011 evaluation mentioned “enhance access in clinics,” “worked ... with clinical staff on access,” and a goal that “patients waiting on the access list more than 30 days from the desired date will not exceed 1%.” There were many other items included within this evaluation that were unrelated to access and wait times, such as

“Organizational Stewardship,” “Interpersonal Effectiveness,” and “Information Security.”

- o His FY 2012 evaluation mentioned “increased access through virtual care modalities,” “assures access to VA care by ensuring Specialty Care ... patients will not wait more than 14 days from desired date,” and “assures access to home and community based services.” There were many other items included within this evaluation that were unrelated to access and wait times, such as “Collaboration,” “Transparency,” and “Conflict Management.”
- o His FY 2013 evaluation contained the phrases “expand access to healthcare services,” “attempts to improve access,” and “Strategically Improving Access.” There were many other items included within this evaluation that were unrelated to access and wait times, such as “Customer Service,” “Communication,” and “Emergency Preparedness and Response.”
- o His FY 2014 evaluation mentioned “timeliness in providing care,” “implementing strategies to reduce wait times,” “improve access,” and “reduction of wait times.” There were many other items included within this evaluation that were unrelated to access and wait times, such as “Customer Service,” “Business Acumen,” and “Building Coalitions.”
- o His FY 2015 evaluation contained the phrases “expand access,” “timeliness in providing care,” “strategies to reduce wait times,” and “timeliness related to Compensation and Pension examinations.” There were many other phrases included within this evaluation that were unrelated to access and wait times, such as “Foster an environment of continuous learning,” “Improves...relationships with community partners,” and “leverage information technologies.”
- VA OIG reviewed the electronic personnel file for senior leader 1. The review disclosed that from FY 2010 through FY 2015, senior leader 1 received five monetary awards as a result of his performance evaluations and one “Contribution Award.”

VA OIG reviewed senior leader 1’s performance evaluations that spanned from FY 2010 through FY 2015. The review disclosed the following:

- o His FY 2010 evaluation contained multiple references to veterans’ access to care. The document contained the phrases “Percent of unique patients on the access list waiting more than 30 days from desired date,” “Compensation and Pension Exam timeliness,” “identifies unique opportunities to expand quality, access, and timeliness of care,” “provide timely and appropriate access to healthcare,” and “Access and Scheduling.” There were many other items included within this evaluation that were unrelated to access and wait times, such as “Patient Satisfaction,” “Safety,” and “Disease Management.”
- o His FY 2011, FY 2012, and FY 2013 evaluations did not mention access or patient wait times.

- o His FY 2014 evaluation contained multiple references to veterans' access to care. The document contained the phrases "timeliness in providing care," "strategies to reduce wait times," and "improve access." There were many other items included within this evaluation that were unrelated to access and wait times, such as "Leading People," "Customer Service," and "Business Acumen."
- o His FY 2015 evaluation contained multiple references to veterans' access to care. The document contained the phrases "ensure appropriate and timely clinical services," "Ensures appropriate access to ... home and community based services," and "Access Management." There were many other phrases included within this evaluation that were unrelated to access and wait times, such as "Supports VA's emergency preparedness," "collaboration with internal and external stakeholders," and "resource management."

Senior leader 1's FY 2011 and FY 2012 performance evaluations received from service chief 7 did not contain any supporting documentation. Service chief 7 confirmed that no additional documentation was available.

VA OIG reviewed supporting documentation for the "Contribution Award" that senior leader 1 received in 2012. The review disclosed that senior leader 1 was assigned as an interim service line chief for more than 8 months. The document stated that senior leader 1's "performance ... was nothing short of exceptional." The document further stated that in this role, senior leader 1 "helped the entire medical center improve patient care and business processes." This documentation did not mention access or patient wait times.

- VA OIG reviewed the electronic personnel file for former director 2. The file showed that from FY 2010 through FY 2015, she received four monetary awards as a result of her performance evaluations.

VA OIG reviewed former director 2's performance evaluations covering FY 2010 through FY 2015. The review disclosed the following:

- o Her FY 2010 evaluation contained the phrases "Percent of unique patients on the access list waiting more than 30 days from desired date," "Compensation and Pension Exam Timeliness," "identifies unique opportunities to expand quality, access, and timeliness of care to veterans," "Access and Scheduling," and "Provide timely and appropriate access to healthcare." There were many other items included within this evaluation that were unrelated to access and wait times, such as "Safety," "Disease Management," and "Human Resources."
- o Her FY 2011 evaluation mentioned that she implemented a "clinic that should help ... podiatry access," that she was "improving local access for...veterans who live in this rural area," and that "[She] has risen to lead in challenging times for access within her facility." There were many other items included within this evaluation that were unrelated to access and wait times, such as "Information Security," "financial management," and "emphasis on ending homelessness."

- o Her FY 2012 evaluation contained the phrases, “ensures increased access through virtual care modalities,” “assures excellent access to VA care by ensuring Specialty Care...patients will not wait more than 14 days from desired date,” “assures timely and appropriate access to Mental Health Services,” “assures access to home and community based services,” and “assures timeliness of Compensation and Pension exams.” There were many other items included within this evaluation that were unrelated to access and wait times, such as “resource management,” “staffing needs,” and “promotes a learning organization.”
- o Her FY 2013 evaluation contained the phrases, “Significant improvements in Primary Care access,” “timely completion of Compensation and Pension examinations,” “increase patient-driven access,” and “manage supply and demand to increase levels of access.” There were many other items included within this evaluation that were unrelated to access and wait times, such as “Creates an organizational environment that is free from discrimination,” “teamwork,” and “Uses technology to enhance processes.”
- o Her FY 2014 evaluation contained the phrases, “improved access in Primary Care and Specialty Care,” “ensure appropriate and timely Non-VA care service,” and “Ensures access and increases the average daily census of veterans.” There were many other items included within this evaluation that were unrelated to access and wait times, such as “Advances goals of the VA Diversity and Inclusion Strategic Plan,” “Opioid management,” and “Executes the operating budget.”
- o Her FY 2015 evaluation contained the phrases, “Expand access to treatment,” “greater access...for patients awaiting the initiation of treatment,” “ensuring access to care in less than 30 days in primary care, specialty, and mental health care,” and “Significant improvements in access have been achieved reducing wait times in primary care, MH, and specialty care.” There were many other items included within this evaluation that were unrelated to access and wait times, such as “Balances change and continuity,” “fosters high ethical standards,” and “Patient Safety.”

Issue 3: Investigation of Allegation That the NEAR Call List Was Neglected and Veterans Were Improperly Removed From the List in Advance of an Audit

Interviews Conducted

- During the interview of CS-58 on July 10, 2014, CS-58 alleged that VAMC Beckley management improperly removed patients from the NEAR Call List³ in advance of a VHA audit. CS-58 stated that in approximately April 2014, CS-58 noticed that the scheduling directive mentioned the NEAR Call List. At that time, CS-58 had little knowledge of the list. CS-58 stated that he or she believed the Enrollment Coordinator and the Primary Care Management Module (PCMM) were responsible for managing this

³ The NEAR Call List is a tool to be used by enrollment staff to communicate to Primary Care Management Module Coordinators or schedulers, at the veteran’s designated preferred location, that a newly enrolled veteran has requested an appointment during the enrollment process.

list. CS-58 further stated that he or she was asked for assistance with contacting patients on the NEAR Call List. CS-58 stated that he or she was shown the NEAR Call List, which contained a total of 62 names. CS-58 stated that the people working on this project were ordered to get the list cleared. CS-58 stated that he or she worked on this project with other employees. CS-58 said the names from the NEAR Call List were placed in a spreadsheet so progress on the list could be monitored. CS-58 stated that the individuals working on this project called the veterans on the list using telephones located in their respective offices. CS-58 said one of the people working on the project removed some of the veterans' names from the list following multiple unsuccessful attempts to reach them by telephone. CS-58 stated that by the close of business on May 13, 2014, there were approximately 20 veterans' names left on the NEAR Call List whom they were unable to reach by telephone. CS-58 provided VA OIG with a copy of the spreadsheet containing the names of the 62 veterans on that NEAR Call List.

- On July 10, 2014, PSA1 stated that he first heard about the NEAR Call List in approximately April 2014 when he overheard coworkers talking about it. He said that VAMC Beckley regulations stated that the Enrollment Coordinator and the PCMM were responsible for managing the NEAR Call List. He said SMAS1 was the current Enrollment Coordinator and administrative employee 3 currently served as the PCMM. He stated that in approximately April 2014, he and PSA2 located the NEAR Call List. He said he "found veterans that had been sitting on it for years." He added that when he and PSA2 located the list, approximately 120 veterans were waiting to be scheduled for an appointment. He stated that in approximately May 2014, PSC2 and SMAS1 requested that he and PSA2 assist with contacting patients on the NEAR Call List. He said they did assist but "didn't make a whole lot of headway with it." He stated that he thought there was one individual on the NEAR Call List who was deceased but he was not able to provide any further information.
- On July 14, 2014, confidential source CS-59 (CS-59) stated that on the day preceding the VHA audit, senior leader 1 told CS-59, "You've got three veterans that are on this NEAR List and I need your guys to get them off of there." When CS-59 received this call, there were approximately 60 names on the NEAR Call List. CS-59 stated that senior leader 1 went on to say, "I want this list gone by the end of the day." CS-59 explained that months before this conversation with senior leader 1, they had seen a copy of the NEAR Call List that contained more than 100 names. CS-59 said that after this telephone call, SMAS1 was tasked with clearing the NEAR Call List. CS-59 said they knew SMAS1 had removed names from the list without first talking with the veterans. CS-59 further stated that they had seen comments entered by SMAS1 on the NEAR Call List in Vista that read "was unable to contact, remove from list."
- On July 17, 2014, SMAS2 said he had no knowledge of efforts to clear the NEAR Call List but he knew that SMAS1 had been monitoring this list. He was asked if he had knowledge of the NEAR Call List being cleared before a VHA audit so that auditors would not see that the facility had a large number of veterans waiting to be enrolled for VA health care. He replied, "...that probably happened but I'm not saying that ... happened for that reason."

- On July 23, 2014, specialist 2 stated that his responsibilities at VAMC Beckley included pulling data requested by VAMC Beckley management. He explained that he first learned about the NEAR Call List in June 2014 when senior leader 1 asked him to locate and print a copy of the report. He stated that at the time, there were eight or nine veterans on the list. He said he had later pulled the list (NFI) and found that there were zero veterans on it. He said he did not know the process that led to the list being reduced to zero because he was only responsible for pulling the data.
- During the interview of PSA4 on April 1, 2015, she confirmed that sometime in 2013 or 2014 she had assisted PSA2 with contacting veterans to offer appointments. She stated that she was not familiar with the NEAR Call List but believed that she had been instructed to assist PSA2 with contacting veterans by specialist 4. She said it was possible she was assisting with the clearing of the NEAR Call List when she contacted these veterans but she did not know where PSA2 had obtained these names. She said she thought she had called approximately 50 veterans. She added that she thought these veterans had already been enrolled at the facility but had not yet received care. She also stated that she was not aware of a VHA audit that occurred at VAMC Beckley around May 2014.
- During the interview of PSC2 on May 5, 2015, he stated that around June 2014, he had taken a training course related to the NEAR Call List. He said he had only accessed the NEAR Call List twice and that this occurred during that training. He said he did not have an in-depth knowledge of this list and had never accessed it outside of that course. He said he had been told that SMAS1 was responsible for monitoring the NEAR Call List and that if necessary he would be a “backup.”
- During the interview of administrative employee 1 on May 6, 2015, he said he thought the NEAR Call List was implemented approximately 4 or 5 years ago. When asked about the status of the NEAR Call List around May 2014, he said he had heard a rumor that the list had been neglected by HAS and that there were a large number of veterans on the list who had not been scheduled for appointments. However, he denied having any direct knowledge of the situation. He said he heard that when HAS learned about this, there was “a rush to get these patients off.” He stated that when he accessed the list around that time, he noticed a steep decline in patients waiting for appointments once HAS employees had taken action on this issue. He said he thought that the neglect of the NEAR Call List was more the result of disorganization rather than malicious intent on the part of HAS. He said he had zero knowledge of any patients being improperly removed from the NEAR Call List and that he was now responsible for accessing the list and sending it out to schedulers each week. He said the schedulers were expected to contact the veterans on the list and schedule appointments for them.
- During the interview of SMAS1 on May 7, 2015, she said there were emails from employees at other VA facilities who were discussing the NEAR Call List in approximately April 2014 or May 2014 (NFI). She stated that at the time, service chief 1 and senior leader 1 had asked her, “How did we miss this?” She said they were referring to the fact that the facility had not been monitoring the NEAR Call List. She stated that following this conversation, she had located the NEAR Call List and found

approximately 11 or 12 veterans on the list. She said she could not recall how long these veterans had been on the list. She stated that she was then instructed to call these veterans and offer each of them an appointment. She seemed to recall that SMAS2 and the program analyst assisted her with contacting these veterans. She stated, however, that neither PSA4 nor PSA2 assisted with the clearing of the NEAR Call List. VA OIG informed SMAS1 that she, in fact, had a list of more than 50 patients who were allegedly on the NEAR Call List at that time. She reiterated that there were “only a dozen names on it” but she could not remember how many veterans she had contacted by telephone. She stated that she was confident all of the veterans on the list had been contacted. She added that if veterans wanted an appointment, they were scheduled for one. She said that when veterans were scheduling their first appointment at VAMC Beckley, she would obtain the desired date from each patient. She stated that the direction to clear the NEAR Call List “had nothing to do with an audit.” She further stated that she did not even recall a VHA audit being conducted around that time. When she was informed that after reviewing her telephone records, VA OIG found no record of her calling any of the veterans on the NEAR Call List, she replied, “It should be in the record. If I put that I called the veteran, then I called the veteran.” She stated that she never improperly removed any veterans from the NEAR Call List.

When reinterviewed, SMAS1 agreed that the review of the NEAR Call List would have been her responsibility. She said, “It went right over the top of my head. I didn’t see it in the directive.” VA OIG provided her with a copy of the aforementioned spreadsheet, which contained 62 veteran names from the NEAR Call List. She confirmed that this spreadsheet did appear to be the NEAR Call List that she had been tasked with clearing around April 2014 or May 2014. When asked to explain why she had previously stated the spreadsheet only contained approximately 11 or 12 names, she said she must have forgotten how many names were on this list. She reiterated that she was unaware of any veterans who had been improperly removed from the NEAR Call List.

- During the interview of the program analyst on May 7, 2015, he stated that he was aware of the existence of the NEAR Call List but that his responsibilities had never included monitoring this list. He said, “I did not regularly monitor that report, but I would sporadically go in and look at it.” He stated that PSC2 was reviewing the NEAR Call List long before he even knew it existed and that around June 2014, PSA2 was also monitoring the NEAR Call List. VA OIG explained to him that it had been reported that VAMC Beckley management had no knowledge of the existence of the NEAR Call List until approximately April 2014. He said, “I would say that that’s an accurate statement.” He said the registration process for veterans had changed over the years and his understanding was that the NEAR Call List was “... nothing that, you know, we, historically, were able to pull any beneficial data from.” He said he never assisted SMAS1 with calling veterans on the NEAR Call List and offering them appointments. He said, “I remember SMAS1 taking on the NEAR Call List, I remember her asking me some questions.” He stated that he recalled that SMAS1 had asked him what the report was called and he had given her a “high-level overview” of the report. He said supervisors in HAS “were not micromanagers” and it would not surprise him if they were not aware of the NEAR Call List. He said he believed that during the time that former service chief 1 was still employed at VAMC Beckley, some employees probably were

monitoring the NEAR Call List. He observed that “it was a big loss of knowledge” when former service chief 1 retired. He went on to say that it would not surprise him if service chief 1 and senior leader 1 did not know about the list because that might have been something former service chief 1 “always took care of.”

- During the interview of senior leader 2 on May 13, 2015, he said he believed that HAS management had always been aware of the existence of the NEAR Call List. He said, “It was being ignored by HAS. They knew it existed. They weren’t paying attention because they didn’t have to. There was no accountability for it. The NEAR List was ignored because it wasn’t causing us any problems on a statistical basis.” He said that HAS started to take action on the NEAR Call List approximately 2 years ago when it was discovered that the NEAR Call List was not being managed. He added that this discovery was made by administrative employee 4, employees in VAMC Beckley’s Rural Health Program, and former director 2.
- During the interview of service chief 1 on July 15, 2015, he said that he first learned about the existence of the NEAR Call List in approximately March 2014. He said that after allegations surfaced at VAMC Phoenix⁴ related to inappropriate scheduling practices, “It became a nationwide push for everybody to look at (the NEAR Call List).” He said he had never seen the NEAR Call List before. He seemed to recall receiving a telephone call from senior leader 1 asking if he was familiar with the NEAR Call List. He stated that he had told senior leader 1 he had never heard of this list. He recalled that senior leader 1 was very upset because HAS had not been monitoring the list. He said he knew that senior leader 1 directed SMAS1 to contact patients on the list to offer them appointments. He said, “They had it cleared up by the time I got back here to work that ...following week. I don’t know how many people we had on it, but to get it cleared off that fast, I don’t think it could have been a whole lot.” He said SMAS1 was now responsible for reviewing the NEAR Call List daily and she sent him an email with the total number of patients on the list. He stated that if SMAS1 was out of the office, SMAS2 took on this responsibility. He said he had no knowledge of any veterans on the NEAR Call List being improperly removed.
- During the interview of senior leader 1 on August 26, 2015, he said that he had heard the term “NEAR Call List” during his employment at VAMC Beckley but did not know what it was. He said, “When did I find out what it was? About 2 days before the scheduling audits happened, after Phoenix happened.” When asked if others in HAS had knowledge of the NEAR Call List, he said, “To my knowledge, it caught all of us off guard.” He said the scheduling audit occurred sometime in the spring of 2014. He noted that there was only one sentence about the NEAR Call List in the scheduling directive. He said, “We missed it.” He stated that HAS was not managing the NEAR Call List as it should have been. He went on to say, “We had worked really hard to do the right things. And we had completely missed it. So did I want the list worked before the auditors got there? Of course I did. Did I want it worked inappropriately? No. And that was never my

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

guidance.” He said that after allegations of a secret wait list at VAMC Phoenix surfaced, he received “email traffic about the NEAR List.” He stated that soon after receiving these emails, he directed SMAS1 to locate VAMC Beckley’s NEAR Call List. He stated that SMAS1 subsequently located the list, which he estimated contained approximately 340 names. He said he thought some of the names had been placed on the list as far back as the 1980s, and he recalled that “a lot of them [veterans] were dead.” He said he had tasked SMAS1 with calling the veterans on the list and offering them appointments. He recalled that specialist 4 and PSA2 may have also assisted with contacting veterans on the list. He estimated that over the course of 1 week, they reduced the list to approximately 19 names. He stated that one individual was not contacted because of his age. He said, “...the patient was going to be 103 years old or 5 or 8, something extraordinary, and it was from back in earlier times.” As a result, this patient was never contacted but senior leader 1 said he was removed from the list. He stated that telephone calls were made to all of the others on the list and appointments were scheduled for the individuals who could not be reached. He stated that following the scheduling of these appointments, a letter was mailed to each veteran notifying them of their appointment. Were there any veterans on the NEAR Call List who were improperly removed? He replied, “Other than the guy that was 105 or 8...would that have been technically inappropriate? Maybe.” He went on to say that he had no knowledge of anyone else being improperly removed. He explained that the NEAR Call List was now being regularly monitored and that he received daily updates on its status. He also stated that while SMAS1 was initially responsible for the NEAR Call List, SMAS2 had now assumed this responsibility.

- During the interview of former director 2 on September 16, 2015, she said that VAMC Beckley started reviewing its scheduling practices after allegations of a secret wait list at VAMC Phoenix surfaced. She said that after hearing about these allegations, VAMC Beckley management reviewed the NEAR Call List. She said she knew HAS was reviewing the NEAR Call List “often enough” because it “didn’t have a significant number of veterans on [the NEAR Call List] and people were being timely and getting scheduled.” She said she could not provide an estimate as to how many names were on the list at that time. She said, “...it’s my recollection that there was not a regular review of that NEAR List on a daily or weekly basis.” She went on to say, “...prior to maybe a year, year and a half ago... it was looked at, but not on a routine basis.” She said this review caused HAS to start monitoring the NEAR Call List regularly. She stated that she did not know specifically who at VAMC Beckley had been monitoring the list over the years but she thought it might have been SMAS1. She said, “I think it was with the switch over of people in Health Administration Service, and I don’t think the knowledge of the organization and the processes that should be there always got transferred.” She said she now received regular updates on the status of the NEAR Call List from administrative employee 1, VACO, and the VISN.
- During the interview of the VISN senior leader on April 20, 2016, he stated that it was discovered that many VAMCs were not actively monitoring their respective NEAR Call Lists. He said he did not recall former director 2 specifically telling him about the fact that VAMC Beckley employees were not managing this list.

Records Reviewed

- VA OIG reviewed a copy of the VA Access Audit & Wait Times Fact Sheet, dated June 9, 2014. This document showed that the Access Audit, which was conducted at VAMC Beckley on May 14, 2014, found that 29 veterans were on the NEAR Call List on this date.
- VA OIG reviewed the spreadsheet received from CS-58 that contained the names of the 62 veterans from the NEAR Call List. This review determined that between May 12 and June 5, 2014, SMAS1 made notes that indicated that she attempted to contact by telephone 46 veterans from the NEAR Call List. SMAS1's notes indicated that she successfully contacted 22 of these veterans. VA OIG agents attempted to reach these individuals to confirm that they had been contacted by SMAS1. VA OIG agents successfully reached 23 of these veterans or their family members by telephone.
 - Contact with 15 of the veterans corroborated SMAS1's notes on the Near Call List spreadsheet.
 - VA OIG agents contacted four veterans (or their family members) who stated that they do not believe they received a telephone call from anyone at VAMC Beckley.
 - Two veterans said they had spoken with SMAS1, which was in direct contradiction to SMAS1's own notes that indicated she had not been able to reach these particular veterans.
 - One veteran, whom SMAS1 said she was unable to contact in her notes, had a telephone number listed in CAPRI. An OIG agent was able to reach this individual, who stated that he had never lived in West Virginia.
 - One veteran, who SMAS1 said did not respond to her telephone call, was reached by an OIG agent. This was the only veteran out of the 23 contacted by OIG agents who requested to receive VA medical care. (**Note:** On January 27, 2015, VA OIG provided contact information for this veteran to clerk 1. Clerk 1 indicated that she would follow up with this veteran to see if he would still like to receive care. An OIG review of this veteran's CAPRI records showed that he subsequently received an appointment at VAMC Beckley, in February 2015.)
- VA OIG agents were unable to reach the remaining 23 veterans.
- VA OIG reviewed SMAS1's office telephone records for the period of April 1 through June 30, 2014. The review identified telephone numbers for 44 of the 46 veterans whose names SMAS1 had removed from the NEAR Call List. VA OIG subsequently conducted a search of SMAS1's telephone records that cross-referenced the telephone numbers of these 44 veterans. The search confirmed that SMAS1 dialed telephone numbers for 39 of the veterans on the NEAR Call List. Five veterans' telephone numbers could not be located in SMAS1's telephone records.

- VA OIG located a record for each of the 62 veterans on the NEAR Call list within VAMC Beckley's medical records system. Records for 5 of the 62 veterans showed that they had received medical care from VAMC Beckley.
 - Veteran 1 appeared to have received care as a result of SMAS1's telephone call.
 - Because his VAMC Beckley medical records spanned from October 2012 to March 2015, veteran 2 appeared to have already been in receipt of medical care at the time that he received a telephone call from SMAS1.
 - Because his VAMC Beckley medical records spanned from February 2012 to August 2015, veteran 3 appeared to have already been in receipt of medical care at the time he received a telephone call from SMAS1.
 - According to SMAS1's notes, veteran 4 did not want an appointment when she contacted him. This veteran received medical care from VAMC Beckley approximately 5 months later.
 - Veteran 5 attended a medical appointment at VAMC Beckley after he had expressed to VA OIG that he would like to receive VA medical care.
- Despite the fact that their personal information had been entered in VAMC Beckley's medical records system, records for the remaining 57 veterans showed that they had never received medical care at VAMC Beckley. Notes in the Compensation and Pension Record Interchange (CAPRI) for 15 of the 57 veterans who had not received care at VAMC Beckley stated that these veterans did not wish to receive medical care at that time. At the time of this review, one of these veterans had a future appointment at VAMC Beckley while another veteran's record showed he had not attended his first scheduled appointment at VAMC Beckley. Records for two other veterans showed they had received medical care at other VAMCs. One of these veterans was receiving medical care at another VAMC around the time that SMAS1 contacted him while the other veteran had received care at another VAMC as recently as 1 month before SMAS1 attempted to reach him. Remarks in CAPRI showed that 2 of the 57 veterans who had not received care at VAMC Beckley were deceased. Because SMAS1 did not date her notes, it is unknown whether these veterans died before or after her attempts to contact them.

Issue 4: Investigation of Allegation That Administrators Mismanaged the Eligibility Determination Process

Interviews Conducted

- During the interview of CS-58 on July 10, 2014, CS-58 stated that administrators had mismanaged the eligibility determination process. CS-58 indicated that he or she attended training, which caused him or her to believe that VAMC Beckley employees were making many inaccurate eligibility determinations that were not in accordance with the agency's most recent eligibility rules. CS-58 said, "The computer system's telling me

if a veteran has over \$80,000 net worth/income it pops up, 'not enrolled.'" CS-58 was being given the same guidance from VAMC Beckley staff. CS-58 said the eligibility rules related to the income threshold changed, which increased the number of veterans eligible for care. This was an effort "to expand the enrollment system to allow more veterans into the system." CS-58 said that despite the new guidelines, "Staff has turned away hundreds of veterans." CS-58 said that at various times, he or she reported this information to various members of medical center management. CS-58 acknowledged that the HEC still made the final eligibility determination. In addition, CS-58 said there was no way to delete an application from the computer system. CS-58 said that he or she might have put information in the system that was later removed, possibly by clerk 2 or SMAS1, and that this would affect the veteran's eligibility (NFI). CS-58 said that he or she also noticed that veterans' applications for VA health care were not transferring to the HEC. CS-58 stated that "there were thousands that were stuck," which led CS-58 to believe that these veterans were not receiving timely eligibility determinations from the HEC. CS-58 stated that he or she noticed that, on February 12, 2013, this problem resolved itself. CS-58 further stated, "Since that time, I haven't seen actual backlogs of thousands like that being stuck." CS-58 felt that this was a nationwide problem as he or she had heard similar complaints from employees at other VA facilities. CS-58 also claimed that five veterans died while waiting to be enrolled at VAMC Beckley.

When reinterviewed, CS-58 elaborated on his or her previous statement concerning these deceased veterans. CS-58 that said at least one of these veterans was on the NEAR Call List. In approximately September 2013, CS-58 attempted to contact veterans who he or she believed might actually have been eligible for VA health care despite being previously rejected. At that time, CS-58 learned that four other veterans were deceased. (**Note:** During this interview, CS-58 did not specify when he or she attempted to contact these veterans but during a previous interview, he or she stated that this occurred in approximately September 2013. CS-58 also did not specify the time frame when these veterans were previously rejected. The Office of Audits and Evaluations (OAE) reviewed the circumstances surrounding the five deceased veterans whom CS-58 alleged had been wrongfully rejected for health care enrollment and died before being notified that they were eligible for care after all. OAE determined that in four of the cases, the allegations were unsubstantiated as the veterans had been enrolled before their deaths. In the remaining case, death occurred before enrollment but evidence did not allow VA OIG to conclude that the veteran was wrongfully rejected at the time of the initial application.)

- During the interview of PSA1 on July 10, 2014, he alleged that administrators had mismanaged the eligibility determination process. He said VAMC Beckley had made many inaccurate eligibility determinations that were not in accordance with the agency's most recent eligibility rules. He said during the years 2010 and 2011, he had received very little training. He said, "I turned many veterans away over their income and different issues and said they weren't eligible." He stated that in August 2012, he completed training during which he had learned "the real rules and regulations" concerning eligibility. He said he knew that clerk 2 was using outdated eligibility rules. He said that MSA19 used outdated eligibility rules at one time but now used current regulations when completing enrollments. He stated that he believed there were times the HEC had determined a veteran was ineligible based on a VAMC Beckley employee's

recommendation (NFI). He said he did not believe VAMC Beckley employees had done this with malicious intent. He stated, "It's a training issue." He stated that he believed "that at the senior levels they don't want...all these veterans to be able to use the VA...due to the influx of veterans and now making access horrible." He said he had noticed that information he entered for patients was later removed by another VAMC Beckley employee, which he believed had affected veterans' eligibility determinations. He also alleged that "the computer was not transmitting data to HEC like it was supposed to be overnight." PSA1 said that in early 2013, he had found that approximately 8,000 veterans "were stuck in process...no determination made either way." He stated that he could tell some of these veterans were already receiving VA health care services and others were not. He said he reported these issues to the VISN senior leader, former director 3, the program analyst, service chief 1, and senior leader 1. However, he said he did not believe any of these individuals ever investigated this issue. He said he noticed that, on February 12, 2013, 4,000 veterans "had switched from in-process to enrolled ... overnight." He also said that he could not explain why approximately 100 applications were "inactivated" or "just went away." He said he and PSA2 found that five veterans had died while waiting to become enrolled at VAMC Beckley and that he believed at least one of these veterans was on the NEAR Call List. He said he thought another deceased veteran should have been on the NEAR Call List but was not, for an unknown reason. He said he could not recall the names of these veterans. He said he was not aware of any established patients who had died while waiting to be scheduled for an appointment.

- During the interview of CS-59 on July 14, 2014, CS-59 said that PSA2 and PSA1 became aware of changes to the eligibility rules. CS-59 stated that senior leader 1 and service chief 1 were not aware of these changes and that the nationwide VA computer systems were never amended to reflect that change. CS-59 stated that as a result, veterans were being wrongly rejected by VAMC Beckley staff after applying for VA health care. CS-59 stated that VAMC Beckley had made many inaccurate eligibility determinations, which were not in accordance with the agency's most recent eligibility rules. CS-59 stated that in approximately 2012, they learned that approximately 8,000 veterans whose records dated back to approximately 1998 were stuck "in-process" within the eligibility computer system. CS-59 believed this to be an issue associated with the HEC server. CS-59 stated that in approximately July 2012, he or she notified VAMC Beckley management (he or she did not identify whom they notified); however, it was not until February 11 or 12, 2013, that the program analyst submitted a formal request to get this problem resolved. CS-59 stated that on the date the request was submitted, 4,000 veterans became "enrolled" overnight. CS-59 stated he or she believed this situation delayed veterans' eligibility determinations, which likely caused them to believe they were ineligible for care. CS-59 also alleged that VAMC Beckley's enrollment staff were using a low-priority disposition. CS-59 stated that he or she believed this disposition resulted in veterans being denied enrollment and their application not being transferred to the HEC for review. However, CS-59 said, "I don't know that to be fact." CS-59 stated that details concerning these eligibility issues were provided to the VISN senior leader and former director 2 in February 2013 but that they did not address the problem. CS-59 added that former director 3 and service chief 1 were also made aware of these issues.

- During the interview of SMAS2 on July 17, 2014, he stated that he served as VAMC Beckley's Enrollment Coordinator for approximately 1 month in October 2013. He explained that in this role, he would complete the process of enrolling veterans who wished to receive VA health care. He stated that he entered information provided by the veteran in VistA and this information was then transferred to the HEC for review. He said the HEC verified the information and made the final determination concerning enrollment. He stated that there were times when he would enter a veteran's information in VistA and the veteran's status would show "rejected" because of a "lack of evidence." However, the veteran would be listed as "enrolled" a couple of days later. He stated that he believed the HEC was responsible for changing the veteran's status. He added that there were issues concerning transferring data to the HEC and that records were "stuck in process." He said he did not have specific details concerning this incident but thought it was eventually resolved.

When reinterviewed, SMAS2 was asked if it was possible for veterans to have their applications for VA health care denied by VAMC Beckley before the paperwork had been transferred to the HEC. He replied, "I don't know that that could be possible...It's not possible." He said that, according to the way the system was designed, every application should be sent to the HEC. He said that if there was an issue with this information transferring to the HEC, it was likely the fault of the computer system. He was asked if there had ever been a time when a veteran's application for VA health care was approved by the HEC but the veteran was later denied care by the facility. He said, "Not to my knowledge...there's no reason why anybody would ever turn them away." He stated, "I don't believe that anyone intentionally or knowingly did something to deny anyone benefits." He believed that if there was an issue with a veteran's benefits, it was related to a computer system error or a communication problem.

- On July 23, 2014, administrative employee 5 said former employee 1 told her that patients were being denied enrollment for VA health care when he thought they should have qualified. She said she thought these denials were occurring at VAMC Beckley and not at the HEC.
- On July 23, 2014, MSA19, Admissions, stated that his responsibilities had included enrolling veterans who wished to receive VA health care. He stated that after he entered information provided by the veteran in VistA, the system would show an initial eligibility determination based on the information provided. He said the information was transferred to the HEC, which made the final eligibility determination. He said he had noticed a delay in the HEC's review process and did not know the cause of this delay. He stated that he had seen instances in which the initial determination showed the veteran was eligible but the HEC later determined the veteran was ineligible. He stated that there had been recent changes to the eligibility rules. He said that at one time, a veteran would not qualify to receive VA health care if his or her assets totaled more than \$80,000. He said he believed this had since changed and that the sum of a veteran's assets did not affect their eligibility.
- On May 6, 2015, MSA1 stated that in 2014, her responsibilities at the community-based outpatient clinic (CBOC) in Greenbrier County, WV, included enrolling veterans in VA

health care. She stated that she would enter information provided by the veteran into VistA and the computer system would show an initial eligibility determination. She explained that if the determination showed that the veteran was rejected she often called clerk 2 to ask her to review the information. She said she recalled clerk 2 telling her on multiple occasions that the rejections were accurate. She also stated that on several occasions when she said the veteran's rejection was accurate, PSA2 told her that the veteran was actually eligible. She said PSA2 had attempted to address this enrollment issue with HAS but "it fell on deaf ears."

- During the interview of SMAS1 on May 7, 2015, she said that she worked as the Enrollment Coordinator and that her responsibilities included enrolling veterans in VA health care. She said veterans provided information that was entered into the computer system. She said that although an initial determination was received based on the information provided, the veteran's application was still transferred to the HEC for review. She said the HEC always made the final eligibility determination. She added that she had seen instances in which the HEC enrolled a veteran who was not actually eligible. She stated that in these cases, she would alert the HEC to the error so they could further investigate. She said there had been times when a VAMC Beckley employee had entered erroneous information in the computer system, which resulted in an inaccurate enrollment. She said all of these applications were reviewed by the HEC, which made the final determination. She stated that she was not aware of any applications that had not been reviewed by the HEC.

When reinterviewed, SMAS1 said that specialist 4 had alleged that there were veterans "being registered and they were hanging in pending status." She stated that she, specialist 2, and the program analyst had found that "there was no glitch" with the computer system. She said some veterans were in "pending status" because they did not provide all of the information required by VA to complete the enrollment. She said that if all of the veteran's information had not been submitted, "We can't verify him." She said the allegation that "...we had had veterans that died because we weren't taking care of them...it's not true." She further stated, "We don't have people waiting that are enrolled with VA that have died."

- During the interview of the program analyst on May 7, 2015, he stated that he went through training at the HEC as an enrollment coordinator. He said there had been changes over the years to the enrollment process. He said the facility was responsible for registration of the veteran and the HEC was solely responsible for the enrollment determination. He said the facility would "typically follow the HEC's decisions" and that VAMC Beckley employees would contact the HEC to obtain further information if there were concerns. He said if it was ever determined that a veteran had been enrolled erroneously, that information would be provided to the HEC to investigate. The HEC would still make the final decision as to whether the determination should be changed.
- During the interview of former service chief 1 on July 14, 2015, he stated that he worked as an enrollment coordinator during his employment at VAMC Beckley. He also confirmed that the HEC always made the final eligibility determination.

- During the interview of service chief 1 on July 15, 2015, he stated that PSA2 and PSA1 had raised concerns about the transferring of applications from VAMC Beckley to the HEC. He said he had no evidence of any problems concerning the transferring of these applications. He said those individuals whose applications had been sent to the HEC were listed as “pending verification,” which meant that someone at the HEC was still processing the application. He stated that because PSA2 and PSA1 believed there were a number of veterans whose applications were never transferred to the HEC, they had provided him with a document listing these individuals. He said he had conducted a search for each of these veterans in VAMC Beckley’s medical record system and found that all of them were receiving care. He said even though their status still showed “pending verification,” “it did not impact them receiving healthcare.”
- During the interview of senior leader 1 on August 26, 2015, he confirmed that there were several thousand applications in pending status for a time. He said that, typically, when veterans provide their applications for VA health care, the computer shows an initial determination, the results of which the VAMC Beckley employee shares with the veterans. He said, “[Specialist 4] actually pointed out a good thing, that they were seeing that the HEC was enrolling a lot of them behind us.” For example, he stated that the initial determination would show the veteran was ineligible, but that after reviewing the application, the HEC would later find the veteran eligible. He said VAMC Beckley implemented a system charging their staff to send letters to veterans to inform them that while they had initially been determined to be ineligible, the HEC would still review the application and make the final determination. The letter asked the veteran to follow up with the facility in a certain number of days for an update on the determination.
- During the interview of former director 2 on September 16, 2015, she confirmed that the eligibility regulations had changed. She stated that at one time, a regulation advised that a veteran’s net worth was to be considered when evaluating whether he or she qualified for VA health care. She said “... that evidently was changed a couple of years ago but it wasn’t, I don’t think, adequately communicated to the field.” She confirmed that “... some people were still under the impression that that was part of that eligibility determination.” She said she had received an email in which someone from VACO agreed that the information provided by PSA2 and PSA1 concerning the changes in eligibility regulations was accurate. She said she had discussed the issue with senior leader 1, who told her he thought HAS employees understood the eligibility rules. She stated that once they received clarification on this issue, senior leader 1 ensured HAS staff understood this new regulation. She stated that VAMC Beckley employees did not make the final decision regarding a veteran’s eligibility for VA health care. She said all of this information was transferred to the HEC, which made the final determination. She said “...veterans that our staff may have thought weren’t eligible because of net worth were determined to be eligible by HEC and were actually enrolled and receiving care.” She said there was a concern that veterans were left in a pending status for a period of time. She said these veterans had not completed a means test, and that these veterans would remain in a pending status without this information. She said “...a lot of those veterans were enrolled. They were continuing to receive care, even while in a pending status.” She said this was a national issue, not something specific to VAMC Beckley. She said sometimes when a veteran submitted an application for enrollment in VA health

care, VAMC Beckley treated that veteran even before receiving the HEC's final determination. She said this frequently occurred if the veteran wanted to be treated in the Emergency Department at VAMC Beckley. She stated that there were times when these veterans were later determined to be ineligible by the HEC, and they then had to transition to private health care.

- During the interview of the VISN senior leader on April 20, 2016, he stated that VAMC Beckley employees did not have the ability to make an eligibility determination for a veteran. He confirmed that this determination was completed by the HEC. He added that he did not have any further knowledge about this complaint.

Records Reviewed

VA OIG investigators obtained a copy of a VA OIG OAE report titled *Review of Alleged Mismanagement at the Health Eligibility Center* (Report Number 14-01792-510, dated September 2, 2015). The report confirmed that the HEC did have approximately 867,000 pending records as of September 30, 2014. However, OAE was unable to reliably determine how many records were associated with actual applications for enrollment. This report explained that all applications submitted by medical center employees fed into HEC's Enrollment System, which served as VHA's official electronic system of record for veteran health care enrollment information. The enrollment program made a final enrollment determination by evaluating evidence of military service and financial income status. According to this report, about 307,000 of the approximately 867,000 pending records were for individuals who were reported as deceased by the Social Security Administration. This report also confirmed that in January 2013, the HEC identified more than 11,000 unprocessed health care applications.

Issue 5: Investigation of Allegation That VAMC Beckley Employees Were Scheduling Appointments Without Obtaining Input From the Patient

Interviews Conducted

- During the interview of PSA1 on July 10, 2014, he stated that he knew some schedulers in the Primary Care Clinic and Specialty Clinic would make appointments without obtaining input from the patient. He said that in many cases, patients were not contacted by telephone and a desired date was never obtained. He said, "I have witnesses of people that say it's happened." (**Note:** During the course of this investigation, PSA1 never provided specific names to investigators.)
- During the interview of Primary Care Clinic MSA8 on July 15, 2014, she stated that she would schedule an appointment without obtaining input from the patient if (1) a physician requested that a patient return on a particular date and (2) the patient did not visit her desk upon leaving his or her appointment. She said the patient would receive a notification letter in the mail 2 weeks before the scheduled appointment. She also stated that the patient would receive a telephone call the day before the appointment to give him or her the appointment details. She said that upon exiting VAMC Beckley, the patient

did not know that he or she had an upcoming appointment unless he or she stopped at her desk.

- During the interview of administrative employee 1 on May 6, 2015, he said he learned in approximately May 2013 that schedulers in the Specialty Clinic were not obtaining input from the patient before scheduling consultations. He said, “I was seeing an increase in no-shows.” Consequently, he called the patients who did not show up for their scheduled appointments and said the patients told him that they had not spoken with anyone at VAMC Beckley concerning the scheduling of the appointment. He said he spoke with PSC5 and PSC3, who are both schedulers in VAMC Beckley’s Physical Medicine and Rehabilitation Clinic, and they told him that instead of contacting the patient, they were using the date the physician requested the patient to return as the desired date. He explained that he had counseled them about this practice and that temporarily resolved the problem. He said, “I can’t sit here and tell you right now they’re still not doing it.” However, he stated that these schedulers were not in violation of VA policy because these issues were not specifically mentioned in the scheduling directive.
- During the interview of MSA5 on September 15, 2015, she stated that her practice for scheduling a return appointment was determined by whether a patient visited her desk upon exiting VAMC Beckley. She explained that if the patient came by her desk after his or her appointment, she would tell him or her the date the provider wanted the patient to return. She stated that she would also ask the patient to confirm whether that time would work. She said she allowed the patient to pick the date and then made the appointment for that selected date. She stated that if the patient did not stop by her desk after an appointment, she would use the date provided by the physician as the desired date. She further stated that she would schedule the appointment without obtaining input from the patient and then send a letter to the patient that included the appointment details. She said that in this situation, she was instructed by SMAS1 “to use the provider’s date.” She also stated that she was “never instructed to call the patient” to get his or her desired date. She estimated that, weekly, there were probably 5 or 6 out of 48 patients from whom she did not obtain a desired date when scheduling a return appointment.
- On September 15, 2015, service chief 1 stated that the patient should always be contacted to obtain a desired date before scheduling an appointment. He said new scheduling guidance released several months before this interview stated that a patient should be contacted before scheduling an appointment. He said the new guidance directed that a patient should be contacted two times and that these attempts should be documented. He said the scheduler should then mail the patient a letter. He said there was confusion as to whether this was a letter to ask the veteran to call VAMC Beckley to schedule an appointment or if this letter was meant to reference an appointment already made by the scheduler. In his opinion, the scheduler should make the appointment and send a letter that includes the appointment details.
- During the interview of MSA9 on September 15, 2015, she stated that it was normal to schedule an appointment without obtaining input from the patient before the recent release of the scheduling guidance. She said she typically attempted to reach the patient by telephone two times and that she would schedule an appointment if he or she could not

be reached. Once the appointment was scheduled, she stated, she mailed a letter to the patient that included the appointment details. She said the new guidance dictated that a scheduler should speak with a patient before scheduling an appointment.

- On September 15, 2015, MSA12 stated that she would proceed with scheduling an appointment if a patient could not be reached by telephone. She explained that she used the date the physician provided as the desired date. She said she would mail a letter to the patient that included the appointment details.
- During the interview of MSA14 on September 16, 2015, he stated that he would use the date provided by the physician as the desired date, before the new guidance, which was issued a few months before the interview. He said, “Now we could make two phone calls and a letter trying to get a hold of them which in my personal opinion, as a veteran, and as an employee, that’s a waste of efficiency and time.” He said the provider generally spoke with the patients before the end of their appointment to ensure the patients understood that they needed to return in a certain amount of time. He stated that, in addition, the patients received an automated telephone call 3 days before their scheduled appointment to give them the appointment details. He stated that despite the concerns he raised about this process, he had always mailed a letter to the patients to give them the appointment details.
- During the interview of MSA17 on September 16, 2015, she stated that she would schedule an appointment without obtaining input from the patient if (1) a physician requested that a patient return on a particular date and (2) the patient did not visit her desk upon leaving his or her appointment. She stated that in this scenario, the desired date was not obtained from the patient and instead she would enter the date the physician provided as the desired date.
- During the interview of the VISN senior leader on April 20, 2016, he stated that scheduling a patient without obtaining input from the patient was a practice commonly followed at VAMC Beckley and other VA facilities. He said that sometime in 2014, schedulers received guidance that this practice should no longer be followed. To his knowledge, according to the current guidance, all schedulers must have a conversation with the patient before scheduling an appointment.

Issue 6: Investigation of Allegation That Former Physician 1 Engaged in Inappropriate Scheduling Practices

Interviews Conducted

- During the interview of social worker 1 on May 6, 2015, she said that MSA1 reported to her that former physician 1 prohibited her from accepting walk-in patients and scheduling patients past 1:00 p.m. This allegedly occurred from approximately January 2014 to May 2015, when social worker 1 and former physician 1 were working at the CBOC in Greenbrier County, WV. She said she subsequently reported this information to (1) former service chief 2, (2) RN2, and (3) senior leader 1. She said there was an expectation that a provider would examine 10 to 12 patients per day but she did not know

whether this information could be found in a formal policy. She estimated that former physician 1 was examining approximately eight patients per day. She stated that former physician 1 told her that he needed to limit his workload because he required additional time for the management of laboratory orders and other required paperwork. She said that, as a result of former physician 1's decision not to accept patients after 1:00 p.m., "I don't think anyone was really harmed." However, she said she believed that this made it more difficult for veterans to receive care.

- During the interview of MSA1 on May 6, 2015, she denied that former physician 1 prohibited her from scheduling patients past 1:00 p.m. She said that former physician 1's schedule had 10 available appointment slots but he would often tell her to only schedule 6 patients. In addition, she said she recalled instances when former physician 1's nurse, nurse 1, denied requests for appointments from walk-in patients. MSA1 stated that she was unsure whether former physician 1 directed nurse 1 to deny these patients an appointment or nurse 1 made the decision to do this herself.
- On May 7, 2015, nurse 1 said she worked with former physician 1 for approximately 2 years at the CBOC in Greenbrier County. Nurse 1 said former physician 1 did not refuse to schedule patients after 1:00 p.m. She said former physician 1 was unable to block appointment slots because his schedule was managed by other VA employees. She said former physician 1 examined approximately 5 to 10 patients per day. She also estimated that physician 4, another physician at the CBOC in Greenbrier County, examined about the same number of patients. She said the number of patients that former physician 1 saw varied due to no-shows and walk-ins. She stated that she was not aware of any policy that directed physicians to examine a certain number of patients per day. She said the CBOC in Greenbrier County was relocated to VAMC Beckley. As a result, former physician 1's scheduled tour of duty shifted by an hour to allow for additional travel time. She stated that former physician 1's first appointment was moved from 8:00 a.m. to 9:00 a.m. and his last appointment time was moved from 3:30 p.m. to 2:30 p.m. She said that when former physician 1 was not seeing patients, he was managing "alerts" and tasks relating to patient care. She further stated that she did not feel that former physician 1 tried "to get out of patient care" and she did not believe former physician 1 did anything unethical or improper.
- During the interview of MSA17 on September 15, 2015, she stated that former physician 1 only wanted to schedule six patients per day but VAMC Beckley management wanted former physician 1 to schedule 10 patients per day. She explained that former physician 1 wanted to decrease the number of patients he was seeing because he was behind on work-related paperwork. She further stated that former physician 1 stayed late at work to complete some of these work-related tasks.

Issue 7: Investigation Into Allegation That the Program Analyst Proposed Following an Improper Scheduling Practice

Interviews Conducted

- During the interview of supervisory employee 1 on July 15, 2015, she stated that the program analyst had asked her and MSA2 to remove more than 30 patients from the Eye Clinic appointment schedule in VistA and to place new patients in the vacated slots. She indicated that the program analyst's motivation to move these patients "had something to do with access numbers" and "wait times." She said, "We refused to do it... we thought it was wrong to move people that were already scheduled." She stated that this occurred in approximately late February 2014 and that at that time, the Eye Clinic was very full. She said she did not believe any patients were ever removed from the schedule or even shifted around. She reportedly did not know who else was involved in the creation of this plan other than the program analyst nor did she believe the Eye Clinic physicians were aware of his proposal.
- During the interview of MSA2 on August 25, 2015, she said she had received instruction from the program analyst to move patients who were scheduled in the Eye Clinic. She said, "I just vaguely remember him wanting us to move all these patients...to a different appointment time." She stated that she could not recall the reasoning behind this request. She said the patients were going to be rescheduled in appointments on dates further out than their original appointment date. She said she and supervisory employee 1 denied the program analyst's request to move the patients; she did not believe any patients were ever moved. She also stated she did not believe that the Eye Clinic physicians knew about the program analyst's proposal.
- On August 26, 2015, the program analyst stated that around February or March 2014, he was working as a section chief in an area where his responsibilities included monitoring access and wait times. He said he had proposed moving approximately 100 to 200 patient appointments in the Eye Clinic because "[the clinic] was developing a backlog and their wait times were getting unmanageable." However, he said his motivation was to "try and get as many patients in as close to their desired date as possible." He said, "Sometimes that would mean moving a patient that had a 1-day wait time, rescheduling him a couple weeks out but that would open up access for those patients that had been waiting for months." He stated that he had approached SMAS2 and service chief 1 and both had disagreed with his proposal. Despite SMAS2's opposition, he said he thought he spoke with schedulers about this plan. He said, "It wasn't an effort to game the system. It was an effort trying to get as many patients in within 30 days of their desired date as possible." He said this was the first and only time this type of plan had been proposed. He stated that he was not entirely sure if patients were actually moved as a result of his proposal but he said, "I'm pretty confident that at least some were." He said that scheduling patients within 30 days of their desired date was the national standard for specialty care and that this was an effort to meet that standard. He said he believed this plan was in line with the scheduling directive because "in intent it was the best for patient care to get the greatest number in." He said he personally came up with this proposal and it did not originate with anyone else in

management; a spike in NVCC requests was what prompted his proposal to rearrange the Eye Clinic schedule.

- On August 26, 2015, SMAS2 said that around February or March 2014, the program analyst proposed moving patients who were scheduled in the Eye Clinic. He said the program analyst was making this proposal because access in the Eye Clinic was a consistent problem. He said he recalled thinking that this was unethical, so he had told the program analyst that he did not agree with his proposal. He also recalled discussing this proposal with service chief 1. As well, he said he had approached MSA20, who was a scheduler in the Eye Clinic at the time, and MSA20 had shared his own concerns about the proposal. He said he knew patients were never moved.

When reinterviewed, SMAS2 stated that he recalled that the program analyst had presented his proposal in one of the conference rooms. He also seemed to remember that the program analyst had been there with service chief 5 and MSA5. He said the program analyst was making this proposal to ensure that fewer patients would have to be sent to private physicians as a result of the access issues in this clinic. He said he believed the program analyst “did not feel like he was doing something wrong” and instead believed that he was doing “something smart business-wise.” He stated that he had approached MSA20 about this issue after his interview with agents on August 26, 2015. He said MSA20 located an email related to this proposal in which he asked schedulers if anyone would volunteer to assist with the rescheduling patients in the Eye Clinic. MSA20 found a second email that said volunteers were no longer needed because there would be no rescheduling of patients. He stated that MSA20 told him that she thought she had received a list of patients slated to be rescheduled. He said he believed that list came from the program analyst. However, he said MSA20 had told him that she never rescheduled any of these patients.

- On September 15, 2015, MSA20 stated that around March 2014, SMAS2 asked her if she wanted to work overtime because they had a list of patients who needed to be rescheduled. She explained that when she learned that she was being asked to push some patients’ appointments out further to place other patients in those vacated slots, she became concerned. She stated that she thought someone, possibly SMAS2, had showed her the list of patients to be rescheduled. She said she refused to assist and recalled that no patients were rescheduled as a result of this request. She said she thought she had received an email from SMAS2 telling her to “disregard” his previous request to reschedule patients. She stated that she had never received guidance like this at any other time of her employment.
- During the interview of service chief 1 on September 15, 2015, he stated that he recalled being approached by the program analyst and SMAS2 to discuss the program analyst’s plan to move patients scheduled in the Eye Clinic. He said he did not feel comfortable with the proposal. As a result, no patients were ever moved.
- During the interview of MSA5 on September 15, 2015, she stated that, in March 2014, there were access issues in the Eye Clinic that resulted in the facility having to send patients to private physicians for care. She said she recalled speaking with service chief 5

and the program analyst about how to resolve the clinic's access issues. She said they proposed to move patients around so that more patients could receive appointments closer to their desired dates. She said the plan was never to change the patients' desired dates. She said she attended a meeting where this proposal was discussed with administrative employee 1, service chief 4, VA employee 1, service chief 5, the program analyst, service chief 1, and SMAS2. She said she never heard anything else about this proposal since that meeting and did not know if patients were ever moved.

Records Reviewed

- VA OIG reviewed documentation provided by the program analyst, including:
 - o An email (dated February 14, 2014) that the program analyst sent to multiple VAMC Beckley employees. In the email, the program analyst stated, "We are seeing a sudden spike in NVCC request for routine eye exams (26 in the past three days) ... this influx has caught me by surprise."
 - o An Outlook meeting invitation (scheduled for February 26, 2014 at 1:30 p.m.) that the program analyst had sent to 12 VAMC Beckley employees. In the meeting invitation, he stated, "My staff have worked to develop an alternative to NVCC to improve access in the optometry clinics with a substantial cost avoidance to the facility. We would like to meet with the key players to discuss this proposal and potential cost savings." (**Note:** The program analyst stated, in reference to this, that the only people he could recall attending this meeting were SMAS2 and service chief 1. This meeting invitation was never sent to any of the optometry physicians at VAMC Beckley and the program analyst could not recall if they were ever involved in this discussion.)
 - o An email (dated February 26, 2014) that the program analyst sent to SMAS2 and supervisory employee 1. In this email, he stated, "So the point is just stretching out the two weeks to give us room to pull the old patients forward. To start we need to move a few full days. 4/4 gets moved to 4/18. 3/21 moves to 4/4. 4/7 moves to 4/21. 3/24 moves to 4/7. 4/10 move to 4/24. 3/27 moves to 4/10. 3/20 moves to 3/27."
 - o An email string dated March 17, 2014. RN1 first began this email string by sending an email to the program analyst in which she stated, "Have you completed the rescheduling of the optometry patients that we discussed a couple of weeks ago, to improve access?" The program analyst responded to RN1 by saying, "Not as of yet. [SMAS2] raised some ethical concerns..."
 - o Three emails, all dated March 19, 2014 and in which the program analyst provided SMAS2 and service chief 1 with the Optometry Clinic's wait time data. He said he was reviewing patients who were scheduled for appointments that were more than 14 days from their desired date. (**Note:** The program analyst said he misspoke in the earlier interview when he told VA OIG investigators that he was reviewing the patients scheduled for appointments that were more than 30 days from their desired date.) The emails showed there were 119 patients scheduled for appointments that were more than 14 days from their desired date. The program analyst said he

believed his proposal was not in violation of VA policy because the directive did not prohibit the canceling of patient appointments. He further stated that the goal of his proposal was to get more patients seen closer to their desired date. He added that after reviewing his emails, he did not believe this plan was ever carried out.

Issue 8: Investigation Into Allegation That Physician 1 Manipulated the Desired Date

Interviews Conducted

- In an interview on March 31, 2015, MSA3 said she sent an email (discussed in the Records Reviewed section of this Issue) to alert the program analyst, service chief 1, and senior leader 1 that physician 1's Pain Management Clinic was nearing capacity because appointments were being scheduled for dates exceeding 90 days. MSA3 said she did not suspect physician 1 was doing anything inappropriate. MSA3 had no complaints about physician 1 and said she was not aware of physician 1 following or directing any improper practices.
- During the interview of the program analyst on May 7, 2015, he stated that he could not recall all of the details concerning this email exchange. He said he thought physician 1 was pushing patients out and "making those wait times and stuff look better." He said he did not regularly interact with physician 1 but was not aware of physician 1 following inappropriate practices.
- During the interview of service chief 1 on July 15, 2015, he reported that physician 1's clinic was booked out 90 days and that his patients' desired dates were also approximately 90 days out. He said he did not recall the details concerning this incident. However after reviewing the emails (discussed in the Records Reviewed section of this Issue), he said he thought physician 1 was assigning desired dates based on the clinic's availability instead of assigning a desired date based on the patient's needs. He stated that he did not recall addressing this issue with physician 1 nor could he recall how it was resolved. Beyond the issues mentioned in this email, he stated that he had no knowledge of physician 1 following inappropriate practices.
- During the interview of senior leader 1 on August 26, 2015, he said physician 1 was issuing new consultations and noting that it was clinically appropriate to see the patient in 90 days. He recalled feeling uneasy about the possibility that a patient who needed an appointment for pain should be waiting 90 days for one. He said, "He's keeping his access numbers down by pushing that workload out there on a consult." He said that either he or former service chief 3 addressed this issue with physician 1.
- On August 27, 2015, physician 1 stated that when he received a consultation for a patient, he would consider the patient's needs. Based on this information, he determined the date the patient should be examined. He said he did not base his decision on clinic availability. After examining a patient and determining that he or she should return to the clinic, he had a discussion with the patient about when he or she would like to return. He stated that he ensured that the date the patient requested was clinically appropriate and they would come to an agreement on the desired date. He said ultimately it was the

patient who determined the desired date. He said he was not aware of any deliberate manipulation of wait-time data at VAMC Beckley.

Records Reviewed

VA OIG identified and reviewed emails which suggested that physician 1 was following inappropriate practices. One email, with the subject line “Pain Consults” and dated June 7, 2013, was sent from MSA3 to the program analyst, service chief 1, and senior leader 1. In this email, MSA3 stated, “On the new Pain Management Consults after physician 1 reviews them he is scheduling them out there past 90 days. He is giving us the desired date when he wants to see the patient and we use that.” Senior leader 1 forwarded this email to former service chief 3. In this forwarded message senior leader 1 stated, “He’s gaming the system.” In a reply message to the program analyst and senior leader 1, service chief 1 stated, “Ok we KNOW he’s manipulating the DD if he’s telling them to schedule 90+ days out.”

Issue 9: Investigation Into Allegation That Providers Directed Clerks Not To Fill In Their Schedule Openings Created by Cancellations

Interviews Conducted

- During the interview of administrative employee 1 on May 6, 2015, he said that he thought MSA8 and PSC2 had reported this issue to him. He said he knew that former physician 4, physician 5, and VA employee 2 were following this practice. He said physicians had also told schedulers to block their schedules during certain hours, without going through the proper channels to obtain prior approval. He added that former physician 3 “favored” this practice. He said this practice had been followed for approximately 3 to 5 months before he and senior leader 2 were able to address the problem with the physicians. He said he believed the practice stopped after this discussion with the physicians.
- During the interview of senior leader 2 on May 13, 2015, he said that he had sent this email (discussed in the Records Reviewed section of this Issue) because he believed providers were not filling openings created in their schedules, to allow more time for other work or for the purpose of leaving work early. He said, “A good portion of our primary care would do that on occasion.” He could not recall specific names of individuals who had done this. He said that “eventually it did stop” after he addressed the issue and that the providers started “using the slots much more efficiently.”
- During the interview of service chief 1 on July 15, 2015, he said that he was unaware of any specific guidance from providers not to fill openings in their schedule that had been created by cancellations. He stated that he had heard rumors of doctors making statements like, “If I have a patient cancel, you can’t put another patient in that slot without speaking to me about it first.” However, he could not provide names of individuals who had made such statements. He said in situations in which there were same-day cancellations, schedulers were limited in their ability to fill these openings.

- During the interview of MSA2 on August 25, 2015, she stated that she was aware of physicians who had overbooked their schedule. Consequently, when a patient would cancel, the physician would ask the scheduler not to fill that appointment slot. She said she had heard rumors that primary care doctors had “fussed at the clerks” for filling openings in their schedules created by cancellations, but she could not provide any specific examples.
- During the interview of senior leader 1 on August 26, 2015, he said that he believed this discussion dealt strictly with same-day cancellations. He said that same-day cancellations were very difficult to fill. He further stated that he was not aware of any specific incidents in which physicians had directed schedulers not to fill their schedules with openings created by cancellations.
- During the interview of MSA5 on September 15, 2015, she stated that she was told, when she worked in the Dental Clinic, an appointment slot should be left open when a patient canceled that appointment on the same day. She said it was unclear why this was the rule in the Dental Clinic since it was the only clinic with this rule. She explained that if a patient in the Dental Clinic canceled on any day other than the day of the appointment, she was allowed to fill that appointment slot. She said other clinics would allow schedulers to fill openings in the schedule created by same-day cancellations but required that a scheduler first receive approval from a physician before scheduling a patient in these slots.

Records Reviewed

VA OIG reviewed VAMC Beckley employee emails and identified an email string (dated July 27, 2012) in which senior leader 2 alleged that providers were instructing schedulers not to add openings in their schedule created by cancellations. Senior leader 2 sent this email to administrative employee 1, senior leader 1, service chief 1, and former service chief 3. Administrative employee 1 replied, “I’ll get you a list of providers who don’t want patients added when they get a cancellation according to the scheduling/nursing staff.” Senior leader 1 responded, “Everyone on this message knows...there’s no way for me to fill same day cancellation slots.”

Issue 10: Investigation Into Allegation That Former Physician 2 Directed Improper Scheduling Practices

Interviews Conducted

- During the interview of service chief 1 on July 15, 2015, he could not recall all of the details concerning this incident. He said he thought former service chief 3 and former employee 2 were attempting to implement some new practices after they returned from a conference around this time. He said he thought former service chief 3 and former employee 2 may have discussed the implementation of these practices with former physician 2. He said he thought these practices were followed for just “weeks.” He said he did not recall having a conversation with former physician 2 or MSA4 about it. He

said he believed the program analyst must have counseled the individuals involved but he could not recall the specific details.

- On September 14, 2015, MSA4 was asked if former physician 2 directed him to follow the improper practices referenced above. He said he had been a scheduler for former physician 2 for approximately 6 months in 2013 or 2014. He said he did not recall ever receiving guidance from former physician 2 not to schedule patients out beyond 10 calendar days and to instruct patients to call back to schedule an appointment. He said if a patient called to request an appointment, he always scheduled the patient for an appointment at that time. He said he never told a patient to call back so that he could schedule the appointment at a later time. He denied having any knowledge of former physician 2 following improper practices or directing others to do so.
- During the interview of MSA5 on September 15, 2015, she said she had never asked a patient to call back to schedule an appointment but she recalled MSA9 following this practice. She said that when MSA9 was busy, MSA9 would either ask the patient if she (MSA9) could call the patient back or she would ask the patient to call back at a later time. MSA5 said she recalled times when MSA9 did not call a patient back for “a couple of days.” She said MSA9 did not have malicious intent but rather was overwhelmed. She acknowledged that a few veterans probably never received a call back from MSA9 even though some of those patients may have called back the clinic. She said she recalled one veteran who, after being told by MSA9 that she would call back, eventually recontacted the clinic and said, “You never called me.”
- During the interview of MSA9 on September 15, 2015, she was asked if she had ever told a patient to call back later to schedule an appointment. She initially said, “I don’t tell them to call back. If I cannot help them at that moment, I take their name, number, and I call them back.” She later admitted there were times when she asked the patient if they would like her to call them back or if the patient would prefer to call the office at a later time; the patient, she explained, might request to call the clinic back at a later time. She added, “If they didn’t call me back, I would call them.” She said there had been occasions when the computer system was malfunctioning or the clinic was extremely busy. She stated that these were times when she might have told patients that she needed to call them back. When asked if there had ever been patients whom she told she would call back but were never contacted, she replied, “There is always going to be times where the patients fall through the cracks.” She said she could not recall any specific instances when this happened.

Records Reviewed

VA OIG reviewed VAMC Beckley employee emails and identified an email from service chief 1 to the program analyst and SMAS1. In this email (dated May 3, 2013), service chief 1 stated that former physician 2 directed MSA4 not to schedule patients out beyond 10 calendar days. In the same email, service chief 1 suggested that former physician 2 directed MSA4 to instruct patients to call back to schedule an appointment.

Issue 11: Investigation Into Email That Showed a Patient With a Wait Time of 18,199 days (Approximately 49.8 years)

Interviews Conducted

- During the interview of administrative employee 1 on May 6, 2015, she said that he had identified a scheduling error in which a scheduler entered the wrong desired date. This resulted in the patient's wait time being erroneously calculated at 18,199 days.
- During the interview of senior leader 3 on May 6, 2015, she said she did not remember the details surrounding this email. She said errors could occur when schedulers entered an incorrect date in VistA. In her opinion, this email had to be referencing some kind of error.

Records Reviewed

- VA OIG reviewed VAMC Beckley employee emails and identified an email (dated October 22, 2009) from administrative employee 1 to senior leader 3. In the email, administrative employee 1 wrote, "That pt that is out there 18,199 days I would not worry about him. He'll be dead by then." The email indicated that the veteran was waiting for an appointment in the Physical Medicine and Rehabilitation Clinic.
- VA OIG reviewed the veteran's medical records, which showed that the veteran had been examined shortly after, on October 29, 2009, by former physician 3, in the Physical Medicine and Rehabilitation Clinic.

Issue 12: Investigation Into Allegation That Former Physician 3 Was Following Inappropriate Scheduling Practices

Interviews Conducted

- During the interview of CS-58 on July 10, 2014, CS-58 said that he or she had heard of VAMC Beckley clinics (NFI) canceling patients before their scheduled appointment "so they won't have to have a no-show." CS-58 said, "...if they don't think you're going to show up, they'll cancel you. If you do show up, they put you back in the system."
- On July 23, 2014, CS-59 said that when he or she arrived for his or her appointment, the female scheduling clerk said, "...we have in the system here that you called and canceled." CS-59 said when he or she told the scheduler he or she had not canceled his or her appointment, the scheduler explained that the schedulers in the specialty clinics at VAMC Beckley often canceled patients' appointments before they arrived. CS-59 stated that the scheduler further indicated that this was done so that if the patient did not show up for the appointment, that clinic's "no-show" rate would not rise. CS-59 also stated that the scheduler told him or her that the schedulers "get fussed out when their no-show rate gets too high" and then put CS-59 back on the appointment schedule. CS-59 did not identify the female scheduling clerk.

- On May 6, 2015, administrative employee 1 was asked about (and provided a copy of) an email from senior leader 2, dated March 5, 2014. In the email, senior leader 2 asked administrative employee 1, “What about those veterans who ‘don’t show up’ that ‘someone’ has told the appointment is cancelled? Isn’t that just gaming the system?” Administrative employee 1 said he had received reports that the Mental Health Clinic once canceled a patient’s appointment that had falsely been documented in the system as “Canceled by Patient.” He recalled the wife of VA employee 3 explaining that when she arrived at her podiatry appointment, the scheduler had said, “We’ve already had you checked out.” When asked if this email also referenced an allegation that, to ensure that his no-show rate did not rise, former physician 3 directed schedulers to cancel appointments before the patient arrived and to reschedule the appointment if the patient showed up, he said he had heard that former physician 3 had schedulers call a patient and, if the patient did not answer, the scheduler was to cancel the appointment and mark it as “Canceled by Patient.” He added that this was “totally wrong,” and thought that former physician 3 was following this practice around 2013. He also said he recalled having a “big argument” with former physician 3. He stated that former physician 3 was counseled about this matter by senior leader 2 and senior leader 3. When asked if this practice ever stopped, he replied “not dramatically.”
- During the interview of the program analyst on May 7, 2015, he was asked about (and provided a copy of) the email string referenced above (dated November 20 and 21, 2012) in which he alleged that former physician 3 was following an inappropriate scheduling practice. He said he did not believe this was a practice that former physician 3 had ever actually implemented but instead, it was “his creative solution to a problem.” He stated that in his opinion, former physician 3 was considering following this practice to make his clinic’s data, to include “no-shows,” look better. He said, “He got chewed out about his numbers and then was trying to find a way to fix his numbers so he wouldn’t get chewed out again.”
- During the interview of senior leader 2 on May 13, 2015, he said that former physician 3 was canceling veterans’ appointments before they would show up, to avoid having an elevated no-show rate. Senior leader 2 said he knew that this was a practice that former physician 3 had implemented in his clinic. Senior leader 2 said, “I had to address it several times because he kept doing it.”
- During the interview of service chief 1 on July 15, 2015, he was asked if he had knowledge of former physician 3 directing schedulers to cancel appointments and then to reschedule the patients if they showed up, to avoid having an elevated no-show rate. He said, “I remember hearing [senior leader 1] losing his mind over that. I don’t remember how it was addressed but I’m positive that he took care of it.” He said senior leader 1 would have spoken with senior leader 3 and service chief 6 about this issue.
- During the interview of PSC4 on August 24, 2015, he stated that during his time working in the Physical Medicine and Rehabilitation Clinic, he had no knowledge of former physician 3 following inappropriate scheduling practices. He also said he was never instructed to cancel appointments and then to reschedule the patients if they showed up.

- On August 25, 2015, service chief 6 was asked about (and provided a copy of) the email string referenced above (dated November 20 and 21, 2012) in which the program analyst alleged that former physician 3 was following an inappropriate scheduling practice. She said she vaguely recalled the incident. She said she believed former physician 3 was told that his clinic had a high no-show rate and that this was his plan to fix this problem. She also recalled that the no-show rate in former physician 3's clinic was approximately 12 or 13 percent around the time of this email. She said VAMC Beckley clinics were told the goal was to have a no-show rate below 10 percent. She stated that she learned about former physician 3's plan when one of the clerks (NFI) notified VAMC Beckley management. She said she did not think this practice was ever implemented because VAMC Beckley management was quickly notified. She added that she believed that senior leader 2 counseled former physician 3 about the matter.
- On August 25, 2015, MSA9 was asked if she had knowledge of former physician 3 directing schedulers to cancel appointments before the patient arrived and then to reschedule the appointment if the patient showed up. She said she worked as a scheduler in former physician 3's clinic around 2011 and could not recall him providing this guidance to schedulers at that time. However, she said she thought that former physician 3's clinic had a high no-show rate around that time.
- During the interview of PSC3 on August 25, 2015, she stated that she did not recall former physician 3 being concerned with his clinic's no-show rate. She said former physician 3 had no problem designating a patient as a no-show in VistA if the person did not attend his or her appointment. She said former physician 3 did regularly rearrange his patients' appointments to suit his schedule. However, she added, "If somebody would show and had a real issue, he would try to see them." She said that in cases in which former physician 3 initiated the canceling of a patient's appointment, these appointments were designated as "Canceled by Clinic." She stated that "for the most part, he was considerate...with the patients." She said she recalled that a "couple times a week" former physician 3 would tell her, "move this patient, see if they're willing." She said that she was often told to ask a patient to move to a different slot on the same day as his or her scheduled appointment. When asked if patients would be able to keep their appointment time if they objected to the change, she replied, "Generally yes." She said she recalled that, during the years she was a scheduler in former physician 3's clinic, he asked her at least three or four times to reschedule all appointments for a particular day and that he provided very short notice (NFI).
- On August 25, 2015, MSA13, Specialty Clinics, said she worked as a scheduler in former physician 3's clinic for approximately 2 or 3 years until his retirement a few weeks preceding this interview. She said former physician 3 regularly asked her and other schedulers to rearrange his appointments to suit his schedule. She said there were times when former physician 3 asked his schedulers to cancel all of his appointments on 1 day so he could take leave. She stated that when senior leader 2 learned about this practice, he asked former physician 3 to submit any future leave for approval before canceling patients. She said she recalled former physician 3 once wanting to cancel appointments because it was too hot in his office. She stated that, at another time, former physician 3 wanted to cancel his clinic because one of the machines he used to conduct patient tests

was not functioning properly. She said former physician 3 was not concerned about having a high no-show rate. She further stated, “I don’t think he’s ever canceled for that reason.” She said when former physician 3 asked schedulers to rearrange his appointments, “None of us really would do it.” According to MSA13, former physician 3 suggested canceling one patient because he had already seen that patient once and did not believe a follow-up appointment was necessary. She said former physician 3 had told the scheduler that if this patient were to show, the scheduler should put the patient back on the schedule and he would examine the patient. She said she did not believe former physician 3’s motivation for canceling appointments was to manipulate the clinic’s data. She said she recalled that he also had to cancel patients at one time because his wife had some health problems. She said he often canceled appointments at the last minute. She said that all of the appointments canceled by former physician 3 were marked as “Canceled by Clinic.” She stated that former physician 3 never told schedulers to use the next available date as the desired date instead of contacting the patient to get his or her preferred date.

- During the interview of MSA16 on August 25, 2015, she said that if former physician 3 had a gap in his schedule, he would ask her to call a patient scheduled later in the day to see if he or she could come in earlier. She said she did not recall former physician 3 ever asking her to cancel all patients on his schedule at any time. She said she did not believe that former physician 3 ever canceled patients in an attempt to affect his no-show rate. She said former physician 3 was transparent with her concerning how many no-shows he had each day. She said former physician 3 always allowed the patient to choose his or her desired date and never attempted to manipulate this process.
- During the interview of senior leader 1 on August 26, 2015, he said he knew former physician 3 told his schedulers not to make appointments for patients who had a high no-show record. He added that former physician 3 told schedulers that if the patient decided to show up, that person could be placed back on the schedule at that time. He said that he had been quickly notified about this system and that management took action to ensure schedulers were not following this practice. He said he did not believe this practice was ever implemented and did not know former physician 3’s motivation for providing this guidance.
- On September 15, 2015, senior leader 3 was asked about (and provided a copy of) the email string referenced above (dated November 20 and 21, 2012) in which the program analyst alleged that former physician 3 was following an inappropriate scheduling practice. She said she recalled this incident and believed that former physician 3 was counseled by management about this practice. She said that most likely this instruction by former physician 3 resulted from a conversation with administrative employee 1 about the physician’s no-show rate. She said this practice was inappropriate but she did not believe the schedulers ever followed this practice.
- During the interview of MSA20 on September 15, 2015, she stated that she worked as a scheduler in former physician’s clinic from approximately late 2006 to 2009. She said she was never directed to follow any improper practices by former physician 3. When asked if he directed any inappropriate practices to manipulate wait times, she replied, “He

had no clue about any of that.” She further stated that former physician 3 had very little involvement in the scheduling process.

Records Reviewed

VA OIG reviewed VAMC Beckley emails and identified an email string (dated November 20 and 21, 2012) that began with a message from the program analyst to former physician 3, Physical Medicine and Rehabilitation Clinic. In the email, the program analyst stated, “It has come to my attention that you have been asking the clerks to cancel appointments these past couple of days with the instructions to reschedule the patient if they show up.” The program analyst continued, “...it appears to be one of the inappropriate scheduling practices.” This email was forwarded to other VAMC Beckley managers to include (1) service chief 6, (2) nurse 2, (3) senior leader 1, (4) service chief 1, (5) senior leader 2, and (6) senior leader 3. As well, the email was forwarded to various VAMC Beckley schedulers to include (1) PSA5, (2) PSC3, and (3) MSA13.

Issue 13: Investigation Into Email Discussion About Implementing a “7-Day Therapy Rule”

Interviews Conducted

- On July 13, 2015, senior leader 3 was asked about (and provided a copy of) the email (referenced in the Records Reviewed section of this Issue) involving former physician 3 and physician 2. This email was forwarded to senior leader 3, who sent an email to VAMC Beckley senior executive staff in which she stated, “This is very concerning to me. Despite the recent meeting and distinct clarification that a treatment plan should be...based upon patient need he has now attached numerous others to the email string. I am very concerned that our veterans are not receiving what they need and deserve.” She immediately recalled the message and in a new message stated, “This is concerning to me...you should not base what a patient’s clinical needs are on meeting a certain day of deadline.” She went on to say, “You look at the clinical picture of the person and you craft a therapy plan based on what their needs are and what the goals are ...” She said she did not know if this idea originated with former physician 3 or physician 2. She said that around May 2014, former physician 3, VA employee 4, and all of the VAMC Beckley senior executive staff members met to discuss the issue. She said that the senior executive staff had told former physician 3 that the length of a patient’s care should be determined by the “clinical case.” She said she reported this issue to senior leader 2, who then spoke with former physician 3. She said this practice was never implemented at VAMC Beckley. When asked about the motivation behind the suggestion, she said there may have been a desire “to optimize on the Veterans Equitable Resource Allocation (VERA) aspect. I don’t know.”⁵ She stated that even if this had been implemented, she did not believe that former physician 3 would have personally benefited in any way. She stated that she did not think that former physician 3’s performance appraisal would have been affected in any way by the implementation of such a rule. However, she noted that management had been asking physicians to be more

⁵ VERA was the model that was used to allocate financial resources to VHA’s 21 VISNs.

engaged in their patients' treatment plans. She said she wondered if this was former physician 3's attempt to participate more in that process.

- During the August 25, 2015 interview of service chief 6, she was asked about (and provided a copy of) the aforementioned email involving former physician 3 and physician 2. She said she recalled a meeting that occurred to discuss these issues but asserted that this practice was never implemented. She said that she and former physician 3 had had disagreements about patient care issues. She stated that former physician 3 would justify his discharge of patients by saying that they had plateaued before, she felt, it was medically appropriate.
- During the interview of senior leader 1 on August 26, 2015, he was asked about (and provided a copy of) the aforementioned email involving former physician 3 and physician 2. He stated that he and others in management at VAMC Beckley had met with former physician 3 to discuss some of his actions and determine whether they were clinically appropriate. He added that during the meeting, there also had been a discussion about hospital funding. He said he did not agree with former physician 3's proposal because patients needed "varying degrees of physical rehabilitation." He said that, as a result, this practice was never implemented.
- On September 14, 2015, physician 2 stated that he currently served as the Medical Director of the Community Living Clinic, the Hospice Palliative Care Unit, Home-Based Primary Care, and the National Telephone Call Center. Physician 2 was given a copy of the aforementioned email, which involved him and former physician 3. He said there were times when upon the arrival of patients, former physician 3 would not accept a patient who had been referred to the Physical Medicine and Rehabilitation Clinic. He said this resulted in a discussion about patient care among former physician 3 and others in management at VAMC Beckley. He stated that during such a discussion, former physician 3 had brought up this question about a rule, which would mandate that a patient receive 7 days of therapy. However, he said a 7-day therapy rule was never implemented because a patient's health condition determined how long the patient needed to receive treatment. He said he felt that former physician 3 misunderstood the point that management was trying to convey during this meeting. He said he had not observed any actions on the part of former physician 3 to be in conflict with VA regulations.

Records Reviewed

VA OIG reviewed VAMC Beckley employee emails and identified an email (dated June 13, 2014) in which former physician 3, Physical Medicine and Rehabilitation Clinic, said that he and physician 2 had discussed having a "7-day therapy rule," which would require patients to receive treatment for 7 consecutive days. This practice would have resulted in a larger reimbursement for the facility. In the email, former physician 3 stated that this idea originated with physician 2. Former physician 3 further stated, "I maintain that we need to use clinical criteria to determine if the patients are ready for discharge."

Issue 14: Investigation Into Allegation That Schedulers Placed Documentation in a Drawer and Delayed the Processing of Consultations

Interviews Conducted

- During the interview of PSA1 on July 10, 2014, he alleged that MSA3 was not immediately scheduling consultations and instead would place the paperwork in a drawer. He said, “[MSA3] was being instructed to not complete the orders or schedule the veterans...and lock their orders into a drawer.” He said physician 6 directed MSA3 to follow this practice. He said physician 6 and MSA3 would take time to discuss the pending consultations and MSA3 would schedule the veterans only after this discussion had taken place. He said he felt that this resulted in a delay in the processing of the paperwork. He stated that MSA12 was occasionally asked to schedule for physician 6 and that she was also aware of this practice. He stated that MSA12 told him that she “wasn’t even allowed to schedule...because there was a drawer full of people that needed to be scheduled and she couldn’t just throw somebody in over top of them.” He also stated that he had overheard MSA20 telling another coworker (NFI) that her supervisors directed her to “sit on certain compensation paperwork and not... get it scheduled.” He said he recalled MSA20 disclosing that schedulers in the Compensation and Pension Clinic placed consultations in a drawer and delayed the processing of the paperwork. He said he wondered if the purpose of this practice was to space out appointments so the clinic did not appear to be overwhelmed.
- On July 15, 2014, MSA20 said she had never placed consultations in a drawer and she had never delayed their processing. She said she was not aware of any VAMC Beckley clinics following this practice. She said she received requests for Compensation and Pension examinations each morning from the VA Regional Office (VARO) in Huntington, WV. The paperwork for one veteran often would include requests for examinations from more than one clinic. She stated that she would schedule appointments for the veteran in each of the requested clinics. She said she was required to schedule these appointments immediately because Compensation and Pension examinations must be returned to VARO Huntington within 30 days.
- During the interview of MSA8 on July 15, 2014, she stated that she worked as a scheduler in the Specialty Clinics around 2010. She stated that she knew schedulers in these clinics placed consultations in a drawer. She said that when a scheduler received a consultation, he or she placed a note in VistA, which alerted the physician that a consultation had been received and that an appointment needed to be scheduled. She stated that consultations were placed in a drawer only after this note had been entered in VistA. She said the scheduler could not make an appointment until they received guidance from the physician. She stated that the paper consultations were maintained in a drawer and reviewed daily until a response had been received from the physician. She said she recalled instances when she did not receive a response from the physician for several weeks. In these cases, she said she would approach the physician or a nurse to inquire about scheduling the appointment. She said she was not aware of any instances in which a consultation had never been scheduled. She said this practice was improper because some patients had to wait weeks or months for an appointment.

- During the interview of MSA12 on July 16, 2014, she explained that consultations were maintained electronically. She said she had never placed consultations in a drawer or delayed their processing. She added that she did not know of any employees who might have done this.
- During the interview of supervisory employee 1 on July 17, 2014, she explained that consultations were to be acted on within 7 days of receipt. She stated that consultations were tracked in VistA but that she also kept physical copies of the consultations in a drawer until the patient had been scheduled. She said these paper copies served as a reminder that the appointment had not yet been scheduled. She stated that once the appointment had been scheduled, she would shred the paper copy of the consultation. She also explained that a scheduler could never cancel a consultation but could discontinue a consultation. In this case, the provider would receive an electronic notification recording the action. She stated that the placing of the paper consultation in a drawer had never resulted in the delay of a consultation. She insisted she had never intentionally delayed the processing of a consultation and had no knowledge of other schedulers who might have done this.
- During the interview SMAS2 on July 17, 2014, he said he knew some schedulers were placing consultations in a drawer. However, he stated that he was not aware of this practice being followed for the purpose of hiding consultations or delaying their processing. He said that schedulers placed a hard copy of the consultation in a drawer only while waiting for the physician to review the order and give the scheduler permission to schedule the appointment.
- During the interview of MSA13 on July 22, 2014, she described the consultation process. She said that all consultations were reviewed by the receiving physician. She stated that physical copies of the consultations were kept in a folder that was maintained in a drawer because physicians often liked to review the paper copy of the consultation. She said this practice was not followed to hide consultations or delay their processing. She added that consultations were all maintained electronically in VistA and that schedulers ran daily consultation reports to monitor which consultations still needed to be scheduled.
- On July 29, 2014, physician 6 stated that he had not directed schedulers to keep consultations in a drawer. He said that he had no knowledge of consultations being maintained in drawers in any clinic at VAMC Beckley.
- During the interview of MSA4 on March 31, 2015, he said he worked as a scheduler from 2012 to 2013. He indicated that at the time of this interview, he had plans to return to a scheduling position in about 1 month. He said he knew schedulers kept consultations in drawers. However, he said that if the paper consultation were ever lost, this would not affect the scheduling of that patient because this information was maintained electronically in VistA.
- During the interview of administrative employee 1 on May 6, 2015, he stated that around 2013, he found that there were between 20 and 25 physical therapy consultations that had not been acted on within the required 7-day time frame. He said he found that the

consultations had been placed in a folder and set on a printer. He stated that he had approached the schedulers (NFI) in this clinic to share his concerns. He said, “It was a practice that I have not seen happen since.” He was given a copy of an email from him to senior leader 2 and VA employee 5, dated March 25, 2013. In the email, administrative employee 1 stated, “Looks like we have more than 22 out pass 5 years. Some of these patients are deceased.” He immediately recalled this email and stated that these were instances in which patients had requested that one of their previous consultations be reopened. He said these patients had not waited 5 years for care. Instead, the consultations still included the original consultation request date. He indicated that this practice had since changed and consultations could not be reopened. He stated that providers were now required to create a new consultation.

- During the May 13, 2015 interview of senior leader 2, he was shown a copy of the email referenced above from administrative employee 1 to him and VA employee 5. He said that in cases when patients died, this resulted in the consultation “never being realized.” In other cases, it meant the providers had completed the consultation but the consultation was not closed as it should have been, for some reason.
- During the July 15, 2015, interview of service chief 1, he was asked about his knowledge of VAMC Beckley employees delaying the processing of consultations. He stated that approximately 15 years ago, former employee 3 was caught with “a whole drawer full of consults.” He stated that this led to patient care being delayed. He said that, at the time, there was no scheduling directive and that he knew that former employee 3 retired soon after this incident. He said he had no knowledge of any other employees who had placed consultations in a drawer or delayed their processing.
- During the interview of senior leader 1 on August 26, 2015, he stated that consultations were to be acted upon within 7 days of receipt. He said there had been rare instances when it was discovered that VAMC Beckley employees had placed consultations in a drawer, leading to a delay in the processing of this paperwork. However, he stated that he could not recall any specific examples. He recalled an isolated incident when MSA20 got behind on “text orders,” which he defined as orders received from physicians. He stated that MSA20 worked additional hours to catch up and that this issue was resolved.
- During the interview of MSA5 on September 15, 2015, she stated that she took 1 week’s leave around August 2013. She said, during that time, no one scheduled consultations in the Urology Clinic. She explained that these consultations were not scheduled because “nobody bothered to provide any sort of coverage.” She said this had delayed patient care by at least one week. She stated that as soon as she returned from leave, she had scheduled these consultations. Aside from this instance, she said she was not aware of anyone placing consultations in a drawer or delaying their processing.

Issue 15: Investigation Into Allegation That Physicians Were Discontinuing Consultations Without Examining Patients, Which Resulted in Patient Care Delays

Interviews Conducted

- On March 30, 2015, nurse practitioner 1 relayed concerns about delays in the processing of consultations at VAMC Beckley. She stated that she often sent “E-Consults,” which were a formal request for a physician to examine a patient, to Specialty Clinics. She added that in many instances, she was asked to conduct further testing on the patient before a physician would agree to an examination. She said there had been instances when the physician had sent a consultation back to her two or three times. She stated that in each of these instances, the physician would ask her to conduct further testing before he or she would agree to examine the patient. She said she regularly experienced these problems when sending consultations to physician 3, a urologist. She said she believed that physician 3 did not want to do the work that was required of him and that this contributed to the fact that Primary Care staff was overwhelmed. She stated that physician 3’s actions delayed the processing of consultations and ultimately delayed patient care.
- On May 5, 2015, administrative employee 3 said he had noticed some patient care issues in the Urology Clinic at VAMC Beckley. He said that physician 3 saw approximately six patients per day—fewer than any other physician. He also said that physician 3 continually canceled patient consultations. He stated that physician 3 justified this by pretending that the patient needed to have a specific diagnostic test completed before he would agree to examine the patient. He said that physician 6 and nurse practitioner 1 had expressed concerns about the fact that physician 3 continually canceled patient consultations.
- During the interview of senior leader 2 on May 13, 2015, he was asked if he has knowledge of any VAMC Beckley employees having delayed the processing of consultations. He said physician 3 regularly discontinued consultations that he received from Primary Care physicians. He stated that physician 3 justified this action by pretending that the Primary Care physician needed to complete additional tests before physician 3 would agree to see the patient. He said this delayed the processing of consultations and it delayed patient care. He stated that he did not believe physician 3 had malicious intent but instead took this action for the purpose of “self-protection,” “workload protection,” and a desire to “control the process.” He said he believed this was a way for physician 3 to decrease his workload. He said physicians were technically allowed to discontinue consultations as long as they provided justification for this action.
- On July 14, 2015, physician 3 said he often had to return consultations to Primary Care physicians because additional tests were required before he could conduct the examination of a patient. He said some physicians were reluctant to order certain tests until he instructed them to do so. He said physicians could view the Urology Consultation Package, where he has listed the most common urologic conditions and the tests that needed for those conditions. He stated that if a physician did not complete one

of the listed tests, he would ask the physician to do so and resubmit the consultation once the test had been completed. He stated that this did not adversely affect patients. He also stated that this did not delay patient care.

- During the interview of service chief 1 on July 15, 2015, he stated that he had received complaints regarding physician 3 sending consultations back to Primary Care physicians under the pretense that the patient required further testing before he could conduct an examination. He stated that he knew this aggravated Primary Care physicians but that physician 3 was still “making a medical call.” He said physician 3 was “dispositioning the consults in accordance with the directive to my knowledge.”

Issue 16: Investigation Into Allegation That Management Prohibited Schedulers From Using the EWL

Interviews Conducted

- During the interview of PSA1 on July 10, 2014, he alleged that schedulers were prohibited from using the EWL. He stated, “They will not put anybody on an EWL here. Somebody shows up on that EWL, somebody’s coming to my office to talk to me about it.” He said he thought he was given this direction by SMAS1, service chief 1, or the program analyst.
- During the interview of CS-59 on July 14, 2014, CS-59 stated that VAMC Beckley only used the EWL for the Specialty Clinics. CS-59 added that other VAMC Beckley clinics did not use the EWL.
- During the interview of MSA8 on July 15, 2014, she claimed that there had been Primary Care patients on the EWL approximately 8 years before this interview. She stated that she had been tasked with contacting these patients to schedule appointments for them. She said that after completing this task, she was told that schedulers should no longer use the EWL. She said she could not recall who had provided this guidance. She said she did not believe Primary Care had used the EWL since that time. She explained that when a Primary Care scheduler had difficulty making an appointment for a patient, he or she would make sure the patient was seen in the Emergency Department; alternatively, the scheduler would schedule an appointment with a nurse for the patient.
- During the interview of PSC1 on July 15, 2014, he alleged that management prohibited schedulers from using the EWL. He said he recalled a time between 2009 and 2011 when schedulers in HBPC placed patients on the EWL and he had been directed by telephone to remove the patients from the EWL. He could not recall who provided this guidance but thought it might have come from senior leader 3. He said that at the time, the understanding was that HBPC patients should not be placed on the EWL. He said he had received this guidance from nurse 3.
- During the interview of MSA11 on July 15, 2014, he said that he had been told not to use the EWL by MSA14 and also probably by PSC2. As a result, he said he had never used the EWL.

- During the interview of supervisory employee 1 on July 17, 2014, she reported that she had never heard anyone in management prohibiting schedulers from using the EWL. She stated that former service chief 1 had instructed her to use the EWL when necessary. She said she only recalled placing about two patients on the EWL during her employment at VAMC Beckley. She said she rarely needed to use the EWL because she had generally been able to get patients scheduled in the clinics where she worked.
- During the interview of SMAS2 on July 17, 2014, he stated that he had never heard anyone in management prohibiting schedulers from using the EWL. However, he said, “It’s obviously frowned upon to have patients on the wait list” because this reflected negatively on the facility. He said he recalled an instance when some patients could not be scheduled so service chief 1 had directed VAMC Beckley employees to place these patients on the EWL. He did not provide more details on the subject.
- During the interview of MSA13 on July 22, 2014, she stated that she last used the EWL around 2007. She said the use of the EWL was discouraged at VAMC Beckley and that someone had told her, “We don’t have that anymore, no electronic wait list.” She said she thought she had received this instruction from former service chief 1. She stated that she believed they had not needed to use the EWL because when the clinic had no availability, the facility would pay for the veteran to see a private physician.
- During the interviews of MSA14 on July 23, 2014 and March 31, 2015, he stated that the EWL was for patients who could not be scheduled for an appointment within 90 days. He recalled being told that “it wasn’t a good thing” for patients to be placed on the EWL because this information will be relayed to officials at the VISN level. However, he stated that he had never been prohibited from using the EWL. He said employees could overbook the appointment schedule to allow patients who were unable to obtain an appointment within 90 days to see a physician. He said this was generally how he would go about resolving these issues. He said, “I don’t care about wait times. I care about doing it correctly.”
- During the interview of former MSA1 on July 24, 2014, she stated that VAMC Beckley management had discouraged the use of the EWL. She stated that at one time, she had placed patients on the EWL and that service chief 1 and others in VAMC Beckley management (NFI) “wanted me to get my wait list cleared.” She said that rather than waiting for openings in the schedule, service chief 1 had told her to, “Ask the doctor if you can overbook” the patients.
- On July 24, 2014, an information technology specialist was asked about the EWL; she stated, “I was basically told never have an electronic waiting list.” She said she could not recall who had instructed her never to use the EWL. She said that during her time as a scheduler at VAMC Beckley, she never needed to use the EWL because the clinic always had availability.
- During the interview of physician 6 on July 29, 2014, he said the use of the EWL was “frowned upon” by VAMC Beckley management because they did not want to see

patients waiting for appointments for long periods of time. He reportedly had no knowledge of VAMC Beckley management prohibiting the use of the EWL.

- During the interview of PSC3 on March 31, 2015, she stated that former service chief 1 and possibly former employee 2 told her she was prohibited from using the EWL in approximately 2007. She stated that instead of placing patients on the EWL, “they were sourcing people out or something.” She stated that this guidance had since changed and now schedulers were allowed to use the EWL if necessary.
- During the May 7, 2015 interview of SMAS1, she was provided a copy of an email from senior leader 1 to VAMC Beckley schedulers, dated April 28, 2009. In the email, senior leader 1 told the schedulers, “I realize that other services are pushing to keep from having an electronic wait list. So if you’re approached by anyone else asking you to do something outside of the directive show them this email and direct them to [former service chief 1], [SMAS1], or myself.” SMAS1 said she could not recall the context of this email. She stated, “I don’t know what he’s referring to” when senior leader 1 mentioned “other services.”
- During the interview of the program analyst on May 7, 2015, he stated that guidance came out “doing away with the EWL” around 2008. He said that several years ago, the EWL was implemented again, adding that since this time, he had never heard anyone prohibiting schedulers from using the EWL.
- During the interview of senior leader 2 on May 13, 2015, he said that he was not aware of anyone prohibiting the use of the EWL. He said management may have said, “We’d rather not have a wait list.” He stated that in doing so, management was telling physicians, “Please see patients a bit more rapidly and be more efficient.”
- During the interview of service chief 1 on July 15, 2015, he stated that he had never heard of anyone at VAMC Beckley prohibiting the use of the EWL. He further stated that he had never provided this instruction to schedulers.
- During the interview of PSC4 on August 24, 2015, he said he had received conflicting guidance from his peers concerning the use of the EWL. He stated that some of his peers had told him that he was allowed to use the EWL and others had told him the use of the EWL was prohibited. However, he said he had never received guidance from VAMC Beckley management indicating that the use of the EWL was prohibited.
- During the interview of MSA16 on August 25, 2015, she stated that she had been told by her peers during on-the-job training when she first worked as a scheduler at VAMC Beckley never to use the EWL. However, she stated that approximately 2 years ago, she was told that this guidance had changed and that patients could be placed on the EWL if necessary.
- During the interview of senior leader 1 on August 26, 2015, he stated that guidance had been issued by former director 1 around 2004, namely, never to use the EWL. VA OIG gave senior leader 1 a copy of the aforementioned email (dated April 28, 2009) in which

senior leader 1 told schedulers, “I realize that other services are pushing to keep from having an EWL so if you’re approached by anyone else asking you to do something outside of the directive show them this email and direct them to [former service chief 1], [SMAS1] or myself”. He said he did not specifically recall this email and did not know if this guidance was provided by one individual. He remarked that he obviously had concerns that some providers might be giving improper guidance to schedulers and that he wanted to make sure everyone was following the directive. VA OIG gave senior leader 1 an email that he had sent to service chief 2, VAMC Fayetteville, (dated May 21, 2013) in which he stated, “I think we need to clarify VISN 6 does not allow EWLs. That’s not exactly correct. They may not want veterans on the EWL right now because of access numbers but there’s not a prohibition on the legitimate use of the EWL.” He claimed not to remember the circumstances surrounding the email but knew there had never been direction from VISN 6 that prohibited the use of the EWL.

- During the interview of MSA18 on September 15, 2015, he stated that he had been told by other schedulers when he was hired in 2011 that he was never to use the EWL. He further stated that he had recently been told that the EWL was available for use if necessary.
- During the interview of former director 2 on September 16, 2015, she stated that she was not aware of any direction from VAMC Beckley management prohibiting the use of the EWL. However, she said that around 2009 or 2010, “they didn’t have an electronic wait list available” for patients in the HBPC program. She said she thought the reason for this was because “...those patients are enrolled in Primary Care. It’s not that they’re waiting for the Home-Based Primary Care without getting services.” She said she thought this decision was reversed around 2011 or 2012 when it was later determined that patients who were waiting for care in the HBPC Program should be included on the EWL.
- During the interview of the VISN senior leader conducted on April 20, 2016, he said he had no knowledge of VAMC Beckley management directing schedulers never to use the EWL. He said that, to his knowledge, the EWL should be available to schedulers in all clinics at VAMC Beckley if they needed to use it.

Issue 17: Investigation Into Allegation That Employees in the HBPC Program Maintained a List of Patients Waiting for Care

Interviews Conducted

- On July 15, 2014, PSC1 stated that he worked in HBPC from approximately 2008 to early 2012. He explained that around 2008, the HBPC Program reached maximum capacity and the Joint Commission informed HBPC management that there were too many patients in the program. As a result, HBPC discharged 29 patients from the program; they were then placed on the EWL by nurse 3 and PSC1. He stated that around 2009, someone from the director’s office at VAMC Beckley, possibly senior leader 3, had instructed him and nurse 3 to stop using the EWL. He said he was directed to remove the patients from the EWL and place their names on a spreadsheet that he titled “HBPC.” He stated that when a consultation was received for a patient, the information

on that consultation was entered on the HBPC spreadsheet. He said the patients listed on the spreadsheet were prioritized based on their varying degrees of urgency. He explained that if a consultation were received for a terminal patient, that patient would be given priority over other patients. He said that another spreadsheet was created that listed all patients who had been admitted to the program. He stated that when a space in the program opened, a patient's name would be removed from the HBPC spreadsheet, which listed the waiting patients' names, and placed on the spreadsheet that listed the names of all of the admitted patients. He said the HBPC spreadsheets were maintained on the HBPC drive where only HBPC employees could access them. He said nurse 3 used the spreadsheet regularly. He said the following employees likely had knowledge of the spreadsheet: (1) administrative employee 2, (2) social worker 3, and (3) RN3. He stated that around the time he left HBPC, scheduler 1 started working as a scheduler in HBPC. He said he knew that scheduler 1, who had since passed away, relied on this spreadsheet when he worked in HBPC. He claimed that he did not know anyone else in HBPC who would have had any reason to view this spreadsheet. He stated that when he left HBPC around June 2012, the HBPC spreadsheet was still being used. He said he wondered whether HBPC was instructed to remove patients from the EWL in an attempt to hide wait-time data from VISN officials.

- On July 16, 2014, social worker 3 stated that from approximately August 2007 through August 2011, she worked in HBPC at VAMC Beckley. She said her duties within HBPC consisted of scheduling visitations to patients' residences. She said she did not believe HBPC ever used the EWL and recalled that patient "loads" were managed using calendars that were stored on a shared network drive.
- On July 22, 2014, administrative employee 2 said the HBPC clinic had used various methods to track patients. She stated that from approximately January 2010 through October 2012, the names of patients waiting to receive care were listed on a spreadsheet that was saved on an access drive for HBPC employees to view and edit. She stated that in late 2012, HBPC started using the EWL. She said that at the time of this interview, no patients were on HBPC's EWL. She stated that she did not know what method was used before January 2010. She said PSC1 helped create and maintain the spreadsheet on the access drive. She located copies of several HBPC spreadsheets, which she provided to the interviewers. She stated that former scheduler 3 assisted with transferring the names of the patients from the spreadsheet located on the access drive to the EWL (NFI). She stated that she erased the spreadsheets on the access drive when HBPC started using the EWL because they were no longer needed and the access drive was becoming cluttered.
- On July 29, 2014, senior leader 3 stated that when she started her employment with VAMC Beckley in 2008, between 80 and 100 patients were enrolled in the HBPC Program and approximately 5 or 6 veterans' names were on the EWL. She said she had a conversation with senior leader 1 around 2009 or 2010 during which they discussed the fact that HBPC should be using the EWL if necessary. She stated that she had not directed HBPC employees to remove individuals from the EWL and place their names on a spreadsheet. She said she did not know HBPC was using a spreadsheet to track those individuals who were waiting for care. She stated that around 2011 or 2012, she had received an email from VISN employee 2 in which HBPC was directed to start using the

EWL. She said she believed the email had been sent to VISN employee 2 by a VACO employee.

- On April 1, 2015, physician 2 stated that he initiated the HBPC Program in 2007 and that he started seeing patients in this program in early 2008. He said he worked in HBPC with (1) former service chief 4, (2) nurse practitioner 3; (3) scheduler 2; (4) social worker 3, and (5) nurse 4. He stated that former service chief 4 left the program and nurse 3 started working in HBPC. He said the HBPC Program could only accommodate approximately 100 to 120 patients; however, during the time that he worked in HBPC, the program was never nearing capacity. He stated that at the time he left HBPC, approximately 70 or 80 patients were enrolled in the program; as a result, there was no need for the program to maintain a list of patients waiting for care. He said a list of admitted HBPC patients was maintained electronically but he had no knowledge of HBPC ever maintaining a list of patients waiting for care. He said the plan was to hire more staff if the total patients in the HBPC program ever reached capacity. He said he eventually left the program after unresolvable issues arose between him and nurse 3. He said he did not know if HBPC ever reached capacity after he had left the program. He said that during the time he worked in HBPC, he was unaware of the existence of the EWL and did not know if HBPC ever used the EWL.
- During the interview of service chief 1 on September 15, 2015, he stated that he did not know that the HBPC program maintained a list of patients waiting for care. Service chief 1 said he thought the HBPC Clinic was excluded from the scheduling directive because "...that program didn't function with scheduling the same way everything else did." He also said, "I don't really know how they were keeping track of patients."
- During the interview of former director 2 on September 16, 2015, she stated that she believed that HBPC Programs at all VA facilities were not using the EWL for a time. She said, "I think when they first implemented Home-Based Primary Care they didn't have an electronic wait list available for them." She said she thought this guidance came out around 2009 or 2010 and the reason for this was because "...those patients are enrolled in Primary Care. It's not that they're waiting for the Home-Based Primary Care without getting services." She said, "...when you're looking at the EWL...you're looking at people that are sitting there waiting on care and the people that are referred for Home-Based Primary Care aren't sitting waiting on care. They're waiting for care in a different setting, in their home rather than in the facility." She said she thought this decision was reversed around 2011 or 2012, when it was later determined that patients waiting for care in the HBPC Program should have their names placed on the EWL. When asked about the HBPC spreadsheet, she said this was likely being used during the time that the HBPC Program was not allowed to use the EWL. She said they were keeping track of patients through this spreadsheet because "they didn't want to lose those referrals." She said, "They were supposed to shred and do away with the spreadsheet, yes."
- During the interview of the VISN senior leader conducted on April 20, 2016, he claimed having no knowledge of HBPC employees maintaining a list of patients waiting for care.

He said he believed the EWL had always been available to schedulers in all clinics at VAMC Beckley, if they needed to use it.

Issue 18: Investigation Into Allegation That Some VAMC Beckley Employees Maintained Unofficial Waiting Lists

Interviews Conducted

- During the interview of service chief 1 on July 15, 2015, he stated that, around 2005, he heard that VAMC Beckley's Optometry Clinic maintained an unofficial patient wait list that former service chief 1 had discovered. However, service chief 1 said he had never seen the list.
- During the interview of senior leader 1 on August 26, 2015, he claimed that, around 2004, former MSA4 maintained a list of patients waiting for care. He stated that when a physician in the Eye Clinic (NFI) unexpectedly left his or her position, the physician's future appointments were canceled. He stated that former MSA4 maintained a list of roughly 1,400 patients whose appointments were canceled. He said when management discovered the list, former MSA4 received disciplinary action and all of the patients were scheduled for appointments with private physicians. However, he said these patients might have had to wait "a few months" for these appointments. He said he knew that former MSA4's intention was never to manipulate wait times, adding that former MSA4 did not know what to do with these patients.
- During the interview of former director 2 on September 16, 2015, she stated that "several years ago" management discovered that one clinic, possibly the Radiology Clinic, was maintaining a list with the names of patients waiting for care. She said management told those responsible "...you can't do that. You have to have them in the Electronic Wait List." She said this discovery led to management visiting each clinic to find out if any others were maintaining unofficial wait lists. She said, "I don't think they found any others." She added that senior leader 1 had always told HAS employees they should never maintain unofficial wait lists.

Issue 19: Investigation Into Email in Which Service Chief 3 Mentioned Placing the Names of Mental Health Clinic Patients on a List

Interviews Conducted

- On May 5, 2015, service chief 3 said that social worker 2 was in the process of transferring to another position at VAMC Beckley. She stated that social worker 2 provided her with a handwritten list of her patients because they needed to be reassigned to new providers. She said social worker 2 had met with each of her patients to discuss their future treatment options. She said some of the patients reportedly did not want any further treatment and others said they wanted to be reassigned to a new provider. She stated that the patients who asked to be reassigned were contacted by social workers in the Mental Health Clinic; if the patient requested an appointment during that telephone call, the social worker transferred the patient to a scheduler to make the appointment.

She said she believed that all of the patients who expressed to social worker 2 that they wanted to continue treatment were contacted. She explained that for the patients who told social worker 2 they did not want any further treatment, she was directed to clearly document that in the patient's record. She said she was not aware of any patients who requested an appointment but were never scheduled. She stated that she provided a list containing the names of social worker 2's patients to social worker 4, whom she had asked to oversee the reassignments. She said she believed all of the patients who wanted care were scheduled with a new provider within 30 days. She said, "...it wasn't any kind of formal list around people waiting" and "...using the term 'list' implied something that it wasn't intended to imply." She said she believed that social worker 2 had already drafted the list before receiving this email from service chief 1.

- During the July 15, 2015 interview of service chief 1, he was asked about (and provided copies of) the emails (referenced in the Records Reviewed section of this Issue). He stated that because social worker 2 was leaving the Mental Health Clinic, her patients had to be transferred to a new provider. He said he told MSA12 to continue to schedule patients because they could be transferred to a new clinic at a later date, if necessary. He said he provided this instruction because he wanted to ensure those patients would receive care. He declared that he did not believe there were any patients harmed or negatively affected as a result of this situation.
- During the August 26, 2015 interview of senior leader 1, he was asked about (and provided copies of) the emails referenced above. When asked if he recalled this incident, senior leader 1 said, "Vaguely." He said service chief 3 was counseled about this issue right after management had become aware of her instruction. He said, "To my knowledge, our clerks never adhered to any of her guidance."

Records Reviewed

VA OIG reviewed VAMC Beckley employee emails and identified an email (dated February 10, 2014) in which service chief 3 told MSA12, "No more patients are to be rescheduled with [social worker 2] for any reason. Anyone who calls or is contacted about cancelling an appointment should be told that we are not able to reschedule at this time. Then, a list should be maintained of all these patients so we can call them all once we have a more firm plan." This email was forwarded to service chief 1, who sent a reply message to service chief 3 on that same date and in which he stated, "...under NO circumstances will we ever tell patients we cannot schedule them and write them down on a list. That is forbidden by numerous directives..."

Issue 20: Investigation Into Allegation That Mental Health Clinic Providers Had Canceled Large Numbers of Patients for the Purpose of Participating in Union Activities

Interviews Conducted

- On April 1, 2015, CS-57 alleged that specialist 1 and nurse practitioner 2 regularly canceled patient appointments for the purpose of participating in union activities. CS-57

provided a list of recent cancellations in specialist 1's clinic and in nurse practitioner 2's clinic for the period of October 1, 2014 through March 24, 2015.

- On April 2, 2015, administrative employee 6 stated that she had heard rumors that specialist 1 and possibly nurse practitioner 2 were regularly canceling patients' appointments for the purpose of participating in union activities. She said administrative employee 1 showed her documentation that indicated that they had canceled the same patients "...six, seven, eight times in a row," which she believed negatively affected patient care. She alleged that specialist 1 and possibly nurse practitioner 2 had marked these cancellations as "Canceled by Patient" when they should have been marked "Canceled by Clinic." She stated that she arrived at this conclusion after noticing patients whose appointments were marked as "Canceled by Patient" on a date that a union activity occurred.
- On April 2, 2015, service chief 3 said specialist 1 and nurse practitioner 2 had official roles within the American Federation of Government Employees (AFGE) union. As a result, they were allowed to spend a certain number of working hours participating in union activities. She said this caused issues with continuity and quality of care because she often received short notice of their need to participate in union activities. She stated that if patient appointments were scheduled during the time of a union activity, the appointments were canceled. She said she has discussed the matter with senior leader 3 and senior leader 1, who told her that she must allow specialist 1 and nurse practitioner 2 to fulfill their union duties. She said she recalled a time when she had declined a request to allow nurse practitioner 2 to participate in a union activity because the latter had given very short notice. At the time, she explained that nurse practitioner 2 had been able to rearrange some of her patients' schedules so she could participate in the union activity. She said she also recalled receiving a letter from a veteran who was "complaining that [specialist 1] cares more about the union than he cares about...his veterans." She claimed having no knowledge of the documentation used by schedulers to record in VistA that an appointment had been canceled. She said when an appointment had to be canceled because of a conflict with a union activity, there often was some discussion in emails exchanged between providers and VAMC Beckley management. She said she believed the vast majority of specialist 1's cancellations resulted from his participation in union activities. She said nurse practitioner 2 recently had some cancellations resulting from her participation in union activities but she also had health issues that required her to take quite a bit of sick leave. She said that also contributed to the large number of the patient cancellations in the clinic.

When reinterviewed, service chief 3 said she believed all of the cancellations initiated by specialist 1 and nurse practitioner 2 for the purpose of participating in union activities were marked in VistA as "Canceled by Clinic." She said she was not aware of anyone labeling these cancellations as "Canceled by Patient."

- On May 4, 2015, MSA21, Mental Health Clinic, was asked about the frequency of cancellations initiated by specialist 1 and nurse practitioner 2. He said he had heard rumors about the fact that these cancellations were due to the providers' participation in union activities. He said when he was directed to cancel an appointment, he would often

enter a comment in VistA with additional information concerning the reason for the cancellation. However, he said, “We don’t put union duties in because they don’t tell us that.” He stated he would write “provider leave” or “provider out.”

- On May 5, 2015, supervisory employee 2, Mental Health Clinic, said some of the cancellations in specialist 1’s clinic were due to his participation in union activities because specialist 1 was authorized at least one and a half days for union duties each week. She said former director 2 approved all requests from employees for time off for the purpose of participating in union activities and she knew that former director 2 had approved requests for both specialist 1 and nurse practitioner 2. She said nurse practitioner 2’s cancellations might have been related to her participation in union activities but also to sick leave she recently had to take because of a health issue. She said specialist 1’s absence from work for the purpose of participating in union activities had affected patient access. However, she said she did not feel that patients were harmed as a result of the cancellations because they always rescheduled the appointment. She said they made every effort to get the patient seen on the same day but were not always successful. She said patient appointments could be booked many months in advance. If union obligations arose, the clinic would have to cancel the appointment. She said that if an appointment was canceled because a provider’s need to participate in union activities, it was marked as “Canceled by Clinic.” She stated she had no knowledge of these cancellations ever being marked as “Canceled by Patient.”
- On May 5, 2015, service chief 7 said the AFGE Master Agreement provided guidance concerning the number of hours union officials could dedicate to union activities during their normal working hours. (He explained that 4.25 times the number of bargaining unit employees equaled the total number of hours per year available to union officials at VAMC Beckley. All hours that union officials spend conducting union activities throughout the year were deducted from the total amount of available union hours. He said an additional 25 percent was added to the total number of hours for union duties to cover time available to the employees at the CBOC in Greenbrier County. Using this formula, there were approximately 3,666 total hours allotted for union activities at VAMC Beckley. He stated that union official 1 was allowed to devote 100 percent of her time to union duties. This constituted approximately 2,087 hours per year, which was deducted from the total amount of available union hours for the year. He said specialist 1 served as the Union Vice President, which allowed him to utilize 40 percent of his scheduled time for VA union duties.) He explained that union hours were difficult to monitor partly because Human Resources was understaffed. He said supervisors of VA union officials had the authority to approve hours dedicated to official union duties. He stated that it may be the responsibility of Human Resources or VA supervisors to monitor hours dedicated to union activities.
- During the interview of administrative employee 1 on May 6, 2015, he said that while reviewing VAMC Beckley’s statistical data, he noticed a large number of cancellations in specialist 1’s clinic and in nurse practitioner 2’s clinic. He stated that when he reviewed the notes made in VistA by schedulers, he found that many appointments were canceled to allow the providers to participate in union activities. He said specialist 1’s clinic had large numbers of cancellations dating back to 2011 or 2012. He also said that nurse

practitioner 2's clinic had large numbers of cancellations dating back to approximately January or February 2014. He said nurse practitioner 2 also took quite a bit of sick leave, which might have contributed to the large number of cancellations in her clinic. He stated that once he had discovered the issue, he had sent an email about it to senior leader 1, senior leader 3, and service chief 3. He said some of the appointments were canceled close to the appointment date and others were canceled well in advance. When asked if he had reason to believe any patients were canceled and never rebooked, he replied, "probably ... it's possible." However, he could not provide any specific examples.

- During the May 6, 2015 interview of senior leader 3, she was asked about the large number of canceled appointments in specialist 1's clinic and nurse practitioner 2's clinic. She said specialist 1 and nurse practitioner 2 had recently been participating in meetings scheduled to renegotiate the union's Local Supplement Agreement but these meetings had been scheduled well in advance. She said specialist 1 was also on the VISN Labor Management Forum Committee. She stated that on a couple of occasions, specialist 1 had patients scheduled during a week that he had planned to travel. This resulted in these appointments having to be canceled. She said union hours should be tracked by supervisors and Human Resources. She provided the official union time sheets for FY 2012 and FY 2013. She stated that to her knowledge, specialist 1 and nurse practitioner 2 were following the regulations described in the union's Master Agreement, which allowed union officials a certain number of hours to participate in union activities. She said, "There are cancellations that occur ... I don't know that they're in excess." She stated that she had never seen the list of cancellations for nurse practitioner 2 and specialist 1. She stated that nurse practitioner 2 HAD said, "They're telling me I have too many cancellations but...I have seen all of my patients. I don't have an excess number of cancellations." She said service chief 3 had expressed concern about the large number of cancellations in specialist 1's clinic and in nurse practitioner 2's clinic. In response, she told service chief 3 to address these issues with those employees directly. She said she had also told service chief 3 that she could deny a request from an employee if they did not provide advance notice. She said she had also heard administrative employee 1 and senior leader 1 mention the cancellations in these clinics. She had also heard that there was confusion surrounding the issue of characterizing cancellations as "Canceled by Patient" or "Canceled by Clinic," and that management had discussed the need to reeducate some of the schedulers on this issue.
- On May 6, 2015, service chief 7 was provided copies of the official union time forms from FY 2012 and FY 2013. He said he created these documents, which contained estimates of the number of hours that VAMC Beckley employees participated in union activities. He said the official union hours had not been accurately tracked over the years and that this process needed improvement. He stated that he had received limited documentation to support the union hours listed on these forms. He added that union official 1 had told him there was an agreement between the union and VA; the agreement indicated that the hours that union official 2 dedicated to union activities would not be counted when calculating the total number of hours that VAMC Beckley employees participated in union activities. However, he said he had never seen the agreement referenced by union official 1. He said supervisors were expected to provide the exact

number of hours each union official spent participating in union activities but union official 1 suspended this count until the union agreement negotiations had been completed. A part of these negotiations involved coming to an agreement concerning the process of tracking union hours. He said he had directed supervisors to continue to track the hours because this information had to be sent to VACO annually. He said that when he visited the union office in 2012, he saw union official 2 there “100percent of the time.” He stated that he estimated that in FY 2012, VAMC Beckley union officials used approximately 500 more hours than they were allowed for official union duties. However, he said the union claimed they did not exceed their allotted hours; he did not have documentation to prove the accuracy of his own calculations. He said that if the union exceeded its allotted hours during a fiscal year, VA could grant the union additional official time.

- On May 7, 2015, administrative employee 7 claimed she knew that specialist 1 and nurse practitioner 2 had canceled appointments to participate in union activities. She said former director 2 or someone else in VAMC Beckley management approved specialist 1’s and nurse practitioner 2’s participation in union activities and this person then notified service chief 3 of the approval. She stated that each month, service chief 3 and supervisory employee 2 tracked these hours and provided this information to Human Resources. She said that at one time when she assisted with the tracking of specialist 1’s official union hours, he had set aside 2 days per week for official union duties. Consequently, his clinic was “blocked” on those days. She stated that in the past, specialist 1 had been allowed to use approximately 32 hours per month for official union duties; however, this amount had now increased to 40 hours per month. She said she never received an official time log for specialist 1 or nurse practitioner 2. She said she tracked their hours by reviewing their clinic schedules. She said nurse practitioner 2 also had hours dedicated to official union duties but she was unsure of the exact number of hours. She said that when a patient’s appointment had to be canceled, efforts were made to schedule an earlier appointment for the patient.
- On July 15, 2015, nurse practitioner 2 stated that since January 2014, her duties had included working as a union official. She said she had to take quite a bit of sick leave for a health issue, which resulted in an increase in the number of canceled appointments. She said she did not cancel the appointments herself. After she received approval from VAMC Beckley management, the appointment was canceled by a scheduler. She also stated that she had canceled appointments for the purpose of participating in union activities. She said there had been instances in which union meetings were pushed back to the last minute. Instead of rescheduling them further out, schedulers would attempt to contact the affected patients to move them to an available appointment on an earlier date. She said that she was able to give notice to management about upcoming union activities in most cases, and that there were rarely last-minute cancellations. She said she would always put the patient’s needs first. For example, she said she would see a patient during her lunch hour if she had no other availability. She said that despite her occasional need to cancel appointments, she was not aware of any patients whose needs were not met. She said she had never heard of “patients that have complained or had an issue with me not being available.” She said that per the union’s Master Agreement, union officials had hours available for the purpose of participating in union activities, which were expected

to be tracked. She said the canceling of these appointments was not a violation of the Master Agreement. To her knowledge, all appointments canceled for the purpose of allowing her to participate in union activities had been documented as “Canceled by Clinic.” However, she acknowledged having seen instances in which schedulers had used the wrong designation by mistake.

- On July 15, 2015, specialist 1 reported that several years ago, he had been a union steward, which required far less of his time. When he became vice president in December 2014, he assumed more union responsibilities. He said he would attribute the increase in cancellations to the changing of his role over the years. He said he often had to work two Saturdays per month to see more patients. When asked if there were other reasons his clinic cancellations had increased, he mentioned that they had been scheduling meetings to work on updating the local supplemental agreement, which involved participating in negotiations with VAMC Beckley management. He said there had been times when there was inadequate communication between VAMC Beckley management and his direct supervisor concerning the cancellation of appointments. He said he had to receive approval from his supervisor to participate in union activities. When asked if any patients were harmed as a result of their appointment being canceled, he said that VA outpatient 2 became upset because his appointment had been canceled on two occasions. He said, “I don’t think he was harmed at all...he was just upset that he didn’t get what he wanted exactly.” When asked if VA outpatient 2’s appointment was canceled without advance notice, he said, “Probably, but I can’t tell you exactly how close.” He said in this particular case, he had received last-minute notice of an upcoming union meeting that required his attendance. He had raised concerns about remarks being documented in VistA to explain canceled appointments so as to allow the provider to participate in union activities. He felt that this type of documentation was inappropriate. To his knowledge, all appointments canceled for the purpose of allowing him to participate in union activities had been marked as “Canceled by Clinic.” He said when these cancellations occurred, he made every effort to reschedule the patient in an earlier appointment slot.
- During the interview of service chief 1 on July 15, 2015, he acknowledged being aware that specialist 1 and nurse practitioner 2 were canceling patients for the purpose of participating in union activities. He expressed concerns about this practice but stated that he did not believe these individuals were in violation of any VA policies. He said, “I think it does impact patient care. To what degree, I couldn’t say.” To his knowledge, all appointments canceled for the purpose of allowing providers to participate in union activities had been documented as “Canceled by Clinic.”

When reinterviewed, service chief 1 said he contacted administrative employee 8 regarding the fact that VAMC Beckley schedulers were documenting providers’ participation in union activities in the remarks section in VistA. He stated that administrative employee 8 had told him it was improper for schedulers to document this information in VistA because “you’re unofficially tracking AFGE’s hours.” As a result, service chief 1 said he had instructed schedulers to stop documenting this information in VistA.

- On August 6, 2015, administrative employee 1 stated that he had never provided any direction to schedulers to document providers' participation in union activities in the remarks section in VistA. He said he believed that the practice of entering remarks in VistA to provide an explanation for canceled appointments was something that schedulers had been doing for many years.
- During the interview of senior leader 1 on August 26, 2015, he said he was aware that specialist 1 and nurse practitioner 2 were canceling patients for the purpose of participating in union activities. He said these providers were allowed a certain number of hours to participate in union activities. He said VAMC Beckley management could not dictate when that time was to be used. He said he recalled receiving patient complaints concerning specialist 1's clinic cancellations but was not aware of complaints relating to nurse practitioner 2's cancellations. He said he believed that part of specialist 1's clinic was now "blocked," which helped lower the number of canceled patients. When asked how this affected patient care, senior leader 1 said these cancellations did extend patient wait times. However, he said schedulers were expected to reschedule patients immediately. He said all of the cancellations initiated by specialist 1 and nurse practitioner 2 for the purpose of participating in union activities should have been designated as "Canceled by Clinic." He stated that schedulers were expected to give some kind of explanation as to why the appointment was being canceled. He said that dating back approximately 10 years, schedulers had been entering remarks in VistA to explain the reason for cancellations. He said he believed this was based on guidance that schedulers had received in training and staff meetings. He said he was not concerned about schedulers entering remarks in VistA explaining that an appointment was canceled so that a provider could participate in union activities. He said he felt this practice was in accordance with the instruction provided to schedulers.
- During the interview of former director 2 on September 16, 2015, she said she was aware that specialist 1 and nurse practitioner 2 were canceling patients for the purpose of participating in union activities. She said she had discussed this matter with supervisory employee 2, who stated that in these situations she always tried to get the patients rescheduled in an earlier appointment slot. She said supervisory employee 2 told her that "...usually they're rescheduled earlier or rescheduled with a different provider." She said that when she first took her position as director at VAMC Beckley, she spoke with individuals from VACO and Office of Labor Relations concerning providers canceling appointments to participate in union activities. She reportedly was told she must allow this activity and that she could hire another employee to cover these hours if necessary. However, she said, "I've told the managers...if it's not scheduled ahead of time, and you can't make accommodations then you have to say I can give you this but I can't give you that." She said there had been times when she had denied requests for providers to participate in union activities because the request was submitted with very little advance notice. She said her understanding was that this rarely affected patient care because the majority of these patients were rescheduled in an earlier appointment slot. She said she had contacted administrative employee 8 concerning the fact that VAMC Beckley schedulers were documenting providers' participation in union activities in the remarks section in VistA. She stated that administrative employee 8 had told her that this information should not be documented in VistA because it should not be part of the

clinical record. She said the union contract stated that union officials had a certain number of hours that could be used for union duties. These hours were to be tracked by supervisors and provided to Human Resources. She said she believed that these union hours were not being diligently tracked and that she was in the process of arranging more training for the service chiefs to improve this process. She said, “So do I think my official hours that are reported from here are accurate? No, but we’re working on it.”

- During the interview of the VISN senior leader conducted on April 20, 2016, he said that he had no knowledge of this specific allegation. However, he said union officials were allowed to participate in union activities but not at the expense of patient care.

Records Reviewed

Review of the cancellation records provided by CS-57 disclosed that when a patient’s appointment was canceled, schedulers often documented the reason for that cancellation in VistA. Appointment cancellation records for specialist 1’s clinic showed that a total of 278 appointments were marked as “Canceled by Clinic” and 107 appointments were designated as “Canceled by Patient.” Appointment cancellation records for nurse practitioner 2’s clinic showed that a total of 285 appointments were labeled as “Canceled by Clinic” and 143 appointments were designated as “Canceled by Patient.”

Issue 21: Investigation Into Allegation That VAMC Management Instructed Schedulers How to Respond To VA OIG Questioning

Interviews Conducted

- On April 2, 2015, CS-57 alleged that a meeting was organized by VAMC Beckley management before VA OIG arrived at VAMC Beckley, in July 2014, to discuss scheduling practices and to instruct schedulers how to respond to questioning by VA OIG agents. CS-57 said he or she had witnessed SMAS1 and PSC2 talking in a VAMC Beckley hallway about how PSA2 was to blame for the initiation of a VA OIG investigation at VAMC Beckley. CS-57 heard PSC2 tell SMAS1, “Schedulers have been instructed that they don’t have to talk to OIG. Senior leader 1 wants to meet with the key MSAs to make sure we’re on the same page.” CS-57 said that he or she separately witnessed administrative employee 6 and RN4 talking in the hallway at VAMC Beckley about the fact that VA OIG was currently conducting an investigation onsite. CS-57 said he or she heard administrative employee 6 tell RN4, “It’s a shame senior leader 1 is trying to cover his tracks by telling his employees not to talk to OIG.”
- During the interview of administrative employee 6 on April 2, 2015, she said she never made the above comment to RN4. She also said that she had no knowledge of VAMC Beckley management organizing a meeting before VA OIG arrived at the facility, in July 2014, for the express purpose of instructing schedulers on how best to respond to questioning by VA OIG agents.
- During the interview of PSC2 on May 5, 2015, he stated that he had no knowledge of a meeting being organized by VAMC Beckley management before VA OIG’s arrival at the

facility, in July 2014, for the express purpose of instructing schedulers on how best to respond to questioning by VA OIG agents.

- During the interview of administrative employee 1 on May 6, 2015, he was asked if he had heard about a meeting being organized by VAMC Beckley management before VA OIG arrived at the facility in July 2014. He said, “I had heard that, yes. Do I know if it’s true? No.” He said he thought he heard this from MSA20, MSA8, and possibly PSC2. He said he thought VAMC Beckley management organized the meeting to warn schedulers that “OIG’s coming...be careful.” However, he said he did not believe this meeting was being organized in an attempt to cover anything up at VAMC Beckley.
- During the interview of SMAS1 on May 7, 2015, she stated that she had no knowledge of a meeting being organized by VAMC Beckley management before VA OIG arrived at the facility, in July 2014, for the express purpose of instructing schedulers on how best to respond to questioning by VA OIG agents.
- During the interview of the program analyst on May 7, 2015, he stated that he had no knowledge of a meeting being organized by VAMC Beckley management before VA OIG’s arrival at the facility, in July 2014, for the express purpose of instructing schedulers on how best to respond to questioning by VA OIG agents. He said that if senior leader 1 had organized a meeting like this, he would have told schedulers to “...answer all their questions openly and honestly.”
- During the interview of senior leader 2 on May 13, 2015, he was asked if he had heard about a meeting being organized by VAMC Beckley management before VA OIG’s arrival at the facility in July 2014. He said administrative employee 1 told him a meeting had occurred but said he was not asked to participate. He stated that around this time, senior leader 1 had said that VA OIG agents were coming and “when they come...we’re all going to lose our jobs.”
- During the interview of service chief 1 on July 15, 2015, he claimed no knowledge of a meeting being organized by VAMC Beckley management before VA OIG’s arrival at the facility, in July 2014, for the express purpose of instructing schedulers on the best ways to respond to questioning by VA OIG agents. He stated he thought that if senior leader 1 had provided any guidance to schedulers concerning how to respond to VA OIG questioning, he would have said, “Tell the truth.”
- During the interview of senior leader 1 on August 26, 2015, he stated that he had no knowledge of a meeting being organized by VAMC Beckley management before VA OIG’s arrival at the facility, in July 2014, for the express purpose of instructing schedulers on the best ways to respond to questioning by VA OIG agents. When asked if he had heard this rumor, he said, “...so a few people have given me little tidbits about some of the outrageous crap that’s come through here. Yes, I’d heard that.”
- Six additional VAMC Beckley employees were questioned concerning this allegation, to include five schedulers and one supervisor. None of these individuals had any knowledge of VAMC Beckley management scheduling such a meeting.

***Issue 22: Investigation Into Allegation That PSA1 and PSA2 Knowingly Submitted
Fraudulent Enrollment Documents for Veterans Applying for VA Health Care***

Interviews Conducted

- During the interview of PSA1 on July 10, 2014, he stated that he and PSA2 had attempted to alert VAMC Beckley management since around June 2012 of their concerns about improper practices occurring at VAMC. He said they “started coming back and attacking us, “adding that they told him, “Here’s...evidence where we went and looked at what you guys are doing and we found something here where we think you were breaking the law.” He said he told them, “I didn’t break the law trying to...schedule this veteran or enroll this veteran.”
- During an interview of CS-59 on July 14, 2014, CS-59 stated that VAMC Beckley management accused PSA2 and PSA1 of encouraging veterans to provide false information on their application for VA health care. CS-59 further stated that PSA2 and PSA1 never encouraged veterans to provide false information. CS-59 stated he or she felt that service chief 1, senior leader 1, the program analyst, SMAS1, and others may have been frustrated with PSA2 and PSA1 for allowing more veterans to enroll because this likely affected access at the facility. CS-59 stated that he or she suspected that this may also have an effect on performance measures and that it could have affected VAMC Beckley employees’ bonuses.
- During an interview of CS-59 on July 23, 2014, CS-59 said that toward the end of fiscal year 2013, it was unclear whether the Rural Health Initiative would meet a performance measure, which required that they enroll a certain number of veterans in VA health care. CS-59 indicated that, in late 2013, he or she presented evidence that PSA2 and PSA1 had registered a large number of veterans. CS-59 said others could not believe they had been successful in enrolling so many veterans. CS-59 stated that PSA2 and PSA1 were accused of coercing veterans into providing information that would allow them to meet the eligibility requirements for VA health care when in reality they should not have qualified.
- During the interview of the program analyst on May 7, 2015, he stated that SMAS1 made him aware of some questionable veteran enrollments completed by PSA2 and PSA1 around March or April 2014. He said PSA2 and PSA1 “had a goal they were trying to reach of new registrations.” He said they were instances in which “a veteran would come in, give their income information and they would be rejected. Then after that, we would see PSA2 or PSA1, sometimes the same day, go back in and change the income information, dropping lower, making them eligible.” He said he recalled a meeting that had been organized to discuss one of these enrollments in which they found two applications submitted for one veteran. He said he attended the meeting with service chief 1, SMAS1, PSA2, PSA1, and specialist 4, adding, “I don’t think they were doing it to be completely fraudulent... whether intentional or not, they were inadvertently coaching some of these folks to change their income information to bring them under the cap.” He said that “Rural Health had...special appropriation for...a few years and that timeline was coming to an end, and if it wasn’t profitable for the medical center, it

wouldn't be something that in our financial situation, we could continue to support." He said, "There was a lot of anger and animosity" in the meeting.

- During the interview of SMAS1 on May 13, 2015, she claimed she had evidence of fraudulent enrollments. She stated that in April or May 2014, she was reviewing data in the enrollment system because specialist 4 had alleged there were veterans whose applications for VA health care were not being transferred to the HEC. While attempting to determine if there was a system glitch, she said she found that information on VA outpatient 1's application for VA health care had been altered. SMAS1 said she located two applications for this veteran. The first application was completed by clerk 2 in December 2013. On the application, VA outpatient 1 stated that he had paid \$4,000 in out-of-pocket non-reimbursed medical expenses the previous year. She said she found a second application completed by PSA1 approximately 45 minutes after the first one. On the second application, VA outpatient 1 claimed a total of \$7,500 in out-of-pocket non-reimbursed medical expenses. She explained that the out-of-pocket non-reimbursed medical expenses, which were deducted from the veteran's total income, could directly affect a veteran's eligibility for VA health care. (**Note:** VA OIG conducted additional review of these documents and determined that it appeared that the second application was submitted in the computer approximately 2 hours and 15 minutes after the first but that VA outpatient 1 had actually signed the document in February 2014.) She said this was an honor system and the veteran did not have to provide proof of the medical expenses. She said she also found three additional enrollments that she believed contained false information but said this documentation was lost during a recent flood in the building. She said she thought PSA2 had completed a couple of these enrollments but could not recall all of the details. She said that after this information was found, a meeting was organized by service chief 1 around January or February 2014 to confront PSA2 and PSA1 about these issues. She said she believed that PSA2 and PSA1 entered false information because the Rural Health Initiative was at risk of closing if they did not enroll a certain number of veterans.
- On July 14, 2015, VA outpatient 1 confirmed that he had signed and submitted two applications for VA health care. He claimed that he could not recall the name of the individual at VAMC Beckley who assisted with the submission of his applications. He stated that when he completed the first application around December 2013, the VAMC Beckley employee told him that based on his income and medical expenses he was unsure whether he would be granted benefits. He said he was directed to the VA website where he could read about eligibility for VA health care. He said he then took a closer look at his total medical expenses. He said he had undergone open-heart surgery and realized that he had not included these medical expenses in the total amount he had claimed on his application. He said he notified the VAMC Beckley employee that he had additional medical expenses that he needed to claim. After this new information was provided, he said he was approved for VA health care. He added that he had signed the second application form a couple of months later, which was around February 2014.
- During the interview of service chief 1 on July 15, 2015, he said SMAS1 told him that PSA2 and PSA1 had submitted fraudulent enrollment documents for veterans applying for VA health care. He said SMAS1 reviewed approximately 75 applications for VA

health care and found 4 or 5 instances that appeared questionable. In these instances, veterans' income had been changed, which resulted in these veterans becoming eligible for VA health care. He recalled that one patient who had been rejected based on his initial application for VA health care had contacted VAMC Beckley to schedule an appointment. He did not identify this patient. He stated that after the veteran was told that he or she had been rejected, the veteran indicated that he or she had talked to either PSA2 or PSA1 who had told them that he or she was eligible. He said he knew the Rural Health Initiative "had a big push to try and meet a number of new enrolled patients ... If they didn't make it, they may not have a job next year." He stated that he believed they had submitted the fraudulent enrollments to meet that goal. After he learned about the matter, he said he had organized a meeting to confront PSA2 and PSA1 about these enrollments. During the meeting, he reportedly had told PSA2 and PSA1 that he knew "they were erroneously enrolling patients." He stated that PSA2 and PSA1 said the veteran had approached them with additional information concerning his or her medical expenses. He said he believed that PSA2 and PSA1 were upset about being confronted with this information.

- During the interview of senior leader 1 on August 26, 2015, he stated that he was told that PSA2 and PSA1 had submitted two or three fraudulent enrollment documents for veterans applying for VA health care. He said he was told that income information for these veterans had been altered. He said VAMC Beckley management confronted PSA2 and PSA1 about this issue in two meetings. He said he was present for a meeting that occurred around November 2013 but was not present for a meeting that occurred in early 2014.

Issue 23: Investigation Into Allegation of Whistleblower Retaliation

Interviews Conducted

- During the interview of a CS, the CS said that his or her spouse received an anonymous letter describing an extramarital affair that the CS presumably had with another VAMC Beckley employee. The CS stated that a letter, which was addressed to the CS's spouse and contained no return address, arrived in the mail. The CS learned from his or her spouse that the letter discussed the CS's presumed extramarital affair. The CS said he or she believed that PSA3 was responsible for sending the letter to the CS's spouse. The CS indicated that PSA3 had worked very closely with senior leader 1 and service chief 1. The CS said that he or she believed that PSA3 sent the letter to retaliate against the CS for his or her decision to voice concerns about senior leader 1 and service chief 1 following improper practices.
- VA OIG investigators subsequently conducted interviews of multiple VAMC Beckley employees who had indicated having heard rumors that PSA3 had sent this letter to the CS's spouse because PSA3 had close relationships with service chief 1 and senior leader 1. One interviewee suspected that SMAS1 might have been involved.
- On April 2, 2015, PSA3 denied having any involvement in the writing or sending of this letter.

- During the interview of service chief 1 on July 15, 2015, he said he heard from PSA3 about the anonymous letter that was sent to the CS's spouse. He stated that during his conversation with PSA3, she had told him she did not know who had sent the letter. He said, "I have absolutely no idea who sent it." He reportedly had no participation in the writing or sending of the letter and believed that neither senior leader 1 nor PSA3 would have participated in the writing or sending of the letter.
- During the interview of senior leader 1 on August 26, 2015, he reported that PSA3 had told him about the anonymous letter. He said he did not know who wrote the letter but he did not believe PSA3 would be involved.
- During the interview of former director 2 on September 16, 2015, she said she had heard rumors that a letter was sent to the spouse of the CS. She said she did not know who authored the anonymous letter.

Records Reviewed

- VA OIG conducted a search of PSA3's computer and personal network drive for the presence of the anonymous letter sent to the CSs spouse. VA OIG also searched the personal network drives of SMAS1, service chief 1, and senior leader 1 for the letter, but the letter was not located.
- VA OIG conducted a forensic examination of the anonymous letter. The examination did not find evidence significant to the investigation. Fingerprint analysis disclosed that three latent fingerprints were developed on the anonymous letter; however, the fingerprints were not identified.

Issue 24: Investigation Into Allegation That Veterans Were Experiencing Delays When Being Scheduled Through VA's Choice Program

Interviews Conducted

- During the interview of MSA5 on September 15, 2015, she said she had noticed that the process for getting patients scheduled through VA's Choice Program⁶ had been extremely slow. This had resulted in patients waiting for appointments. She stated that third-party provider, HealthNet, was responsible for contacting veterans to schedule their Choice Program appointments. She said there had been delays in the scheduling of these appointments. In some cases, this had left veterans waiting for months for an appointment. She said she continued to monitor the process by following up with HealthNet on the patients who are waiting for appointments.
- During the interview of service chief 1 on September 15, 2015, he was asked if he had any knowledge of this issue. He said, "There is, in my opinion, a delay in care for anybody that tries to use the Choice Program." He said the program used HealthNet and

⁶ VA's Choice Program allows eligible veterans to receive care within their community instead of waiting for a VA appointment or traveling to a VA facility.

that “they haven’t functioned very smoothly since they got up and running.” He said he believed this program was “confusing for the patients” and it “hinges on the patient contacting HealthNet.” He said, “...they added a lot of steps...and it’s slower.” He said this issue was not specific to VAMC Beckley; he knew that many facilities across the country were experiencing the same issues.

- During the interview of former director 2 on September 16, 2015, she was asked if she had heard of any delays in the scheduling of appointments through the Choice Program. She stated, “I’ve been made aware of a lot of issues and hiccups in the process and actually the VISN-6 directors...discussed that with our VISN director.” She said that the VISN senior leader had set up conference calls with HealthNet to resolve these issues. She added that HAS officials had started to document all issues with the program in a spreadsheet. She said, “...those spreadsheets are forwarded to HealthNet before the weekly meeting with the directors so that they can address the issues.”