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

VA Medical Center in Pittsburgh, Pennsylvania
July 13, 2017

1. Summary of Why the Investigation Was Initiated

The Department of Veterans Affairs (VA) Office of Inspector General (OIG) began an investigation in 2014 following media reports that the VA Pittsburgh Health Care System (VAPHS) had a list of 700 veterans waiting for appointments and that computer systems were being manipulated to hide appointment scheduling problems.

2. Description of the Conduct of the Investigation

- **Interviews Conducted:** VA OIG interviewed more than 40 current and former VA employees.
- **Records Reviewed:** VA OIG reviewed VA emails and Official Personnel Folders.

3. Summary of the Evidence Obtained From the Investigation

Interviews Conducted

- Former senior leader 1[1] said it was her understanding that VA medical support assistants (MSAs) were being directed by their immediate supervisors to manipulate computer appointment entries so that it appeared that scheduling performance standards were met when in reality the standards were not being met. She added that earlier that morning (May 30, 2014), MSA1 had told her that immediate supervisors of MSAs directed them to manipulate waiting list numbers being reported in a list known as the "MUMPS"[2] (Massachusetts General Hospital Utility Multi-Programming System) report. She stated that the MUMPS report lists the number of days all appointment requests have been in the system. She explained that MSA1 had also told her that immediate supervisors would run the MUMPS report and then direct MSAs to enter the computer system, make changes, and then exit the computer system, which resulted in the report showing a shorter wait time for an appointment. She also stated that before the VAMC Phoenix

[1] In the early stages of this investigation, former senior leader 1 was still employed at VAPHS.
[2] MUMPS refers to the Massachusetts General Hospital Utility Multi-Programming System. A routine using MUMPS captures scheduling information and generates a report with specific focus on information regarding desired dates.

incident,[3] she had never heard of a New Enrollee Appointment Request (NEAR) List, nor was she aware that VAPHS had nearly 700 veterans on an appointment waiting list. She added that the NEAR List was maintained under the Patient Care Services section, which was led by senior leader 1, senior leader 2, and program manager 1. She also stated that lists of consultation requests were maintained at each specialty clinic office with all clinics falling under the supervision of senior leader 3.

- MSA1 stated that he had been directed to schedule appointments in a manner that did not accurately reflect accurate wait times. According to him, the MUMPS report lists wait time for an appointment in days, and schedulers did not particularly like to see their names on that list—as it would mean they were not scheduling appointments within 30 days. He also said that he was directed to improperly schedule appointments about 2 years ago but did not remember who had told him to improperly schedule appointments.

- MSA2 stated that she was trained to schedule appointments so that the wait time was zero. She said she was not told that this method was improper, but that it was the way it should be done. She added she thought scheduling appointments in this manner was wrong because it did not accurately reflect the true number of days a veteran waited for an appointment. She stated that appointments were scheduled in that manner so that it appeared the appointment was completed within 14 days. She also stated that it was important that excess waiting days not appear on the MUMPS report.

- Former VAPHS employee 1 stated that she was upset that former senior leader 1 had claimed not to have heard of the NEAR List until April 2014. She said she had been detailed to work on the NEAR Call List in 2011 to help reduce the number of veterans on it. She observed that it was an important effort and former senior leader 1 should have been aware of it. She stated that she had never been instructed to mispresent the number of veterans on the NEAR List and had never been told to do anything dishonest.

- Program manager 2 stated that, among her various duties, she oversaw the work of supervisory MSAs and, for two periods of time in the absence of a supervisory MSA, she had taken over the responsibility of MSA supervisor. She said she did not know how to schedule appointments in the Appointment Manager Program, nor did she understand how it works. When asked if she were aware of any directions or instructions from anyone above her in the chain of command to manipulate actual wait times so that they looked lower, she replied that a recent change (shortly before June 2014) might affect wait times. She stated that national guidance from the chair of VA's National Radiology Program directed that appointments should be made based on the provider's "desired date" and not the veteran's desired date. She reportedly had found that schedulers would change the appointment date that was set by the physician's order to match the veteran's desired date for the appointment. She explained that when she learned of this national level direction, she had ordered her schedulers to follow the scheduling directive that

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

stated an appointment should be based on the date the physician specified and to not base the appointment date on the veteran's desired date. When asked if anyone in the supervisory chain above her told her to do anything to make sure appointments took place within 30 days so they would not show up on the MUMPS report, she said she had not given any such instructions nor did she know who gave the direction to change physician order dates to match the veteran's desired date. However, when she learned of the practice, she had stopped it. She said she instructed her subordinates to schedule appointments per the scheduling directive.

- Administrative officer 1 stated that she was not aware of any prohibited scheduling practices that would disguise patient wait times.

- Supervisory MSA1 stated that she was not aware of any manipulation of patient wait times in her office. She said schedulers tried to avoid appearing on the MUMPS report for scheduling an appointment beyond 30 days of the order date. She added that her office did not normally have any issues with the MUMPS report.

- Service chief 1 stated that she had no knowledge of the NEAR List being worked from paper lists nor had she heard of any cancellations made through that list.

- Program manager 1 stated that he assumed his position in mid-2012 and at that time program support assistant (PSA) 1 was assigned to work the NEAR List. He explained that PSA1 was directly supervised by program manager 3 and that both PSA1 and program manager 3 reported to him. He stated that in late 2012, program manager 3 took another position and he (program manager 1) then directly supervised PSA1. He added that senior leader 2 was his immediate supervisor and that he (program manager 1) ultimately reported to senior leader 1. He stated that he was not involved in scheduling veterans for appointments from the NEAR List but did use numbers from it to forecast and justify requests for additional staff positions for the Primary Care Service so as to increase access of medical care to veterans. He further stated that requests for additional staff are known as ADRR requests (Associate Director Resource Request).

  He also stated that the NEAR List was not a well-known topic or a widely used term at VA because of its restricted access. He said the notion that the NEAR List was secret, dormant, and unattended was inaccurate. He stated that PSA1 properly managed the list to the extent that Primary Care staff were available to attend to scheduled appointments. He provided several reasons why the NEAR List grew to a high number of veterans waiting for an appointment:

  - The loss of physicians from the Primary Care staff with short notice;
  - The use of part-time physicians;
  - The disruption from a restructuring of the Primary Care Service, which resulted in the loss of scheduling control of a number of physicians because they were moved to the supervision of the Medicine Service Line;
  - The disbanding of the Intake Desk;
  - The Electronic Wait List (EWL) not used;

- Veterans not closely scrutinized to determine if they wanted a Primary Care appointment;
- Hiring actions were taking about 8 months to hire a new physician.

He stated that he learned that PSA1 had a longstanding practice of routinely using a spreadsheet version of the NEAR List as a working document. He explained that PSA1 found this easier to work with, unlike the outdated DOS computer language that is used in the Veterans Information Systems and Technology Architecture (VistA) application where the NEAR List is located. He stated that the NEAR List was never manipulated, deleted, or emptied of names to hide or disguise the number of names on it. He added that sometime in May or June 2014, program manager 4 conducted a comparative review of the names on the NEAR List and the names on one of PSA1's spreadsheets and did not identifyany discrepancies. He stated that PSA1 was instructed by program manager 4 to stop using his spreadsheet versions of the NEAR List after the allegations about Phoenix VAMC surfaced.

- Program manager 4 stated that he assumed his position in late 2013 and that he reported directly to program manager 1. He explained that PSA1 was responsible for scheduling appointments for about one-half of the veterans on the NEAR List. He further stated that PSA1 was responsible for referring the other half for appointment scheduling to three separate VA entities: OEF/OIF[4] Clinic, Women's Health Clinic, and the Community Based Outpatient Clinic (CBOCs). He added that PSA1 and the three other clinics did a good job managing the NEAR List. He also stated that PSA1 sent him monthly emails reporting the number of names on the NEAR List. He said that program manager 1 and more senior management officials were not included on PSA1's emails. He stated that he used the NEAR List data to justify additional staff requests for Primary Care sent via ADRR, adding that he routinely discussed the NEAR List and ADRR requests with program manager 1. He said he learned that PSA1 used a printed spreadsheet version of the NEAR List because PSA1 stated that it was easier to manage, sort, and annotate. He pointed out that he had told PSA1 to stop the practice and no wrongdoing was discovered with its use. He stated that he was not aware of any under-reporting or manipulation of the number of names on the NEAR List.

  When asked about his knowledge of "phony clinics," program manager 4 stated that Primary Care was asked to assist the Gastroenterology and Pulmonary Clinics because they were unable to schedule appointments within 30 days. To keep track of the list of names, he set up what he said could be described as a "phony clinic" in the Recall/Reminder software to manage this new list of veterans waiting for appointments. He stated that Primary Care set a goal of contacting veterans on this list and scheduling them for an appointment within 30 days. This practice was established so that these veterans would not be lost in the system. He indicated that the most important type of Gastroenterology consult request that needed to be scheduled was a screening colonoscopy.

[4] Operation Enduring Freedom/Operation Iraqi Freedom

- PSA1 stated that he worked the NEAR List from its inception at VAPHS sometime in the early 2000s until 2004 when he was reassigned. He explained that from 2004 to 2010, a registered nurse was assigned as access coordinator and took over the responsibility of scheduling veteran appointments from the NEAR List. He stated that after the registered nurse retired, he resumed NEAR List duties and noted upon his return in 2010 a significant increase in the number of veterans on the list. He identified his immediate supervisors as program manager 3 and program manager 4. He stated that he sent monthly reports with the number of veterans on the NEAR List to senior leader 2, program manager 1, program manager 4, and administrative officer 2, who oversaw the CBOCs. PSA1 stated that he downloaded NEAR List data from VistA to a Microsoft Excel spreadsheet because they were easier to view and easier to filter and move data, to construct an easy-to-understand report. He said he used the spreadsheet as a tool to assist his management with the NEAR List. He stated that he never deleted names from the list and only displayed them on a spreadsheet for ease of use. He added that he was never directed by anyone or offered a financial incentive to falsely report, manipulate, or misrepresent the number of veterans on the NEAR List.

- Program manager 5 stated that she was not familiar with the appointment scheduling process but her duties required her to monitor wait times and access to care. She further stated that she was not aware of any efforts or directions from anyone to disguise or hide true wait times.

- A program analyst stated that a major part of her duties involved her membership on the training committee for MSAs. She said she worked on developing more robust and meaningful training so that MSAs could better understand and be more proficient in scheduling appointments. She noted it was important to emphasize to MSAs that when there is a conflict with the veteran's desired date and the provider's desired date (meaning the appointment cannot be accomplished within 30 days of the provider's desired date), the MSA must contact the provider and ask the provider to select another desired date or contact the veteran and explain to him or her the importance of the appointment. She stated that an MSA cannot make these kinds of determinations without provider involvement.

- Program manager 6 stated that she was familiar with appointment scheduling as she filled in as the supervisor MSA for about 2 years because of a vacancy until supervisory MSA2 was hired. She said her service usually did not have any scheduling problems because of the importance of the procedures it performed.

- Supervisory MSA2 stated that she served as supervisory MSA in a specialty service from late 2013 to early 2014 and served under program manager 2. She explained that she became aware of a way to reset the 30-day time frame for scheduling appointments so that they did not exceed the 30-day requirement. When asked if she used this method, she said she "may have played around with it." She could not identify by name who told MSAs to do it and stated that it was done to make "your numbers" look good (scheduling within 30 days). She reported learning that this activity was occurring in her specialty service when MSA3 told her she was changing wait times. She stated that MSA3 told

her that she was told to do it by a former supervisory MSA; she added that she felt program manager 2 wanted MSAs to change wait times so they were less than 30 days.

- MSA3 stated that she worked as an MSA in a specialty service from late 2011 to early 2014; she was supervised by former supervisory MSA1. She explained that after former supervisory MSA1 left VA employment in late 2012, program manager 2 filled in as supervisory MSA until supervisory MSA2 arrived. MSA3 stated that program manager 2 was always concerned about "the numbers." She explained that the numbers were about whether appointments were being scheduled within 14 or 30 days. She stated that supervisory MSA2 emphasized the numbers, too, but only as a result of program manager 2's interest. She said she learned how to re-enter appointments she had scheduled that were going to be greater than 30 days so that the wait time was less than 30 days. She stated that no one showed her how to re-enter appointments. She said she just learned how to do it once she became very familiar with the VistA program.

  She stated that program manager 2 never told her to change wait times on appointments but program manager 2 was the person to whom this practice was attributed. She further stated that she learned of program manager 2's desire for shortening wait times from program manager 2's staff meetings and emails. She added that former supervisory MSA1 also sent emails directing schedulers to reschedule appointments because the wait time was too long. She stated that she had not saved any of these emails. MSA3 pointed out that when an appointment was re-entered and the wait time was shortened, the actual date of the appointment did not change. The only date that changed was the date the appointment was scheduled. When asked if she showed other schedulers how to shorten wait times, she replied that she had shown others how to shorten the wait times on appointments that they had already scheduled. She said she shortened wait times on her appointments only because those above her wanted her to do it. She also stated that she did not feel that the veteran was being harmed because she did not change the actual appointment date.

- MSA4 stated that supervisory MSA2 was her supervisor from late 2013 to early 2014; after early 2014, program manager 2 took over the supervisory duty. She stated that supervisory MSA2 told her and other MSAs in about December 2013 to bring to her the appointment paperwork for appointments that exceeded 30 days' wait time. She explained that she did not know why supervisory MSA2 made the request until supervisory MSA2 told her (MSA4) to come to her office and she (supervisory MSA2) showed her how to shorten wait times on appointments, so that the wait time was no more than 30 days. She said she believed that up to that time supervisory MSA2 was the only person changing appointment wait times. She also said supervisory MSA2 showed her how to do it so that she (MSA4) could do it herself. She further stated that supervisory MSA2 told her the reason for shortening wait times was to make "the numbers" look better.

  She explained that when shortening appointment wait times, the appointments that exceeded 30 days were not duplicated but re-entered to reset the beginning of the wait time period to the date of re-entry. She stated that she had shortened wait times about

20 times between December 2013 and March 2014. She added that on each occasion, she had asked supervisory MSA2 if she should shorten the wait time. She also said that on occasions, when the appointment was only a few days over 30 days, supervisory MSA2 would tell her not to change it. However, on occasions when the provider selected their desired date as the same date they entered the order, supervisory MSA2 wanted her to shorten the wait time because she (supervisory MSA2) felt the provider was not supposed to use the same date for the enter date and the desired dated. She said she felt program manager 2 was aware of the shortening of wait times. She added that she believed this because shortly after supervisory MSA2 left the specialty service in early 2014, program manager 2 told her to stop doing it. She said she concluded that since program manager 2 had told her to stop, she must have known that she was doing it. She further stated that she did not know if program manager 2 had told supervisory MSA2 to shorten wait times, nor did she know if anyone told program manager 2 to have it done.

She stated that the other MSAs in the specialty service were not shortening wait times because they brought their paperwork to her so she could shorten the wait times for them. She didn't start changing wait times for the other MSAs until supervisory MSA2 left; up to that time, the other MSAs took their overdue appointments to supervisory MSA2 for shortening the wait times. She stated that MSA5, MSA6, and MSA7 brought appointments to her to shorten the wait times. She said that after supervisory MSA2's departure, program manager 2 asked her to send her (program manager 2) a daily email concerning the appointments for which she shortened the wait times. She stated that she sent these kinds of emails to program manager 2 for about 2 months at which time program manager 2 told her to stop shortening wait times. She said it was her opinion that program manager 2 requested the emails in an effort to understand why it was done and to learn about the process. She stated that she felt program manager 2 seemed uninformed about the process of shortening wait times.

MSA4 was reinterviewed and shown 11 emails found during the email review: 9 sent by MSA4 and 2 sent by program manager 2, all dated April and May 2014. The emails were exchanged between her and program manager 2. (NOTE: In July 2014, MSA4 reported that program manager 2 asked MSA4 to send her emails with a listing of appointments for which MSA4 had changed the wait times.) When MSA4 was asked if the 11 emails shown to her were the kind she sent to program manager 2 in response to program manager 2's request, she replied that she couldn't say if these emails with attachments listed the appointments for which she had changed the wait time. She did acknowledge that program manager 2 had asked her to send the lists and that she (MSA4) did send program manager 2 the lists of changed wait time appointments. She said she couldn't think of another reason why she would have sent the nine emails so she concluded that they were in fact in response to program manager 2's request. MSA was also shown 83 additional emails, 72 of which were between her and MSA5. She identified one email (sent in March 2014 from MSA5 to supervisory MSA2) as an example of MSA5 asking supervisory MSA2 to change the wait time on an appointment. She stated that the remaining emails were not related to changes in appointment wait times.

- MSA8 said he worked under the supervision of former supervisory MSA1 and supervisory MSA2. He stated that he had not heard of the practice of MSAs shortening wait times on scheduled appointments so that the wait times were less than the required 30-day standard. He also stated that no one had told him to do it. He said neither former supervisory MSA1 nor supervisory MSA2 ever talked to him about it.

- Former MSA1 stated that he served as an MSA in the specialty service from 2007 until early 2014. He said he was supervised by administrative officer 3, former supervisory MSA2, and former supervisory MSA1. He stated that program manager 2 and former supervisory MSA1 only asked him to change appointment wait times if there was a medical necessity or appointment conflict. He said it was possible that former supervisory MSA1 and supervisory MSA2 had asked him to re-enter an appointment so the wait time would not exceed 30 days. He explained that former supervisory MSA1 and supervisory MSA2 had asked him to change an appointment date just to get a veteran into an earlier appointment. He stated that he was not asked to re-enter an appointment just to shorten the wait time. He added that the shortening of wait time couldn't be done and he did not have the computer access to do it. He stated that neither former supervisory MSA1, supervisory MSA2, or MSA4 had asked him to give them his appointment paperwork so they could shorten the wait time.

- Former supervisory MSA1 stated that when she worked as an MSA, her supervisory MSA from 2007 to 2008 was former supervisory MSA2. She explained that former supervisory MSA2 was suspected of re-entering/re-ordering veteran appointments just before they were going to exceed 30 days in wait time. She stated that former supervisory MSA2 had told her that service chief 2 wanted him to shorten wait times because the Veterans Integrated Service Network (VISN) did not want lengthy wait times. She said former supervisory MSA2 would identify appointments that exceeded 30 days in wait time and cancel the original provider's order and re-enter the order with a new desired date that matched the current date. She stated that the actual appointment date did not change, just the wait time. She said former supervisory MSA2 instructed all the MSAs to re-enter provider orders that had wait times exceeding 30 days to satisfy management's wishes. She stated that when she succeeded former supervisory MSA2 as the supervisory MSA, she put an end to the practice. She explained that when an appointment was canceled and re-entered by an MSA, a new order would appear in VistA. The new order no longer contained the original provider's name; it now showed the MSA's name as the ordering physician. After she left, she said she heard that supervisory MSA2, her successor, was shortening wait times but she had no firsthand knowledge of it. She also said she did not know if program manager 2 had been aware of the practice.

- Former VAPHS employee 2 stated that she knew nothing about secret patient waiting lists. She remarked that service chief 2 was interfering in the current VA OIG investigation and she did not know anything about wait list issues. She made several complaints about VA, all unrelated to the NEAR List and specialty clinic scheduling practices. She stated that a VAMC Pittsburgh union official was knowledgeable about allegations of service chief 2's interference with the VA OIG investigation. She said that

a VA employee known to the union official told her that service chief 2 had been meeting in the past 2 weeks with microbiologist technicians to advise them to answer VA OIG questions with the answer "I don't know."

- MSA6 stated that he has worked at VAPHS since 2001 as an MSA. His immediate MSA supervisors were former supervisory MSA1, supervisory MSA2, and former supervisory MSA2. He explained that at the current time (August 2014), there was no supervisory MSA and program manager 2 was filling in. He initially stated he was never instructed by anyone at VA to change wait times on his scheduled appointments. He said he knew that it was happening but he did not know who gave the instruction to do it. He then said he did not change wait times on his scheduled appointments and that he refused to do it when asked. He stated that no one specifically had asked him to change wait times; it was just a part of what management was telling the MSA staff. He explained that administrative officer 3 was the immediate management supervisor at that time but he did not know if such instructions came from her or someone else. He recalled hearing about it in general conversations and he did not know if any of his coworker MSAs did it. When advised that an OIG investigation had revealed that he had changed appointment wait times, he replied this was the first time he had heard that information. He stated that he did not recall changing wait times but conceded that he may have changed one or two appointments. He noted that his reason to re-enter an appointment was never just to shorten the wait time to satisfy management's desire to have "good numbers." He stated that he did it because an order had been canceled and it needed to be re-entered so the veteran could have an appointment. He added that he did not know that MSA4 had been trained to shorten wait times on scheduled appointments and denied giving her his appointments to shorten wait times.

- MSA9 stated that he had been working as an MSA since 2004. He identified former supervisory MSA1, supervisory MSA2, and former supervisory MSA2 as his supervisory MSAs since 2004. When told that an OIG investigation had identified him as having changed appointments, he admitted modifying information on appointments when he was an x-ray technician and that was because the ordering provider had omitted details from an order. He stated that no one ever had specifically told him to shorten wait times, but it did appear to him that the emphasis on the subject indicated to him that management was interested in having appointments scheduled within 30 days. He said he was never shown how to schedule an appointment in a way that would result in no wait time. He stated that he did not remember former supervisory MSA1 or former supervisory MSA2 asking MSAs to change wait times on their scheduled appointments. He said he thought the intent of re-entering a provider's order to get a new 30-day period was "to keep their numbers looking good." His feeling was that the supervisory MSAs did not like the idea but they did what they were told to keep their jobs. He suggested that administrative officer 3, and later program manager 2, probably told the supervisory MSAs to implement the practice of changing wait times.

- MSA7 stated that she became an MSA in mid-2013 and had been supervised by program manager 2 and supervisory MSA2. She explained that no one asked her to change the wait time of her scheduled appointments that exceeded 30 days. She stated that she was

not told to give such scheduled appointments to anyone else to change. She added that, in January or February 2014, supervisory MSA2 had told her that she (supervisory MSA2) would train her to "fix the desired date so it would not be over 30 days." She stated that the training never occurred and she never changed wait times on her scheduled appointments. She explained that supervisory MSA2 had told her she wanted to train her and others to change only magnetic resonance imaging (MRI) appointments so that they did not appear to take more than 30 days to complete. When asked again if she ever gave any of her scheduled appointments that exceeded 30 days' wait time to anyone to change, she said she did not remember doing it.

She went on to say that supervisory MSA2 had trained MSA4 to change wait times on MRI appointments. She stated that she had spoken to MSA4 about it and MSA4 had said she was uncomfortable doing it and felt she had to do it as a subordinate as well as being a new employee. She added that MSA4 had told her she felt obligated to do it since her supervisor ordered her to do it. She said she now recalled (at the time of the interview) that if she had an appointment that needed to be changed because of the 30-day rule, she put the appointment paperwork in a drawer in the front office. She said her understanding was that MSA4 would retrieve the paperwork from this drawer and subsequently change the wait time. She stated that supervisory MSA2 established this procedure and that the motive for the changing of wait times was "the numbers," meaning keeping wait times under 30 days to complete an appointment.

- Former MSA2 stated that his line of supervisors emphasized the importance of scheduling appointments within 30 days. He added that management implied to MSAs that if they could not schedule an appointment within 30 days, they were to cancel the request and re-submit it so that the appointment would be scheduled in conformity with the 30-day rule. He stated that he did not comply with this instruction because he was not a provider and did not feel qualified to determine whether a veteran's medical needs were being met when he changed an appointment date. He said he felt this instruction was management's use of a loophole to get "their numbers" to where they needed to be. He noted he was not sanctioned for not complying and also noted that management did not put this instruction in writing.

  He stated that the instruction to cancel and re-enter appointments was communicated at staff meetings by service chief 2. He said he had told service chief 2 that her instruction was not right. He stated that former supervisory MSA2 agreed with him and that the other MSAs did not want to do it either, but they felt they had to in order to protect their jobs. He added that former supervisory MSA2 followed orders by disseminating service chief 2's instruction to his subordinate MSAs but former supervisory MSA2 never counseled him for not complying. He said he did not believe that former supervisory MSA2 counseled anyone for not doing it. He also said he thought former supervisory MSA1 may have complied with service chief 2's instruction. He stated that former supervisory MSA1 was investigated for it but thought it was never substantiated. He said he did not know if administrative officer 3 and program manager 2 enforced service chief 2's instruction to cancel and re-enter appointments but thought both definitely encouraged it.

- MSA5 stated that he had worked as an MSA since late 2012. He identified his supervisors as former supervisory MSA1, supervisory MSA2, and program manager 2. He stated that former supervisory MSA1 did not ask him to cancel and re-enter appointments and added that he did not know how to do it. He said he thought MSA4 was taught how to cancel and re-enter appointments exceeding the 30-day wait time limit. He stated that he did not know who showed MSA4 how to do it nor did he know who told her to do it. He said this practice took place under supervisory MSA2. When asked whether he had been told to give his overdue appointments to MSA4 to fix, he said no, but stated that he would call MSA4 and tell her he had an appointment exceeding the 30-day limit and ask if there was a way to get another request from the provider. As a result of these exchanges with MSA4, he said he figured she knew how to make a new appointment. He stated that he may have called MSA4 on a few occasions to get another order for his overdue appointments rather than him contacting the provider and asking for a new order. He said he did not know if she was getting a new order from the provider, but he knew she knew how to re-enter information to get a new order. He stated that supervisory MSA2 had told him to keep track of his appointments that were nearing or were over the 30-day limit and was to notify her of them. He said supervisory MSA2 was able to adjust the wait times because he saw her name on the provider orders, which indicated to him that she had re-entered the order and appointment without contacting the provider.

  MSA5 was shown 55 emails identified during our email review. He identified 24 emails with varying degrees of certainty as emails he had sent to supervisory MSA2 for her to adjust the wait times for appointments that he could not arrange within 30 days. He explained that supervisory MSA2 had instructed him to email to her the appointments he could not schedule within 30 days. He stated that she had told him she could adjust the wait time if it was within a few days of 30 days but that if it was overdue by 5 days, she most likely would have to contact the provider and get a new order. He said he could only assume that supervisory MSA2 changed the wait times on some of his appointments.

- Former supervisory MSA2 stated that in about 2006 or 2007, he became the supervisory MSA until he left VA employment in early 2010. He added that his supervisor was administrative officer 3 who reported to service chief 2. He said the subject of scheduling appointments within 30 days was important and he was familiar with efforts to change paperwork so that it looked like appointments were scheduled within 30 days when, in fact, they were not. He stated that he had received emails on the subject from administrative officer 3 assuming that they originated with service chief 2 or someone higher. When shown an email string starting on June 4, 2008 from administrative officer 3 to him, he acknowledged that, in this email, he instructed his subordinate MSAs to cancel and re-enter overdue appointments without contacting the originating provider. He reportedly had received these instructions from his supervisor via email and that these instructions were discussed at staff meetings attended by MSAs and, on occasion, by service chief 2 and administrative officer 3. He stated that some MSAs canceled and re-entered overdue appointments without contacting the provider, while some MSAs did not. He said he did not know the names of the MSAs who did not contact the provider. He also said he thought service chief 2's motive was to keep the clinic's "numbers"

looking good. He stated that he did not recall any face-to-face conversations with service chief 2 about canceling and re-entering appointments without provider involvement but indicated that she advocated the practice through her emails and memos.

- PSA2 stated that she served as an MSA in a specialty service from about 1999 to 2007, and served as a PSA in a specialty service from 2007 to 2014. She said she was supervised as an MSA by administrative officer 3. She reportedly worked for a short time under former supervisory MSA2 but did not work for former supervisory MSA1 or supervisory MSA2. She stated that she had heard of a practice that MSAs would cancel and re-enter a previously scheduled appointment to obtain a new 30-day period to have the appointment scheduled and completed. She said she was not familiar with the manner it was done nor was she aware that former supervisory MSA1 or former supervisory MSA2 discussed this practice. She stated that she learned about the subject from overheard conversations and that she did not attend staff meetings or take notes of same.

- Administrative officer 3 stated that she supervised MSAs during her term as the administrative officer in a specialty service. She said service chief 2 and senior leader 4 were very concerned with scheduling appointments within a 30-day wait time period. She explained that this issue was discussed during teleconferences at the VISN and the national level. She said the primary problem was "no-show" appointments. MSAs were instructed to contact the provider and ask if the order should be re-entered. If the provider authorized it, the MSA could cancel and re-enter the order and in this way a new 30-day wait time period was created. She said there was poor communication of this process; confusion on the part of MSAs; and poor supervision of MSAs, which led to some MSAs canceling and re-entering an order without input from the provider. She reportedly did not recall service chief 2 endorsing the re-entering of a provider's order without provider contact and input. She stated that national- and VISN-level discussions led to a policy of MSAs entering a "service correction" to the provider order that was over the 30-day waiting period. This was a procedure that was done by the MSA without provider input. She also described the service correction action as one that already existed and was originally used to modify or correct an error made in the provider's order. She stated that the service correction solution was stretching scheduling policy but said it was approved during VISN and national discussions as a way to solve the no-show appointments that created wait times exceeding 30 days.

- A union official was interviewed following an interview of former VAPHS employee 2 who stated that the union official had information concerning an allegation that service chief 2 advised subordinates not to cooperate with a VA OIG investigation. The union official identified a VAPHS employee (referred to, in this report, as the union complainant) as the employee who contacted the union about service chief 2's comments. The union official said she had had two conversations with the union complainant about what service chief 2 said. She stated that the union complainant initially told her that service chief 2 had advised her and others that if they did not know an answer to an OIG question they should say they don't know. She further stated that the union complainant had said to her that service chief 2 did not tell the employees to lie. As for her second

conversation with the union complainant, the union official reported that she did not understand exactly what the union complainant had said about service chief 2's comments.

- The union complainant stated that service chief 2 had told the attendees in a July 2014 meeting that it was perfectly OK to say "I don't know," if they didn't know the answer to a question. He said service chief 2 wanted them to know that saying they didn't know was an acceptable reply to an OIG question. He added that service chief 2 did not refer to a specific OIG investigation. He stated that it was unclear whether the OIG investigation service chief 2 was referring to was the Legionella Disease investigation or the current investigation.

- A supervisory medical technologist stated that he attended a meeting in July 2014 at the request of service chief 2. The meeting was attended by three to four staff members from a specialty section. He said service chief 2 had told them to answer OIG investigators' questions to the best of their ability and to be honest. He stated that service chief 2 had invited the attendees to tell investigators they did not know an answer to a question if that were truly the case. He further stated that service chief 2 had told attendees to not provide answers that they "think" they know when they were not certain of the answer. He explained that the staff became concerned about losing their jobs after learning that administrative officer 4 had asked him for a list of all of his staff members so she could provide it to the OIG for its investigation. He said the staff thought the investigation was about the Legionella Disease issue. He stated that service chief 2 did not identify the subject of the OIG investigation and that there was no other topic discussed during the meeting. He said he did not think service chief 2 was insinuating to the staff to not answer OIG questions, nor did he think any other staff members had a different understanding of her comments.

- A former business manager stated that she had little to no involvement in patient scheduling as there were several management levels beneath her which had that responsibility. She said she recalled that a specialty service had wait-time issues with MRI exams and the problem was addressed by increasing clinic-time availability, adding equipment, improving space allocations, and providing on-call CT exams. She said she was not aware of any discussions concerning work-around practices by MSAs so that they could meet the 30-day wait time objective. She further said she did not know of any instructions given to MSAs to cancel no-show appointments and reschedule them without the provider's input.

  She reportedly was aware of the NEAR List. She explained that the NEAR List was not a subject tracked by the director's office until the spring of 2014, when the VAMC Phoenix allegations became public. After that time, each VA facility, including VAPHS, conducted an access review. As far as she was concerned, former senior leader 1 may not have had knowledge of the NEAR List before that spring. She stated that the NEAR List was a service line function used in the Primary Care unit, which was led by senior leader 2 who reported to senior leader 1. She said she was not aware of any allegations about the use of secret waiting lists or manipulating of, or disguising of, the actual

numbers on the NEAR List. She stated that she learned that PSA1 was the person assigned to work on the NEAR List and apparently was the only person assigned to it.

- Service chief 2 remarked that no-show appointments were problematic for MSAs once they were required to schedule appointments within 30 days of the desired date specified by the provider. She said national-level teleconferences were convened to discuss this issue led by the chair of VA's National Radiology Program. She recalled that former senior leader 1 and senior leader 3 emphasized compliance with timely appointment scheduling, but, in her opinion, offered no additional support. She said she did not allow the falsification of dates related to appointment scheduling. She stated that MSAs could cancel a no-show appointment without contacting the provider because an automatic alert was sent to the provider when an MSA canceled an appointment. The alert notified the provider that the appointment was canceled and they (the provider) were to re-order the exam if so desired. She said she was not aware of the practice of an MSA re-entering an appointment so that the 30-day wait time was reset to make it appear that the appointment took place within 30 days. She also reported not being familiar with MSAs using the "next available date" as the desired date when scheduling an appointment. She notedif this was done, there would be zero wait time. She said she did not know if this practice conformed with scheduling guidelines. She admitted meeting in July 2014 with the microbiology staff, at their request. She stated that the staff were concerned because administrative officer 4 had requested a list of their names for OIG interviews. She recalled the staff being very upset because they had no idea why OIG would want to question them. She said she told the staff to honestly answer questions and denied telling them to not be forthcoming in their answers.

- Senior leader 3 said that in early 2011 he was responsible for the Primary Care unit which used the NEAR List. He stated that in May 2012, Primary Care was placed under the supervision of senior leader 1 and that during the year he supervised Primary Care, there had been concerns regarding the size of the NEAR List. He found that the list contained many veterans who did not want Primary Care appointments. To eliminate names from the list, he directed staff to contact the veterans to determine their wishes regarding a Primary Care appointment. He said he also worked with the Veterans Engineering Resource Center (VERC), which provided some solutions, and that by the time Primary Care was removed from his supervision, the number of veterans on the NEAR List had been significantly reduced. He reportedly lost track of the management of the list until the spring of 2014 when it became a national VA focal point. He said he was familiar with the ADRR process, adding that the NEAR List was mentioned as justification for requesting additional provider slots in Primary Care. He said he had no knowledge of scheduling improprieties by MSAs in the specialty clinics. Senior leader 3 stated that he had learned from a section chief, in June 2014, the following: she had heard that during the weekend of April 26, 2014, program manager 1 reportedly told some of his clerks to shred documents and that a clinical nurse specialist may have additional details.

- The clinical nurse specialist said she did not know anything about the destruction of documents, including documents related to the NEAR List. She stated that no one,

including program manager 1, ever told her to destroy anything. She noted that she was a clinical nurse and was not involved in patient scheduling. She said she recalled having a conversation in April 2014 with senior leader 2 about her practice of printing out "outlier" lists and handing them to physicians so they could see the names of the veterans on the list. She said senior leader 2 told her she should not print out the lists and distribute them because they contained sensitive HIPAA and PHI data.[5] She stated that senior leader 2 felt the information should be shared via a SharePoint computer site. She added that after this conversation with senior leader 2, she had shredded the "outlier" lists. She said it was her decision to shred the lists and senior leader 2 had not told her to do so. She added that this topic could have come up in conversation with the section chief because the section chief liked receiving her lists. She also said that she did not recall specifically telling the section chief that she had shredded the "outlier" lists.

- Senior leader 5 stated that most of his duties at VAPHS concerned operational functions rather than patient clinical issues. He said he became familiar with the NEAR List in the spring of 2014 after the VAMC Phoenix issue became widely known and VAPHS began to look at its NEAR List and patient access issues. He also said he learned the VAPHS NEAR List had about 600 veterans' names on it and the list was assigned to one person, PSA1, who was supervised by program manager 1. He notedthat he was familiar to some of the reasons the NEAR List contained a high number of names: only one person worked on it; the list contained many veterans who did not want to schedule an appointment; and PSA1 did not properly document the patient contact records. He stated that the VAPHS did not use the EWL because former senior leader 2 did not want it used. He said former senior leader 2 may have believed that it was a performance indicator visible to VACO supervisors. He said he did not hear that "phantom clinics" were used or paper lists were used to hide the actual number of veterans' names on the NEAR List. He said he did learn that PSA1 used a printed paper list of the NEAR List names for her work but it was not used in place of the actual NEAR List.

  He stated that he was a member of the director's Quad group.[6] According to him, before the spring of 2014, the NEAR List was not discussed in Quad meetings with former senior leader 1. He reportedly did not recall hearing about the NEAR List during proposals for hiring additional Primary Care personnel. He stated that his job touched on increasing access to medical care for veterans but it did not include appointment scheduling. He added that he would not know who would benefit from manipulation of appointment wait times and he did not know who had performance measures related to wait times in their performance appraisal plans. He acknowledged participating in telephone conversations with former senior leader 1 when they had talked with several congressmen in the spring of 2014. He stated that former senior leader 1 wanted to be proactive in notifying the congressmen about the NEAR List issue because she had been criticized for not being proactive during the recent Legionella Disease issue. He said he and former senior leader 1 did not mispresent to U.S. Congressional representatives the

[5] Health Insurance Portability and Accountability Act and Personal Health Information
[6] The director's Quad is made up of four executive leaders: Deputy Director, Chief of Staff, Associate Director (Patient Care Services), and Associate Director.

number of veterans on the NEAR List.

- Program manager 3 said she learned of the NEAR List in 2010. She stated that the registered nurse handled the NEAR List at that time but when the nurse retired, PSA1 was assigned to it and she supervised PSA1 in that position. She said the NEAR List was not well understood and she worked on trying to manage it better. She described PSA1 as a good employee who worked diligently at scheduling veterans for appointments. She stated that PSA1 kept her and other management officials aware of the number of names on the NEAR List via emails. She said PSA1 used a Microsoft Excel spreadsheet to display the NEAR List names because they were hard to view in the VistA application. She said there was no misrepresentation of the NEAR List numbers on PSA1's spreadsheet. She noted that not removing a name from the NEAR List was essential until it had been confirmed that the veteran did not want an appointment. She stated that she had no concerns about PSA1's notations in the patient records regarding this issue. She added that she used the number of veterans on the NEAR List when talking about and justifying filling vacant provider positions in Primary Care. She noted that hiring new providers was not a speedy process and that more schedulers could have been assigned to the NEAR List but there also was a need for more providers and appointment slots. She stated that around July 2013, PSA1 had told her it was increasingly more difficult to schedule appointments in a timely manner. She said the use of the EWL could have helped but it was not in use at VAPHS. She stated that a VAPHS physician as well as the director's Quad group were all interested in having veterans scheduled for Primary Care appointments as soon as possible.

- Supervisory MSA3 stated that when she became a supervisor, she learned of the NEAR List and that PSA1 was assigned to work on it. She said she did not supervise PSA1 but routinely worked with him helping him find appointment slots for veterans on the NEAR List. She stated that PSA1 worked diligently and was very thorough when speaking to veterans and/or their family members about access to medical care. She explained that the biggest problem for scheduling primary care appointments for veterans was the availability of appointment slots. She stated that the lack of available appointment slots led MSAs to schedule appointments exceeding 30 days, which would later appear on the MUMPS report. She added that Health Administration Service (HAS) application specialists monitored these types of appointments on the MUMPS reports and instructed MSAs to change the waiting times to zero. She said that the only application specialist she could remember was former VAPHS employee 3. She further stated that the MUMPS report was no longer used. She said this occurred during her term as a basic MSA, which was between 2009 to 2010–2011. She said she never heard of the use of paper lists or phony clinics to disguise the number of veterans on the NEAR List. She explained that the EWL was not used to help alleviate the number of veterans on the list. She noted that no-show appointments wasted appointment slots and the system redesign team worked on bettering the management of the NEAR List.

- Senior leader 2 stated that the NEAR List did not become known to him until June 2013. He said he became aware of his responsibility for the list when he learned about Primary Care performance measures. He stated that before June 2013, the NEAR List was

managed by the VERC. He said the director's Quad assigned him the NEAR List and related its desire for him to meet the VISN 4 standard of having 60 percent of veterans on the list seen for an appointment within 30 days. He stated that PSA1 managed the NEAR List and reported to program manager 3 who was replaced by program manager 4. He did not know of any performance issues with PSA1 and described him as a busy and autonomous worker who kept good records. He stated that he was personally involved in the ADRR process for hiring new providers and staff for Primary Care. He said he specifically cited NEAR List statistics as justification for additional personnel positions. He said he presented his ADRR requests to a group that included senior leader 1, senior leader 3, senior leader 5, senior leader 6, and former senior leader 1. He said that the interview process for new providers was lengthy and the hiring process was very slow.

He said the NEAR List continued to grow in size for several reasons: it was difficult and confusing to decide when a veteran could be removed from the list; there were provider vacancies in Primary Care; the providers' patient panels were full; there was an increase in the number of veterans requesting medical care; and the requirement for providers to pay attention to continuity-of-care performance measures was time-consuming. He said he was not aware of any efforts to misrepresent the number of names on the NEAR List, nor was he aware of a financial incentive to do so. He said he was not aware of any financial awards available to MSAs based on scheduling. He said his 2013 performance plan did not contain any financial awards for patient scheduling but that his FY 2015 plan did include it. He noted that the awards encouraged providers to take on new/additional patients and to complete the appointments. He said this was a necessary and effective incentive to increase veteran access to medical care. He further stated that there was no "gaming" of scheduling statistics as evidenced by the unimpressive numbers on the NEAR List.

- Senior leader 1 said she was given the supervision of Primary Care Services in late 2012 or 2013 after it had been taken away from the Chief of Staff office. She stated that before Primary Care Services was placed under her supervision, she knew little about the NEAR List. She added that before the spring of 2014 and the VAMC Phoenix issue, the NEAR List was a concern because more providers were needed to properly manage it. She said she did not learn of the number of veterans on the list until after the spring of 2014. She also said that VAPHS did not use the EWL, which would have reduced the number of veteran names on it. She stated that a VAPHS physician supervised the Primary Care unit until senior leader 2 replaced him. She said program manager 1 was the program manager for Primary Care and program manager 4 was the business manager. She said she was not aware of any problems associated with the NEAR List and performance metrics. She stated that PSA1 was the person who worked with the NEAR List and scheduled veterans for appointments from it. She said he worked alone and she was not aware of any issues with his performance. She reportedly was familiar with MSA appointment scheduling as she was currently a member of the Access to Care Committee, which was created in the spring of 2014. She said she was not aware of any issues in Primary Care regarding the manipulation of wait times. She noted there was confusion with the desired date and how it is used for appointment scheduling in specialty clinics. She said she was not aware of any misrepresentation of the number of veterans on the

NEAR List, nor was she aware of any coercion in this regard. She said she learned the NEAR List was not very flexible to use and the training for it was not standardized. She stated that she was familiar with the ADRR process to fill vacant positions. She noted that the ADRR committee had a representative from Human Resources and a representative from Fiscal Service. She said the director's Quad met every Thursday with the NEAR List being mentioned during routine discussions about filling vacant positions.

- Senior leader 6 said she was named an associate director in 2012 and that the NEAR List was not a part of her responsibility. She stated that in the spring of 2014, HAS, which was under her supervision, took over temporary management of the NEAR List. She said she became aware of the list after the news of VAMC Phoenix was made public. She reported having learned that PSA1 worked on it and scheduled veterans for Primary Care appointments from it. She said she learned from HAS personnel that the NEAR List was not being used effectively and that PSA1 did not manage it well. She was not made aware of any scheduling data manipulation related to the NEAR List or specialty clinic patient scheduling. She said she was aware of MSA confusion in the specialty clinics concerning the use and meaning of the desired date, the first available date, and the provider's desired date. She added that specialty clinics were not under her supervision. She stated that she did not have a performance measure related to scheduling nor was she aware of anyone who did have a scheduling performance measure that encouraged the manipulation of wait times.

- Former senior leader 3 said he never had access problems at his facility and had read a memo about the NEAR List several years ago (prior to the interview). He stated that he did not become familiar with the term until mid-2014, during his temporary VISN 4 detail to Pittsburgh, PA. He said the NEAR List became an issue and a frequently used term as a result of a VA-wide access to care review. He said the person responsible for managing it at VAPHS apparently wasn't doing a very good job because around May 28, 2014, VACO disclosed there were 744 veterans on it. He reportedly learned that one person was assigned to work on the VAPHS NEAR List, but he did not recognize PSA1's name. He said he did not hear that paper lists were used or that there was any misrepresentation of the NEAR List numbers. He confirmed that, on May 28, 2014, he had spoken with senior leader 5 and told him to not contact any congressmen about NEAR List numbers. He said he told senior leader 5 this because he knew that VACO wanted to do a national release of information about it before individual VAMCs released information. He explained that, on May 28, 2014, he had also spoken to a VACO official who had told him to hold off on any release of information because VACO was working on a national release. He stated that he did not learn of any allegations of wrongdoing with patient scheduling in specialty clinics. He also stated that he was not aware of performance awards being tied to performance measures, particularly in relation to appointment scheduling wait times.

- Service chief 3 said he was hired at VAPHS in late 2012 and had no prior experience in his private practices with patient appointment scheduling. He described who handled scheduling in each of the four radiology divisions. He explained that MSAs did the

appointment scheduling for the General Radiology division. He identified supervisory MSA4 as a supervisory MSA who took over after supervisory MSA2 had left that position. He said that program manager 2 would oversee scheduling in the absence of a supervisory MSA and that there was not a great deal of VACO direction for MSAs regarding canceling appointments. He reportedly saw a new directive in February 2016, which was updated in August 2016. He said he heard that before 2012, there was some confusion over the proper way to dispose of provider orders, no-shows, cancellations, and duplicate orders. He stated that performance pay and incentive awards were related to scheduling appointments, but it was just one of several goals tied to awards. He said his concerns were to expand capacity and provide good service to veterans, not qualifying himself for awards. He stated that senior leader 3 was supportive of his efforts in that regard.

Records Reviewed

- VA OIG reviewed program manager 4's email account and found an email dated November 19, 2014 (23:11:04 EST) from program manager 4 to an administrative employee concerning an inquiry into the use of a "secret list" at the Belmont, OH, CBOC. The email showed that program manager 4 had interviewed personnel at the CBOC and discovered the issue discussed was not related to NEAR List veterans. What he had learned was that a list of veterans was created on a shared drive to keep track of previously scheduled appointments that had to be canceled because of the departure of two providers and to ensure the affected veterans were rescheduled.

- VA OIG reviewed an email provided by program manager 4 regarding a NEAR List monthly summary report, which displayed end-of-month statistics ranging from January 1, 2012 through May 2014. Program manager 4 indicated that the monthly totals were not a "monthly" average because the NEAR List was updated daily and these totals were the only real-time figures.

- VA OIG conducted an email account review and found an email dated June 4, 2014 and sent by a technician to program manager 2. The technician's email contained an attachment—VA Form 119, Report of Contact, dated January 2014—with the technician's remarks to program manager 2 that she (technician) had noticed a significant increase in the MRI 30-day wait-time statistics and that supervisory MSA2 was reordering MRI requisitions. The technician reportedly had asked supervisory MSA2 if program manager 2 knew she was reordering requisitions to increase the 30-day wait time and supervisory MSA2 "suggested no, but didn't give me a definite answer." The technician reported that supervisory MSA2 had told her that program manager 2 had asked the MSA staff about the increase in 30-day wait-time statistics.

- VA OIG reviewed 11 emails provided by MSA9. The review disclosed a June 4, 2008 email from former supervisory MSA2 to several MSAs instructing them to cancel and re-enter appointments so that the desired date is within 30 days of the scheduled appointment date.

- VA OIG reviewed a five-page email string dated April 2, 2010 and provided by former MSA2. Pages 4 and 5 feature an email dated May 30, 2008 and sent by former supervisory MSA2 to administrative officer 3. In the email, former supervisory MSA2 wrote that if an appointment date was beyond 30 days of the desired date, the MSA should cancel and re-enter the order with the desired date being the same as the rescheduled appointment date.

- VA OIG reviewed the Official Personnel Folders of 21 VAPHS employees involved in this investigation. The review found that for the 10 employees who had received either Individual Cash Awards (ICAs), Group Cash Awards (GCAs), or Performance Pay (PP) awards, mention was made, in varying degrees, of a component related to patient scheduling. Here are the 10 identified employees:

  - Former supervisory MSA1: Received a $1,095 ICA in 2010. Her performance appraisal narrative summary indicated "she has also worked with scheduling and fee basis staff to ensure that the imaging service meet (sic) its critical performance measures."

  - Senior leader 2: Received a $1,979 ICA in 2014 because he "demonstrated that direct scheduling was fully implemented at VAPHS Heinz Primary Care by the end of Fiscal year 2014."

  - Program manager 4: Received a $1,815 ICA in 2015 because he "was a key contributor to the overall success of the Primary Care SL 2015 outcomes including…reduction in wait times, and operations that contributed to help VAPHS achieve 5-Star SAIL status."

  - Program manager 2: Received two ICAs, one each in 2014 and 2015. In 2014, she received a $1,966 ICA, which cited: "An MRI action plan was instituted to improve Veteran access. This plan has been extremely successful with 91.7% of exams scheduled within 30-days (FY to date)." The second ICA, received in 2015, amounted to $2,000. The ICA justification for this award indicated that "Veteran Access to care has shown marked improvement. This is directly attributable to the successful recruitment of Medical Support Assistant (MSA) scheduling personnel, including a new MSA Supervisor. Imaging exam and procedure wait times consistently best the VA 30-day benchmarks."

  - PSA1: Received a $1,000 ICA in 2010 for patient scheduling. According to the justification written for the ICA, "[PSA's] efforts related to scheduling new patients have been an integral part of meeting this (Access to Care) goal."

  - Service chief 2: Received a $12,500 PP award in 2014 while serving as VP of the clinical Support Service Line. Service chief 2 cited in her self-assessment for the Access to Care criteria that all clinics in her service line had "<30 days wait time from the desired date…" The Access to Care criterion was one of seven criteria described in the self-assessment.

- Service chief 3: Received five awards from 2014 to 2016. Two ICAs each in the amount of $2,000 and three PPs in the amounts of $9,000, $3,638, and $11,000. Each award contained rating components all related to patient scheduling—meeting or exceeding VISN targets (90 percent seen within 30 days) for Imaging Outpatient Wait Times.

- Program manager 1: Received a $2,000 ICA in 2015, which contained this comment in the Leading Change criteria: "He led the charge of our Service Line taking over from HAS the management of the NEAR List."

- Senior leader 1: Received a $2,000 ICA in 2015. Senior leader 1's Self-Assessment, which contained five rating components, noted her service line completed all Community Based Care (CBC) consults within the 90-day time frame with no consults exceeding 90 days and 100 percent of consults being addressed within 30 days. She also noted, "PC (Primary Care) exceeded benchmark of 47% of New Patients seen within 14 days of Create Date. PC exceeded goal of 80% of New Patients seen within 30 days of Create Date."

- Senior leader 3: Received a $2,000 ICA in 2015. His Self-Assessment, containing five rating components, cited under the Results Driven element that the Imaging Service Line "Exceeded the VA-wide 90% benchmark for completion of imaging exams within 30 days."

4. Conclusion

VA OIG confirmed that there were approximately 700 veterans on the VAPHS NEAR List in May 2014. Our investigation found that one employee was assigned to schedule all veterans on the VAPHS NEAR List for their initial Primary Care appointment. No information was developed on the use of paper lists or off-the-books lists to unofficially track the number of veterans waiting on the NEAR List. The reasons for the size of the NEAR List included: only one person scheduled appointments; many veterans on the NEAR List did not want an appointment; staff failed to use the EWL; and appointment slots to schedule appointments were lacking. The lack of appointment slots was widely attributed to the shortage of Primary Care providers. The investigation did not find any misconduct regarding the NEAR List.

Many of the interviewed MSAs reported that they were either encouraged or instructed to manipulate appointment scheduling records so that appointment wait times met VAPHS and VA 30-day performance goals. Reported manipulation included scheduling appointments to "zero out" the wait time and re-entering appointments expected to exceed 30 days to reduce the wait time to below 30 days. Several employees stated that supervisory MSA2 wanted MSAs to change wait times. Supervisory MSA2 stated that she had been aware of a way to reset the 30-day time frame for appointments, so they did not exceed the 30-day requirement, and admitted that she "…may have played around with it." VA OIG found that program manager 2 and administrative officer 3 reported knowledge and/or awareness of scheduling irregularities. A review of staff emails disclosed communications between supervisory personnel and MSAs regarding wait-time manipulation.

While the investigation found that 10 employees had received monetary awards based, in part, on scheduling measures, VA OIG did not find evidence that an employee received an award solely based on meeting VAPHS or VA scheduling performance measures. A few performance appraisals included scheduling performance as one of several components of an appraisal.

VA OIG referred the Report of Investigation to VA's Office of Accountability Review on December 13, 2016.

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