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

VA Medical Center in Asheville, North Carolina
July 13, 2017

1. Summary of Why the Investigation Was Initiated

This investigation was initiated in 2014 following the receipt of an anonymous letter, which alleged the occurrence of numerous incidents of potential wrongdoing among staff at the VA Medical Center, Asheville, NC (VAMC Asheville), and the VA Community Based Outpatient Clinic, Franklin, NC (CBOC Franklin). Additional allegations were raised during the investigation. The allegations included:

- Monitoring by supervisory staff of employees who met with the Compliance Officer
- Intentional destruction of appointment reminder letters
- Wrongful reporting of veterans who had declined care
- Inappropriate deletion of hundreds of patient consults
- Inappropriate scheduling procedures
- Inappropriate conduct by the former Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) Program Coordinator
- Death of 30–100 veterans waiting for an appointment at VAMC Asheville
- County veterans service officers routinely encountered veterans who experienced problems with enrollments and appointments

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** We interviewed 35 current and former VA employees, including schedulers, supervisors, physicians, and senior leaders.

- **Records Reviewed:** We reviewed VA emails, an employee's electronic personnel file, letters of counseling, administrative records, and medical records.

3. Summary of the Evidence Obtained From the Investigation

Allegation 1: Employees Reporting to the Compliance Officer Were Monitored

Interviews Conducted

- One of the allegations contained in the anonymous letter indicated that the facility's internal camera system had been accessed by various service chiefs seeking to identify "whistleblowers," that is, individuals who were seen entering the Compliance Officer's office presumably to lodge a complaint. It was also alleged that staff were allowed to "listen in on calls" when "anonymous tips" were made to the facility's Compliance

Officer. Two employees of the VAMC Asheville Police Service—a senior employee and a management official—were interviewed concerning video coverage of the area leading into the Compliance Officer's office, which is inside the facility's Executive Suite. The interviewees stated that the camera system—operated and controlled by VA Police Service staff—was not used in this manner and that the telephone system could not be used in the manner described in the anonymous letter.

- The Compliance Officer was interviewed about the allegation that her contacts with employees were monitored by video or that their telephone calls were monitored and/or recorded by VAMC Asheville management. She said she had never heard of any allegation pertaining to employees being monitored when coming to her office nor had she ever heard any employee report being deterred from coming to her office because of that concern. She said the fact that her office is located in the facility's Executive Suite could possibly discourage someone from reporting to her. She stated that once (in 2015), an employee had called her and requested to meet at an alternate location because the employee felt uncomfortable meeting in the Executive Suite. She agreed to meet at any other location deemed suitable, but the employee did not follow through with the request.

- A VAMC senior leader stated that she was not aware of anyone monitoring employees going to the Compliance Office. She also stated that she had no knowledge of anyone monitoring the telephones of the Compliance Office.

Records Reviewed

- The VA OIG Office of Audits and Evaluations (OAE) observed the locations of security cameras where the compliance office was located and determined that the vantage point of the security cameras did not provide a view to identify individuals going in and out of the compliance office.

Allegation 2: CBOC Franklin Recall Appointment Reminders Intentionally Destroyed

Interviews Conducted

- CBOC management official 1 was interviewed about her alleged destruction of annual letters that should have been sent to veterans as appointment reminders. CBOC management official 1 stated that she did not destroy the letters and that there was some confusion about how to handle the reminders when CBOC physician 1 had resigned. She stated that letters pertaining to the physician's patients were given to Health Administration Services (HAS) employee 1 and that the patients were temporarily divided among other doctors during the shortage. She added that she did not know of any patients who had died while on alist waiting for care.

  When reinterviewed, CBOC management official 1 stated that the decision to not send the letters was made by CBOC management official 2. However, she said she received a letter of counseling for the issue from an HAS manager. She added she had reported that the clinic was short by two physicians from the beginning upon learning that both physicians were leaving. She further stated that Human Resources personnel would also

have known the physicians were leaving. She stated that she was upset about receiving the letter of counseling but did not fight the matter because she felt responsible and she did not want her staff to be punished. She said she did not feel she had done anything wrong and was visibly upset about the issue during the interview. (Upon review, the letter of counseling did not address a backlog but rather instructed the recipient to adhere to VA policy regarding scheduling practices. Also stated in that letter: "This letter is not a form of disciplinary action and will not be placed in your Official Personnel File (OPF).") CBOC management official 1 explained that of the 400 or so patients with corresponding recall letters that had not been sent, about 150 were not seen at all. The others were triaged by nursing staff or seen by CBOC management official 2 or one of the VAMC Asheville physicians who had come to cover for a period of time.

- Medical support assistant 1 (MSA) was interviewed about patient scheduling practices and recall letters. She stated that recall letters are typically sent out 6 to 7 weeks ahead of a patient's appointment. The letters are sent from CBOC Franklin. She said she believed that when CBOC physician 1 left CBOC Franklin, her patients were seen by other physicians. She further stated that she had never seen a list of patients who had died while awaiting care.

- HAS employee 1 said she had discovered the recall appointment letters for CBOC physician 1's patients during an audit of the CBOC Franklin's scheduling practices. She stated that she had taken the letters to an HAS manager who later had addressed the matter with CBOC staff.

- MSA 2 was interviewed about recall appointment letters allegedly never sent to CBOC physician 1's patients. He stated that CBOC management official 1 had told him not to send the recall letters. He said he believed CBOC management official 1 had himself been told by CBOC management official 2 to hold the letters. He added that he generally kept the letters locked in the bottom drawer of his filing cabinet, except for those he had already handled; which were on his desk. Most likely, he said, HAS employee 1 had confused them for the unsent recall letters.

- CBOC management official 2 said that because of the departures of CBOC physician 1 and CBOC physician 2, the patient panels for the two physicians reportedly went unaddressed for some time.[1] According to him, during the short term, doctors from VAMC Asheville assisted with providing care at CBOC Franklin; when the physician positions were understaffed, the workload became overwhelming and the appointment recall reminder letters were held back. He explained that he made the decision not to mail the letters because there was no physician available to see the patients, and that he felt there would be help hired to assist in the near future or help through the use of *locum tenens* physicians. He stated that VAMC Asheville management was aware of the problem created by the physicians' departures and that CBOC Franklin had a shortage of two doctors. He said no contingency plan had been developed to handle patient panels in the event a similar situation should occur. He remarked that VA could have sent letters to the affected patients to let them know they had not been forgotten but doing that still

[1] The recall appointment reminder letters pertained to those particular patients.

would not have created available appointment slots. He also stated that neither the HAS manager nor the VAMC Asheville director knew that the appointment recall reminder letters had not been mailed out.

- A VAMC senior leader recalled being informed that the letters had not been destroyed but that, instead, there had been a delay in sending them to patients. She said the recall appointment reminder letters were not destroyed but delayed only by a few months and that all of the patients were seen. She stated that she was not aware CBOC management official 2 had decided to hold the letters, but she was aware that letters of counseling had been issued to CBOC management official 1 and to CBOC management official 3 for issues related to scheduling practices.

Allegation 3: Inappropriate Consult Canceling

Interviews Conducted

- A nursing official in a specialty service stated that she had no knowledge of consults in the specialty service being canceled. She said there had been a system redesign generating a list that showed consults as pending, and some were canceled. She explained that the canceled consults would have been canceled by the former chief of staff and that those consults were reviewed and rescheduled as needed, as many were old. She said this occurred around the spring of 2013.

- A VAMC senior leader stated that she believed all actions taken regarding the consultations had been appropriate and correct.

Records Reviewed

- OAE examined all consults closed during FYs 2012 and 2013 to identify instances in which an individual closed a high number of consults on a single day. Such instances could increase the risk that staff did not take the time to appropriately review the consult. OAE analyzed a limited sample of closed consults to determine if staff appropriately reviewed the consult before closing the request. OAE also interviewed VAMC management, enrollment staff, and other medical and support staff.

  OAE did not identify inappropriately closed consults. OAE determined through a limited consult review that medical staff appropriately closed consults. OAE analyzed closed consults and identified one day during which an individual closed 141 consults. OAE reviewed 20 randomly selected consults of the 141 and determined that all 20 contained documentation with comments describing the reasons for closing the consults, such as:

  - The patient had already received care for 16 consults.

  - The patient declined an appointment or failed to respond to scheduling requests for three consults.

  - The patient showed for an appointment but left before being seen, and the patient never rescheduled.

According to the former VAMC Chief of Staff, in 2012, the facility had about 17,000 open consults exceeding 90 days. These consults were referrals to all types of specialty care. As part of VHA's national implementation of new consult business rules, several chiefs of service at the VAMC performed medical reviews of open consults to Urology, Cardiology, Eye Clinic, and Gastroenterology. The medical reviews determined if VAMC Asheville already provided the care, if the veteran still needed the care, or if the service should close the consult and notify the ordering provider that the veteran did not receive care. Staff would notify the ordering provider that they closed a consult without providing care if they determined the veteran canceled or did not show for an appointment more than once.

Allegation 4: Inappropriate Scheduling Procedures and Patients Dying While Awaiting VA Health Care

Interviews Conducted

- VAMC physician 1 stated that she had no knowledge of data manipulation pertaining to patient wait times.

- VAMC administrative employee 1 reported that he was no longer involved with scheduling and that he previously worked in HAS. He said that only VA Form 10-10EZ was used for enrollment; no supplemental form was used. He stated that patients were not asked about current medical conditions nor if they had a private physician. He explained that such information did not affect the VA care the patients received or whether the patients received VA care. He stated that he had never heard of any handwritten lists nor did he have any knowledge of patients dying while awaiting VA health care. He also stated that he had not heard any complaints from veterans about excessive waiting.

- MSA supervisor was interviewed about a list of 47 names contained in an email between him and CBOC management official 1. He stated that both CBOCs Franklin and Rutherfordton were at capacity and he had used the Rural Health Team to accommodate veterans in those areas. He explained that it was "entirely likely" the 47 names on the list were sent to him to schedule with the Rural Health Team. He stated that recently he had to stop using the Rural Health Team to assist with CBOC patients because that team had its own patients. He added that he did not use the New Enrollee Appointment Request report and did not use a wait list.

- MSA3 stated that she was doing new patient scheduling. She explained how she used the "PC Wait List" and attempted to contact veterans in the order they appeared on the list. She stated that she made three telephone attempts and if unsuccessful, followed up with a certified letter. When asked if any patients on the list were determined to be deceased when she called, she answered there were some going back to 2005 but not since she had been in the position (mid-2014). She said she would offer the veterans an appointment at VAMC Asheville and inform them that their care could be transferred to one of two of the facility's CBOCs when appointments became available.

- An HAS manager reported there had been a problem within the Eligibility and Enrollment (E&E) section of HAS, which had been addressed sometime between December 2013 and February 2014. He stated that there had been a turnover in scheduling personnel and that a backlog had developed. He further stated that a former employee had reduced the backlog down to 3 to 4 weeks but that after she had left and was replaced by MSA 4, the backlog returned. He said the new backlog had been discovered when veterans began to call VAMC Asheville to complain about not being scheduled for an appointment. He stated that employees worked overtime on Saturdays for 2 to 3 months to rectify this backlog and that MSA 3 was hired to handle the situation. He added that the backlog was now at 2 1/2 to 4 weeks and that the problem appeared to be with MSA 4's work performance. He described the situation as involving two backlogs: one in the winter of 2013 and another in January 2014. The initial backlog affected between 300 and 500 veterans. He gave various reasons for the backlog's existence, including lack of training and oversight. He stated that MSA 4 had never been disciplined or counseled about the backlog, nor had she been confronted about the issue, because she had transferred to another service within the facility.

  He said that after his staff received calls about veterans not yet being assigned an appointment, he had his staff perform an audit at CBOCs Rutherfordton and Franklin. The audit revealed that recall appointment reminder letters had not been sent to numerous CBOC Franklin patients. He stated that those patients were assigned to a physician who had left VA and were never reassigned to another physician. He added that there was no contingency plan for VA to handle a physician's panel, or changes in patient load, once a physician left. He further stated that the recall letters were withheld and someone, whom he could not identify, made the decision not to send out the letters. He and other staff were aware the physician had left but no one knew that a backlog of patients was forming during that time. He stated that no one at CBOC Franklin had addressed the matter with him. He explained that a letter of counseling had been issued to CBOC management official 1 about the matter, adding that CBOC Rutherfordton clinical staff worked overtime and as a result did not have a backlog problem.

  He stated that Primary Care (PC) staff were not unwilling to accept patients. He reported being aware of a listing of approximately 30 patients who had died awaiting VA care. He further stated that he did not believe the deaths were due to any wrongdoing by VA, based upon the fact that there had not been negative responses from patients' family members indicating or alleging that VA was at fault. He said the list of approximately 30 patients came from a listing of between 1,200 and 1,400 patients who had been called during the previously mentioned backlog rectification. He stated that on a few occasions, the E&E clerk, an MSA, had noted on the spreadsheet used to contact veterans that contact attempts had been made when, in fact, after all veterans on the list had been called, a few appeared to have not been called at all by VAMC Asheville staff during the backlog reduction effort.

  When reinterviewed, the HAS manager stated that CBOC physician 1 and CBOC physician 2's departures had been known and reported during several Wednesday staff meetings, attended by a VAMC senior leader and CBOC staff members participating via video teleconference. He stated that everyone was aware of the provider shortage and

that the patient oversight was his responsibility. When asked if CBOC management official 2—who had admitted that he had made the decision to withhold the recall reminder letters—had received the same letter sent to CBOC management official 1 and CBOC management official 3, or any other type of disciplinary mailing, the HAS manager stated he did not have knowledge of any action taken against anyone outside of his service. He said he had aggressively looked into the New Patient Scheduling section before the VAMC Phoenix [2] allegations. He added that HAS had received several calls from veterans who claimed to have enrolled for health care but never received an appointment. He suggested that MSA 4 was not the best fit for an independent position and needed more supervision. He stated that soon after the audit discovered the backlog problem with New Patient Scheduling, MSA 4 accepted a position with another service at the facility—in essence, she had been promoted. He said, at that point, she was no longer under his authority and he did not feel he could discipline anyone outside his service.

He further stated that he did not believe MSA 4 intentionally marked the veterans as having declined care if they had not. He explained that, unlike now, formal training was not available for the position held by MSA 4, when she was moved to New Patient Scheduling.

- A program specialist stated that she assigned patients to a provider and maintained the physicians' panels. She explained that when a physician left, she would get guidance from either VAMC administrative employee 1 or service chief 1. She said there were "gap doctors," who fill in or the facility can hire temporary physicians known as *locum tenentes*. She added that because CBOC Franklin was missing a physician, service chief 1 and another provider had been providing coverage. She stated that as a matter of practice or policy, a new provider cannot accept new patients for 9 months. She further stated that CBOC Rutherfordton could not accept new patients either. At the time of the investigation, there were approximately 300 patients awaiting care at the two CBOCs. She stated that because CBOC physician 1 and physician 2 left employment at CBOC Franklin, the wait list grew. She said there were no lists of patients waiting to be scheduled at CBOC Franklin but that there had been a list sometime around 2009 or 2010. She also said she was unaware of any veterans dying while awaiting VA health care.

  When reinterviewed, the program specialist stated that she did not have the authority nor did she act as MSA 4's supervisor. She said she never saw MSA 4's supervisor and did not know why MSA 4 had been physically placed in PC without supervision. She stated that MSA 4 was expected to update her (MSA 4's) work on the PC Consult List—an electronic spreadsheet—in addition to using the hard-copy face-sheets that were used to document staff's attempted contacts with veterans. She explained that the PC Consult List had always been used, or at least been used for 3 to 4 years, and that she ran a monthly report to review the data entered by the New Patient Scheduler. When asked if one could tell who had made comments on the face-sheets used by MSA 4 and others, she replied, "No." She stated that she could not verify who had made particular markings

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

and whether all calls documented as having been made were actually made. She further stated that she had checked MSA 4's phone messages on MSA 4's office line, as instructed by service chief 1. She said she had discovered that MSA 4 had accumulated more than 100 pending voicemails while working as the New Patient Scheduler. She stated that soon after MSA 4 had told her that someone had spoken to her (MSA 4) about pending phone calls. She said she assumed a supervisor had addressed the issue with MSA 4.

She also stated that she did not know why MSA 4 had been removed as the New Patient Scheduler. She explained how she (the program specialist) had mailed all the letters to the veterans after the three phone call attempts had been made by MSA 4 because MSA 4 was behind on her work from the start and it was easier for her to mail the letters than to take the time to mentor MSA 4. She stated that the New Patient Scheduling position had been reassigned between HAS and PC for some time. She added that when MSA 4 was in that role, the position fell under HAS but that she (MSA 4) was physically located in PC. She noted that the person in that role had never been behind when the position was under PC. She said she did not know that HAS staff had performed an audit after MSA 4's departure nor did she have knowledge of the content of the audit's findings. She stated that MSA 4 never asked for her help or disclosed how far behind she was in her work.

- MSA 4 stated that she never used the Electronic Wait List (EWL) and that she had worked in New Patient Scheduling for less than a year. When asked if there had been a backlog of patients needing to enroll, she replied she did not do "a lot of entering." She explained that she had seen a backlog and that the HAS manager had scheduled mandatory overtime to address it. She stated that MSAs would make three attempts to notify veterans by phone and if there were no contact, that fact would be documented in the veterans' files.

  MSA 4 was reinterviewed about New Patient Scheduling issues found while she was the scheduler. She stated that she did not know that any problems had been found with New Patient Scheduling when she was pulled from the position and placed in another position still within HAS. She said she was told one day to move from one position to the next and that it was not because of poor performance. She stated that she was told her performance was good and she was never given an explanation as to why she was moved. She reportedly requested to meet with the HAS manager concerning her move but he had refused to meet with her. She stated that, at HAS, she had performed six to seven jobs and had never received any training for any of the positions. She further stated that she had not been the only individual responsible for calling new enrollees nor the only individual categorizing veterans' "face-sheets"[3] as "Declined" regarding VA health care. MSA 4 described the process for contacting new enrollees as making three phone call attempts. She stated that each call was to be made in a 7-day period. If no contact was made by phone, then a letter was sent via Certified Mail asking the veteran to call VAMC

[3] A face sheet is a computer-printed document used by HAS staff that reflects an individual patient's demographics and attempts by HAS staff to contact that particular patient about upcoming appointments. If the patient declined care, it is noted on the face sheet.

Asheville to schedule an appointment. She added that when she began working in that position, HAS was in the process of using an electronic spreadsheet but that process did not work after about 3 to 4 months. She stated that the staff reverted to using the paper face-sheets that contained each veteran's name and demographics. Those sheets were used to document contact attempts and for dispositions.

When confronted with the fact that there had been more than 1,300 enrollees in a "Declined" care folder found when she was removed from New Patient Scheduling, she appeared surprised and said the folder had been in use before her working there. She stated that others, including a program specialist, used the folder. She said she had not documented having called the veterans when truthfully she had not. She stated that if she documented a patient had declined care, then the attempts had been made and either there was no contact with the veteran or the veteran had declined care. She said there might not have been a 7-day lapse between the calls but she insisted she had made the documented calls. She stated that she was never disciplined for job performance pertaining to new enrollees and that she was never confronted about "goofing off" on the job. She admitted that the job was disorganized; she received no training for the job; and she did nothing wrong. She said there was a struggle between HAS and PC to control the New Patient Scheduling position. She stated that she had applied for a position with another HAS service because she felt she was being moved around a lot.

- Lead MSA 1 stated that VAMC Asheville enrolled/transferred approximately 20 new veterans each day. She said she was not aware of any patients who had died awaiting VA health care or of any who were awaiting enrollment. She further stated that veterans with private physicians were not denied VA care. She added that she did not change any dispositions of enrollees and that there was no backlog.

- A nursing official stated that she was not aware of VAMC Asheville staff turning away veterans if they had a private provider or if the veteran had a specific health condition. She said she was not aware of any lists of patients awaiting care who were not on the EWL. She had not heard rumors about anyone being instructed to manipulate wait times at VAMC Asheville. She stated that she had never heard of any consults being canceled without a reason. She denied any inappropriate behavior among any of the staff at VAMC Asheville. She stated that she worked closely with service chief 1 and adamantly denied any inappropriate conduct or the existence of an unauthorized list.

- A program manager stated that she had no knowledge of MSAs asking new enrollees whether they had a private physician or asking about their medical conditions—a practice allegedly used as a screening tool. She explained that a PC provider was always assigned to those applying for care and stated that she had no knowledge of VAMC Asheville employees manipulating lists to make it appear veterans had refused care. She further stated that a standard operating procedure was in place to work consults and that nurses generated the consults. For example, if a veteran expressed his/her wish to go to weight management, a nurse would generate a consult. She stated that she did not delete consults nor did she have access to delete the consults. She said she had not heard anything about veterans who had died while waiting for care.

- Service chief 1 stated that the issue of "snowbirds" was a scheduling challenge at VAMC Asheville and that those patients were not given a PC provider at two different VAMCs. For example, if a patient came to VAMC Asheville requesting a PC provider and that person already had a PC provider in Florida, he would follow a procedure to determine how to schedule that individual's care at VAMC Asheville. He recalled problems occurring once in a while with enrollment since 2011. He stated that the concerns seemed to have centered on MSA 4 and that he had heard she was annotating that she had called patients, when in reality she had not, and that she had not appropriately processed return phone calls. He said this issue came up in late calendar year 2013 and early 2014. He further stated that he did not have firsthand knowledge of the matter. He said two employees had worked overtime to help resolve the backlog created when MSA 4 was scheduling at HAS. The backlog had been reduced to a manageable point until about 3 weeks after the two employees had stopped working overtime; then it had "ballooned" again.

  He stated that because of a physician shortage, CBOC Franklin staff were withholding recall appointment letters. The patients assigned to the physician who had left the CBOC had not been reassigned to another physician. He explained he could have provided gap doctors from the parent VA facility but was unable to do so because the parent facility was short on physicians. He stated that when CBOC physician 1 left CBOC Franklin in January 2014, the clinic was down to one physician for 3,000 patients. He added that last year (prior to the interview) was an "exceptional year" for turnover but that patient care was caught up at both CBOCs.

  He stated that, in May 2014, while on a conference call with an official from VA Central Office, he realized that he was not using the EWL correctly. For example, using a Microsoft Excel spreadsheet for processing patients wanting to go to the CBOC was wrong. He stated that he changed that practice once he realized his mistake. He added that he had no knowledge of any list of individuals waiting to be enrolled. He also stated that he had no knowledge of any veterans who died while awaiting VA health care. He explained that before he was in his current position, the practice was that if a veteran had a private physician, the veteran was not assigned a VA PC provider. He stated that he worked to change that practice—which took about 1 to 2 years—and that the current practice was to assign a veteran a VA PC provider, regardless of his/her status with a private physician.

- A scheduling supervisor stated that the HAS manager decided to conduct a full internal audit of the New Patient Scheduling section. He further stated that when the audit was conducted, MSA 4 was the only MSA working there. He said the audit found that 1,322 patients had been determined to have declined care at VAMC Asheville. He stated that a team worked overtime over six to eight Saturdays and attempted to call all 1,322 patients. The calls were made because the audit had determined that a small number of veterans who had purportedly declined care had not actually been called by the scheduler. He stated that MSA 4 was moved from the position in New Patient Scheduling; he believed that MSA 4 was removed out of an "abundance of caution" and he was not aware of any disciplinary action taken against her. He stated that the HAS manager had worked diligently to improve HAS.

- An MSA supervisor reported that the internal audit conducted by his staff had shown there were 1,322 new enrollees who had declined care at VAMC Asheville. That number and determination were based on accounts or face-sheets of individual veterans who had reportedly declined care. The face-sheets were found in a folder in MSA 4's office. He stated that MSA 4's processes were being carried out on paper, not electronically. He said he did not know if all 1,322 face-sheets found in the file had been created by MSA 4. He explained that he had been authorized to have employees work overtime to contact all of the 1,322 patients to determine whether they had, in fact, declined VA care. Of those contacted, he recalled a little more than 300 had wanted VA care. He said he did not believe the veterans found to be deceased had died as a result of a lack of VA health care. He stated that he was not aware of any family members making such an accusation.

- Program support assistant 1 (PSA) said she knew of one recent situation involving a veteran residing in the area of Blairsville, GA, approximately 2 hours from Asheville, NC, who wanted to transfer his primary care from one VA facility to VAMC Asheville. She said she thought the veteran was a seasonal resident in the area who lived in Florida in the winter. She recalled attempting to coordinate the transfer, which was denied because the veteran had a private provider in Florida. She stated that she had made it clear that the veteran wanted to transfer his VA PC to VAMC Asheville while keeping a private provider in Florida, but service chief 1 and the program specialist had denied his VA PC transfer. She stated that a female victim of Military Sexual Trauma (MST), who had requested a female PC provider, had also been denied. She explained that service chief 1 and the program specialist had denied the female provider assignment because of a reported lack of resources and also because the next physician in the rotation was not a female.

- PSA 2 stated that he was told to shred veterans' application packets once the information was electronically input. He said the packets included 10-10EZ forms and Department of Defense forms-214 (DD-214). He stated that he did not shred the packets but gave them to an E&E clerk who was helping him at the time. He added that he did not feel comfortable with the direction to destroy the records. He stated that he did not know how VA policy addressed that matter but that any other medical records were generally saved and put on file, not shredded. He explained that this occurred approximately 4 to 5 years ago and that he had not worked in that capacity since that time. He stated that in his current position, it had taken months for some veterans to get outside care when it should have taken only a few weeks. He explained that the authorizations to see an outside physician had been approved for many of the patients but that the appointments were never made before they "aged out," meaning the authorizations were too old to act upon and needed to be reauthorized. He said that many of the appointments were for physical therapy, pain management, and dermatology. He also said overtime had been approved to help clear the backlog with the claims assistants for the outside care.

- Confidential source 1 (CS) reported he/she had heard from several veterans that they had been denied treatment by the program specialist because the veterans had outside providers. In many cases, the veterans requested specialty care and the program specialist would advise them to call specialty clinics. CS 1 stated that because the veteran did not have a Primary Care provider, he/she could not receive VA specialty care.

CS 1 stated that many scheduling clerks were improperly trained, contributing to some of the scheduling complaints. CS1 added that he/she had direct knowledge of numerous situations in which veterans had been incorrectly enrolled and that many were not properly enrolled because of inadequate training. A couple of years ago, for example, an aide to a North Carolina senator—who reportedly had served two tours in the Vietnam War, served in the Persian Gulf War, and was a recipient of the Purple Heart—was denied care at VAMC Asheville. CS 1 alleged that VAMC Asheville schedulers were not listing Vietnam War veterans as having been exposed to Agent Orange (when they should have been) and, as a result, hundreds were being denied care or placed in the wrong category. CS 1 stated that he/she had spoken with veterans who claimed to have contacted VAMC Asheville staff for an appointment but had either never heard back or had seen approximately 1 year elapse before some of them were notified of their enrollment status.

CS 1 noted that, on occasion, patients called the facility to cancel their appointments. CS 1 stated that a common practice for VAMC Asheville schedulers was to leave the time slot open as a "no-show," rather than try to fill the slot with another patient. CS 1 explained that if the vacancy was shown as canceled and not filled, then the clinical utilization numbers reflected poorly on the facility. CS 1 reported having direct knowledge of this practice in specialty clinics with veterans being scheduled in the time slots without their knowledge, only to be listed as "no-show," so the original cancellation would not negatively reflect against the facility. CS 1 stated that the veteran would not be aware of the appointment until he/she had received a letter or had been contacted to notify him/her that he/she had failed to show for an appointment.

- CS 2 stated that there had been numerous contacts with veterans who claimed to have enrolled at VAMC Asheville but never received an appointment or never heard back from facility staff for more than a year. Some of those veterans allegedly were told he/she could not go to VAMC Asheville because another facility was closer to the veterans' residence and as such, veterans had to seek care at another facility. CS 2 stated that this happened to a 70-year-old Purple Heart recipient who claimed to have been told by VAMC Asheville staff that he was not eligible for care there. CS 2 said repeatedly that the goal of VAMC Asheville PC was to keep enrollment at a minimum. CS 2 acknowledged that he/she heard language insinuating that particular theme numerous times from colleagues and supervisory staff. CS 2 said service chief 1 had said openly in staff meetings that PC was not looking for new patients. CS 2 stated that when issues involving VAMC Phoenix started to be made public, a VAMC senior leader advised staff not to put anything incriminating in emails and training on proper email usage was provided to staff. CS 2 also stated that funding for certain programs (OIF/OEF and Rural Health) at VAMC Asheville was inappropriately diverted to other programs.

- A VAMC senior leader acknowledged being familiar with the allegation that 30 to 100 patients had died while awaiting care, as well as the situation involving MSA 4. She stated that she had been asked for overtime funding by HAS staff around the winter of 2013 and into 2014, to rectify the issue. She believed 75 to 80 percent of the patients were handled correctly with approximately 20 percent handled incorrectly by MSA 4. She stated that those patients were called after MSA 4 had left the position, adding that

she was not aware of any patient complaints related to this issue. She also stated that VA OIG's Office of Healthcare Inspections (OHI) determined the patients' deaths were not attributed to a lack of VA health care.

- OAE determined that the VAMC enrollment staff used an unofficial form only for veterans who enrolled in person at the VAMC. Upon completion of the form, enrollment staff sent the form to the New Patient Scheduler for scheduling. Veterans were not required to complete the form to receive care

  The form documented whether the veteran received care at another VAMC and if so, which care facility the veteran preferred. The form indicated that the veterans who chose to keep their primary care at another facility would be sent to the referral case manager or traveling veteran coordinator of their preferred facility. This statement in the unofficial form was consistent with VHA Directive 2012 011,[4] which stated that a single facility should follow veterans in primary care and that the facility must use referrals to help patients arrange follow-up care at distant VA facilities.

  VAMC management indicated it was not aware that staff used the supplemental form. After the OIG brought this to management's attention, the VAMC discontinued use of the form because it did not provide value to the enrollment process.

Records Reviewed

- OIG identified and reviewed the letters of counseling that were issued to CBOC management official 1 and CBOC management official 3. We found the content of both letters to be the same: no mention of any backlog but rather instructions for the recipients to adhere to VA policy on scheduling practices. Also stated in the letters was the following, "This letter is not a form of disciplinary action and will not be placed in your Official Personnel File (OPF)."

- OIG reviewed MSA 4's official personnel folder—the review confirmed no disciplinary action was taken.

- OIG reviewed VA emails belonging to the HAS manager, MSA supervisor, MSA 4, and the program specialist. Our review did not disclose any information relevant to the investigation.

- OIG reviewed emails provided by an MSA supervisor. The emails detailed the audit conducted by his staff of the documents found in the New Patient Scheduling office; a listing of 35 (of 1,322) patients who were found to be deceased at the time of the audit; discussion of the tense relationship between staff in HAS and PC, especially dealing with scheduling new patients; and scheduling practices.

- OAE reviewed copies of appointment requests, to address the allegation that VAMC Asheville staff maintained an unofficial wait list of new patient appointment requests for primary care. OAE also interviewed enrollment staff, MSA 3, other medical and support

[4] *Primary Care Standards*, April 11, 2012

staff, and VAMC management responsible for providing enrollment and scheduling oversight.

OAE found that the VAMC used a program in the Veterans Health Information Systems and Technology Architecture called "PC Waiting List" to track newly enrolled veterans seeking an initial primary care appointment. According to staff, when veterans enrolled for care, MSA 3 placed them on the PC Waiting List.

MSA 3 explained how she attempted to contact veterans whose names appeared on the PC Waiting List to schedule an appointment: she would call a veteran up to three times, 5 to 7 days apart, then would document the telephone contact electronically on separate spreadsheets outside of the PC Waiting List. When an attempt was successful, she would schedule a new primary care appointment for the veteran and remove him or her from the PC Waiting List; if unsuccessful, she would send a certified letter asking the veteran to contact the facility to get an appointment. If the veteran did not respond within 30 days of the letter, MSA 3 would close the request for an appointment on the PC Waiting List with the note that the veteran had declined care. On July 9, 2014, OAE identified 99 veterans on the PC Waiting List.

VHA's New Enrollee Appointment Request Call List was a tool designed for enrollment staff's use to communicate to schedulers that a newly enrolled veteran had requested an appointment. According to VAMC staff, the PC Waiting List included veterans from the New Enrollee Appointment Request Call List. While the VAMC's use of the PC Waiting List may have been well intentioned, it did not comply with VHA policy regarding wait lists. VHA Directive 2010-027[5] stated that facilities should use the EWL to list patients waiting to be scheduled, or waiting for a panel assignment. The directive also stated that facilities should not use any other wait list formats (paper, electronic spreadsheets) to track requests for appointments.

- OIG reviewed the face-sheets used by HAS. Our review disclosed that dates on the face-sheets ranged from 2010 through 2014; some of that time frame preceding MSA 4's employment at HAS.

- OAE reviewed the VAMC Asheville's PC Waiting List going back 5 years. The review disclosed that 73 patients had been removed from the list because they had died while being on the list. A document listing the 73 deceased patients was provided to OHI for review.

- OAE requested that OHI determine whether 30 to 100 patients on an "unofficial" wait list had died waiting for care at the facility. The OAE-provided list of the 73 veterans removed from the PC Waiting List between October 1, 2009 and July 9, 2014 contained the annotation "death" next to each name. OHI excluded 27 records from the review because the dates of death preceded the patients' placements on the PC Waiting List. OHI excluded an additional seven records because the medical record did not indicate that the patients were deceased. Further, because the medical records lacked detail on

[5] *VHA Outpatient Scheduling Processes and Procedures* (June 9, 2010)

patients' "desired" appointment dates, OHI concluded that patients would have desired appointments as soon as possible. OHI therefore used the date the patient was placed on the PC Waiting List as the patient's desired appointment date. VHA uses a 90-day window to schedule new patients within their "desired" appointment date.[6]

- OHI determined that all remaining 39 patients either received PC services as requested; were timely scheduled for a PC appointment but either canceled, "no-showed," or declined; were receiving PC elsewhere; and/or died within 90 days of being placed on the PC Waiting List. Many of these patients were in a nursing home or under hospice care at the time of death.

- Because of limited documentation on the patients' medical histories, private-sector care, and causes of death, OHI could not determine whether a completed primary care appointment before the patient's death would have made a clinically significant difference in the patient's prognosis.

- OAE also asked OHI to determine whether staff appropriately documented in the medical records that 35 veterans, who had been on a wait list, declined care. These 35 veterans (of 1,322 who declined care) had died by the time of the OHI review. Around January 2014, facility management received complaints from veterans that the facility had not contacted them for an appointment. In response, management set up a team to call more than 1,300 veterans whose status had been flagged as having "declined care" during 2013. The facility determined that 35 of them were deceased. OHI evaluated the medical records of the 35 deceased veterans to determine whether facility staff had documented the refusal of care. In 25 of the 35 cases, the medical record contained evidence that:

  - The patient or family did explicitly decline primary care (PC)
  - The patient was scheduled for PC and either canceled or no-showed
  - Circumstances obviated the need for PC (such as nursing home placement, hospice care, or home-based primary care)

  The remaining 10 records did not contain sufficient documentation for OIG to determine whether the patient actually declined care. In some of these cases, there were no corresponding clinical or administrative entries. However, in 5 of the 10 cases, we obtained paper documentation suggesting that either the family had formally declined care or the facility had made the appropriate attempts to contact the patient.

Allegation 5: Intentional Destruction of Electronic Recall Appointment Reminders at VAMC Asheville

Interviews Conducted

- When asked about an allegation that HAS employee 1 had intentionally deleted approximately 2,000 recall appointment reminder letters in January 2014, a scheduling supervisor stated that the deletions occurred sometime at the end of July 2014. He said

[6] OHI's work was an assist to this inquiry and was not published

the matter had been an accident, which HAS employee 1 immediately recognized as such, and proceeded to correct the problem. He stated that many of the deleted reminders were for future appointments and no patients had been delayed in getting appointments or letters. He explained that once HAS employee 1 realized the problem, she first addressed those with appointments in the near future, which had prevented the delays. He stated that before this incident, VAMC Asheville staff had changed its protocol; it now sent out reminders 60 days in advance of upcoming appointments, rather than 30 days, which provided a cushion for planning purposes.

He further stated that he did not initially notify his chain of command of the incident. He explained that the HAS manager had first learned of the matter in October 2014. He also stated that once he became aware of the issue, the HAS manager immediately formed a team to correct the problem affecting the remaining individuals with deleted recall reminders. He indicated that the total of the deletions reached approximately 3,400. He did not have a clear answer as to why he did not notify the HAS manager of the deletions as soon as the problem occurred. He said he must not have fully understood exactly what HAS employee 1 had relayed to him or what she had done. He said there was a simultaneous facility cleanup project under way pertaining to other recall letters and thought that was what she was addressing. He stated that HAS employee 1 was not particularly liked by some employees but he did not suspect her of intentionally deleting recall reminders. He could not explain why someone would intentionally delete the letters and said that action would not benefit anyone.

- Lead MSA 2 stated there would be no benefit in deleting the reminders because there were "fail-safes" in place to catch those incidents. She said she was aware of the deletions and expressed her confidence in HAS employee 1. She further stated that the deletions could not have occurred in January because the "fail-safes" would have caught the problem.

- HAS employee 1 stated that she had deleted the reminders. She explained that when she first began working at VAMC Asheville, the recall reminder system was not being used as designed. The system was supposed to be purged regularly under specific circumstances; for example, when dealing with patients already seen or with canceled appointments. Those individuals were referred to as "pasts" or a "past." The pasts were supposed to be purged at various times. She stated that lead MSA 2 had earlier explained the same concept, adding that the system was not being purged at VAMC Asheville. She said that one day, in July 2014, she had selected about 3,400 patients' records for purging. She had changed the parameters from 45 days to 335 days. She stated that she did not realize the purge was going to delete those who still needed appointments and were referred to as "futures" or a "future." She said she believed only pasts would be purged. She stated that when she returned to work the next day, she realized that both pasts and futures had been purged. She said she immediately recognized the problem and proceeded to recover the futures. She stated that the system has a built-in report capable of showing deleted reminders and that she used that report to identify which patients' reminders had been deleted. She said she did not know why anyone would accuse her of intentionally deleting the recall letters. She added that she was hurt by the accusation

because she was trying to use the system the way it was designed. She reiterated that she did not intentionally delete the futures.

- A VAMC senior leader stated that he/she did not know that some 3,400 patient recall appointment reminders had been deleted by HAS staff in 2014 during an attempt to purge the electronic appointment system.

Allegation 6: Problems in the OIF/OEF Program

Interviews Conducted

- A former VA employee, responsible for the Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF) Program at the facility, stated that she did not "sit" on any enrollees' forms, and that the only time she had encountered such forms was when she attended outreach events of military units returning from a deployment. She explained how she was accompanied by a VA HAS employee at these events and she would transfer the enrollment packets to the HAS employee for completion of the enrollment process. She stated that she did not intentionally fail to process numerous OIF/OEF veterans' applications for benefits. She said she had not been instructed to delay processing new enrollees' applications by her supervisor, service chief 2. She stated that she had left that position because of personal issues and not because of service chief 2. She added that she did not falsify follow-up notes in the veterans' records after they had been enrolled.

  When reinterviewed, the former employee stated that she never had any support staff for the program other than herself and one other individual, who was there only for a short time. She said the program was overwhelmed the entire time she was the coordinator. She stated that she had around 4,000 OIF/OEF veterans assigned to her with no supporting staff. She said she discussed the issue with her colleagues at other facilities in Salisbury and Durham, NC, as well as Beckley, WV, and the way the programs at those facilities were staffed. She did not know why she did not get staff. She stated that service chief 2 never instructed her to maintain a minimal workload. She said that on more than one occasion, he instructed her, "don't knock the doors down enrolling people," when doing outreach for veterans returning from OIF/OEF deployments. She stated that she did what she was supposed to do and enrolled whoever needed to be enrolled regardless of service chief 2's comments.

  She further stated that she was clearly aware her program was not being supported and recalled a particular incident involving a veteran's suicide. She could not recall the veteran's name. She stated that information came from staff, at either VA Central Office or Veterans Integrated Service Network (VISN) 6, Durham, NC, indicating that the veteran had committed suicide and was part of the VAMC Asheville OIF/OEF Program; however, she stated that she did not know the individual and was not aware the veteran was part of the program because of the size of her caseload. She said she did not destroy documents—specifically OIF/OEF patient records. She reported that she did not have a stack of records of any kind in her desk drawer when she left employment at VAMC Asheville. She stated that service chief 2 did speak to her about her licensure after a coworker lodged a complaint against her. She explained that the complaint, made by a

social worker, alleged that she had an inappropriate relationship with a patient; she denied this occurred. She claimed that the social worker wanted her job and that when service chief 2 learned of the complaint, he told her the matter had the potential to affect her license. She stated that she had not engaged in an inappropriate relationship and said the male identified in the complaint was not her patient.

- Service chief 2 stated that he was the former employee's supervisor while she was responsible for the OIF/OEF Program. He said he did not instruct the former employee to delay processing new enrollee's applications nor did he threaten her professional license.

- VAMC administrative employee 2 stated that as part of the OIF/OEF Program, she accompanied a social worker assisting returning units and collected and processed the units' members' applications for VA care. She said she was not aware of a listing of veterans never entered into the system or who had died waiting on VA care. She stated that she had not been asked to eliminate veterans' applications because of their medical conditions or if they had private physicians. She also stated that the OIF/OEF Program was on track and there was no backlog and noted that she was not aware of unofficial patient lists of any type.

- A social worker stated that the OIF/OEF Program was understaffed and overwhelmed and that there were problems with veterans who had enrolled but encountered enrollment problems. She said she had no firsthand knowledge of the problems but was told there were "maybe a hundred" DD-214s that had been shredded or not submitted before their filing and that situation allegedly was the work of the former VA employee. She stated that she was not part of the OIF/OEF Program, but of another service, and she had heard the DD-214 rumor some time ago. She said many of the OIF/OEF Program duties fell on her and she did much of the case management—which had been the former employee's responsibility. She stated that she was not aware of any patients' suicides directly related to alleged neglect by the former employee. The social worker also stated that she knew that the former employee had been inappropriately involved with a patient. She said she had reported the matter to service chief 2 and the former employee had left VA employment soon thereafter.

- CS2 stated that VAMC Asheville was funded to fully staff the OIF/OEF Program but did not do so. CS2 said the former employee worked in the program alone without support staff and there was a case manager assigned to the program on paper but not in practice. CS2 stated that when service chief 2 was asked by staff about funding and staffing for the OIF/OEF Program, his response had been, "why would we (VA) create special programs when those veterans are going to die off anyway like Vietnam and Korea Veterans?" CS2 said that comment was voiced more than once and at a time when suicide rates among OIF/OEF veterans were receiving much nationwide attention.

- VAMC physician 2 stated that he was working with patients visiting the PC Mental Health (MH) Clinic, and in the past, had worked on the in-patient unit and with suicide prevention and had been involved with the development of the facility's OIF/OEF Program. He reported that in 2010, he had concerns about the screening process for

OIF/OEF veterans. He stated that he was clinically seeing patients shortly after those patients had been screened by the former employee even though the screens were not showing any clinical problems. However, when he saw the patients, he noted a number of clinical needs, including depression, substance abuse/addiction, readjustment problems following deployments, Post-Traumatic Stress Disorder (PTSD), and post-concussion problems.

He stated that his observations did not "line up" with the former employee's notes and that he had made those observations on "a number" of patients, not just one or two. He had no proof of intentional wrongdoing. He stated that those problems would have been readily identifiable to a trained individual, especially since he was seeing the patients "so soon" after the patients had been screened. (He described "so soon" as being approximately a week following screening.) He said the total number of charts he had found with what he claimed contained missed problems during assessments was approximately six. He added that he felt that was a large number, especially since the notes were "very cursory" and the individuals showed up in crisis soon after their assessments. He stated that he had brought his concerns to the former chief of staff, who was now at another VA location. He said he had showed the former chief of staff several charts to illustrate his concerns. He stated that he was later told the matter was looked into and the situation was "checked out." He further stated that he had not encountered such instances of missed problems since 2010 and that there had been improvement once the OIF/OEF Program Coordinator was replaced.

- A VAMC senior leader denied that the former employee had been assigned 4,000 patients while serving as the OIF/OEF Program Coordinator. She stated that she was aware of the former VA employee's resignation from VA. When asked about her knowledge of the allegations, she responded, "The only comment I can make is [the former employee] did resign." She said she believed the number was "markedly different," meaning fewer than 4,000. She stated that she had no knowledge of missing DD-214s from a military reserve unit based in Greensboro, NC. She said the notion that facility staff lacked the desire to grow the veteran population was "absolutely" untrue. She stated that she did not know anything about the allegation that patients' records were screened rather than the patients. She also stated that the former chief of staff had never brought that information to her attention.

- A VISN senior leader stated that he was unaware of these circumstances and specific allegations but expressed concern that it had been alleged that patients' records were assessed/screened rather than the patients before they presented in a crisis period.

Allegation 7: County Veterans Service Officers Routinely Encountered Veterans Who Experienced Problems With Enrollments and Appointments

During interviews with CS 1 and CS 2, it was alleged that Veterans Service Officers (VSO) in Western North Carolina routinely encountered frustrations when assisting veterans with enrollment or appointment issues at VAMC Asheville. For example, fearing reprisals, none of the VSOs dared to complain to VAMC Asheville staff.

Interviews Conducted

- VSO 1 said she did not have any problems at VAMC Asheville but acknowledged that she had experienced several problems when dealing with VAMC Salisbury. She stated that those problems did not involve E&E staff or physicians returning phone calls. She added that none of the problems encountered at VAMC Salisbury had resulted in patient care issues. (Information specific to Salisbury was handed over to the OIG special agent investigating scheduling allegations at VAMC Salisbury.)

- VSO 2 stated that she did not encounter problems with VAMC Asheville.

- VSO 3 stated that she had heard from numerous veterans who applied for VA health care online and then never heard back from VA after the application had been submitted. She said she assisted those veterans with the enrollment process and noted that, at VAMC Asheville, the process via E&E, was slow. She stated that after she began using the VAMC Asheville Rural Health Team staff, enrollment was cut down to 2 to 3 weeks, which was much faster than going through E&E. She said she assisted veterans with 10-10EZ forms daily and that more problems were experienced at VAMC Salisbury than at VAMC Asheville. At VAMC Salisbury problems included no one seemed to return her phone calls or calls from veterans who had applied for care or were enrolled and were trying to schedule an appointment or inquire about care. (Information specific to Salisbury was handed over to the OIG special agent investigating scheduling allegations at VAMC Salisbury.)

  She recalled a recent example involving a veteran enrolling directly at VAMC Asheville and experiencing problems. She stated that the individual was a zero percent service-connected, Vietnam Era veteran and that during his encounter with a clerk, he was told he was not considered a veteran under "Obama Care." He had presented her with a DD-214 form and a 1010EZ enrollment form but still was told that he was not considered a veteran. She said she thought the clerk had been confused about the Affordable Health Care Act, and the veteran became upset for his not being considered a veteran. The witness did not mention any other issues at VAMC Asheville.

- A VAMC senior leader stated that she had no knowledge of any county VSO having problems interacting with VAMC Asheville staff. She said VAMC Asheville served 20 counties; she denied knowledge of any problems involving any of the VSOs.

Conclusion

Allegation 1

The investigation did not substantiate the allegation that employees who sought to meet with, or speak to, the Compliance Officer had their contacts with that office monitored.

Allegation 2

The investigation did not substantiate the allegation that CBOC Franklin recall appointment reminders had been intentionally destroyed; instead, we found that a manager had made the

decision to stop sending the recall reminder letters following the loss by the facility of two of its physicians. These letters were maintained in a locked filing cabinet.

Allegation 3

The investigation did not substantiate the allegation that consults had been inappropriately canceled. Our review did not identify instances of inappropriate actions in closing consult requests.

Allegation 4

VA OIG determined that VAMC staff used an unofficial wait list to contact newly enrolled veterans and schedule them for primary care appointments. The investigation also determined that scheduler turnover and physician attrition significantly increased the number of patients awaiting care.

VA OIG also found that VAMC staff used an unofficial form for veterans who enrolled in person. After the OIG brought this matter to management's attention, the VAMC discontinued this inefficient practice.

The investigation revealed that 35 veterans, appearing on a list of 1,322 under the status "declining care," were dead at the time of aVAMC internal audit seeking to determine which veterans had declined care. OHI reviewed the 35 veterans' health care files and determined that 25 of them, or their families, had either declined care, been scheduled a PC appointment and then canceled or no-showed, or faced circumstances eliminating the need for a PC appointment. The remaining 10 cases did not have sufficient documentation to determine if the patient actually declined care. However, in five of these cases, VA OIG obtained paper documentation suggesting that either the family declined care or that the facility had made appropriate attempts to contact the patient.

In the case of the 73 alleged deceased patients removed from the PC Waiting List from October 1, 2009 through July 9, 2014, we found 34 records had been removed from review either because the patient's date of death preceded placement on the PC Waiting List or the medical record did not show the patient was deceased. OHI determined that the remaining 39 patients either received PC services as requested; were scheduled timely for a PC appointment but either canceled, no-showed, or declined; were receiving PC elsewhere; and/or died within 90 days of being placed on the PC Waiting List. Many of these patients were in a nursing home or under hospice care at the time of their death. Due to limited information available about those veterans' causes of death, private care, and medical histories, it could not be determined whether a completed primary care appointment prior to the patient's death would have made a clinically significant difference in the patient's outcome.

Allegation 5

The investigation did not substantiate that recall appointment reminders were intentionally destroyed. The reminders were deleted; however, the deletion was in error and the employee responsible immediately began to rectify the situation. The facility also assigned a team to correct the problem of the remaining individuals with deleted recall reminders.

Allegation 6

The investigation found that OIF/OEF Program staff felt they were understaffed.

Allegation 7

The investigation did not find that VSOs were reporting they routinely encountered veterans who claimed to experience problems with access to VAMC Asheville. Two VSOs interviewed stated they did not experience any problems with VAMC Asheville. Two VSOs stated they did experience problems with VAMC Salisbury. One VSO stated she knew of one veteran who had recently had encountered a problem with VAMC Asheville staff.

VA OIG referred the Report of Investigation to VA's Office of Accountability Review on June 6, 2016.

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