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The Special Counsel

February 25, 2015

The President
The White House
Washington, D.C. 20510

Re: OSC File No. DI-14-2953

Dear Mr. President:

Pursuant to my duties as Special Counsel, enclosed please find the Department of Veterans Affairs' (VA) report based on disclosures of wrongdoing at the VA Puget Sound Healthcare System (VA Puget Sound), Tacoma, Washington. The Office of Special Counsel (OSC) has reviewed the report and, in accordance with 5 U.S.C. § 1213(e), provides the following summary of the allegations and our findings.

The whistleblower, Markus A. Overly, who consented to the release of his name, alleged that employees at the VA Puget Sound engaged in conduct that may constitute a violation of law, rule, or regulation, and a substantial and specific danger to public health. Specifically, Mr. Overly disclosed that Veterans Health Administration (VHA) facilities in the VA Puget Sound system did not follow proper scheduling protocols. According to Mr. Overly, the VA Puget Sound facilities instructed employees to enter the patients' appointments as both the desired date and the accepted date, in violation of VHA Directive 2010-027. Mr. Overly alleged that the facilities did this to avoid the frequent appearance of being unable to schedule patients on their desired dates.

The agency could not substantiate Mr. Overly's allegations, noting that limitations in the available data prevented definitive findings. The report noted that statistical data provided by the facility and interviews with other staff indicated that appointments were routinely scheduled beyond desired dates, suggesting that no "zeroing out" policy existed. However, the report explained that some appropriately scheduled appointments do not rule out the possibility that other appointments could have been scheduled in violation of agency policy requirements. In response, the agency advised that the VA Puget Sound should comply with VA Office of the Inspector General and Government Accountability Office recommendations related to the consistent implementation of VA scheduling policies. Based on my review, I have determined that the report meets all statutory requirements and that the findings appear to be reasonable.

Mr. Overly's allegations were referred to then-Acting Secretary D. Sloan Gibson, to conduct an investigation pursuant to 5 U.S.C. §1213(c) and (d). Acting Secretary Gibson delegated the matter to Under Secretary for Health Carolyn M. Clancy to review the matter and take any necessary actions. The Under Secretary for Health directed the Interdisciplinary Crisis Response Team, now referred to as the Office of Accountability Review (OAR), to conduct an investigation. Chief of Staff Jose D. Riojas was delegated the authority to review and sign the report. On December 8, 2014, Mr. Riojas submitted the agency's report to the Office of Special Counsel. Pursuant to 5 U.S.C. §1213(e)(1), Mr. Overly provided comments on the agency report on December 31, 2014. As required by 5 U.S.C. §1213(e)(3), I am now transmitting the report to you. [1]

I. Mr. Overly's Disclosures

Mr. Overly worked as a medical support assistant (MSA) in two service divisions, Health Plan Management and Mental Health. Mr. Overly alleged that lead clerks and supervisors verbally directed MSAs in these divisions to ensure that there were zero days between the patient's desired appointment date and the actual time scheduled for the appointment date. He asserted these instructions were conveyed during employee training and during the regular course of business. In Health Plan Management, Mr. Overly asserted that these directions came from Sheila Arie, the service division section chief, and lead schedulers Genevieve Owens and Tina Green. Mr. Overly also explained that each month, Emo Feltal-Morris, a manager in the Mental Health Service Division, evaluated and audited MSA performance and instructed MSAs who scheduled appointments beyond the fourteen-day target to cancel and reschedule these visits.

VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures* (June 9, 2010), para. 4.c.(4)(b)3 stated that the patient must define the desired date for a return appointment. Mr. Overly explained that the desired date must be recorded in VISTA, the VHA's electronic tracking system. Per the Directive, once the desired date is set in the system, even if that date is unavailable, it may not be altered to reflect the date of an appointment the patient accepts. According to Mr. Overly, the VA Puget Sound

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[1] The Office of Special Counsel (OSC) is authorized by law to receive disclosures of information from federal employees alleging violations of law, rule, or regulation, gross mismanagement, a gross waste of funds, an abuse of authority, or a substantial and specific danger to public health and safety. 5 U.S.C. § 1213(a) and (b). OSC does not have the authority to investigate a whistleblower's disclosure; rather, if the Special Counsel determines that there is a substantial likelihood that one of the aforementioned conditions exists, she is required to advise the appropriate agency head of her determination, and the agency head is required to conduct an investigation of the allegations and submit a written report. 5 U.S.C. § 1213(c). Upon receipt, the Special Counsel reviews the agency report to determine whether it contains all of the information required by statute and that the findings of the head of the agency appear to be reasonable. 5 U.S.C. § 1213(e)(2). The Special Counsel will determine that the agency's investigative findings and conclusions appear reasonable if they are credible, consistent, and complete based upon the facts in the disclosure, the agency report, and the comments offered by the whistleblower under 5 U.S.C. § 1213(e)(1).

facilities instructed MSAs to record the patients' appointment as both the desired date and the accepted date, to avoid the frequent appearance of being unable to schedule patients on their desired dates. He explained that MSAs were directed to enter VISTA to check the patient's desired date, and if the date was unavailable, exit out of the scheduling system, then enter back in, navigate to the date of the first available appointment, and use that date as the desired date and appointment date. As a result of this practice, the system showed that the patient had no wait between the desired date and the actual date of the appointment.

II. The Agency's Report

The report noted that the agency could not substantiate Mr. Overly's allegations concerning improper scheduling practices. The investigative team reviewed Mental Health access data from the facility for fiscal years 2011 through 2014 on patient appointments that exceeded the fourteen day metric. The data indicate the number of patients waiting over fourteen-days for an appointment ranged from a high of thirty-six to a low of zero. There was no data suggesting that schedulers were instructed to "zero out" patient wait times, such as a marked decline in the over fourteen-day appointments on any particular date.

However, the report noted that inherent limitations in the data prevented a conclusion from being drawn in the absence of additional data. Specifically, the report explained that the existence of appointments regularly falling beyond the fourteen-day window does not alone rule out the possibility that some appointments could have been made within the fourteen-day window in violation of policy requirements. The report explained that because the data do not make necessary distinctions, a qualitative analysis was not possible.

The report noted that witness testimony, including that of scheduling clerks, did not indicate that schedulers were ordered to alter data in agency computer systems. Scheduling clerks testified they have never been instructed to cancel and reschedule appointments or otherwise alter patient schedule information to manipulate patient wait time data, other than when they were asked to correct erroneous records. The report also considered Mr. Overly's assertion that management's failure to adhere to scheduling policies endangered public health and safety. However, Mr. Overly was unable to identify any specific cases of harm resulting from the alleged improper scheduling practices.

The report recommended that the VA Puget Sound comply with recommendations from the VA Office of the Inspector General (OIG), in which the OIG recommended the facility participate in a nationwide review of veterans on waiting lists and engage in internal routine quality assurance reviews of scheduling accuracy. The report also recommended that the facility comply with Government Accountability Office

recommendations indicating that local VA facilities should follow scheduling directives established by the VA's Under Secretary for Health. As of the date of this closure letter, the VA Puget Sound is actively implementing these recommendations.

During his interview, Mr. Overly reported additional allegations that were not contained in his OSC referral letter. These included the assertion that there was an insufficient number of patient care providers at the facility and that two work-place incidents were not properly investigated. The agency did not substantiate either of these allegations.

III. The Whistleblower's Comments

Mr. Overly disagreed with the evidence, findings, and conclusions contained in the report. He asserted that the agency investigators have an inherent conflict of interest in investigating their own agency and they failed to look at data that would have supported his allegations and asserted that other employees who were interviewed were not candid out of fear of reprisal. He questioned the substance and validity of the investigation, and suggested that if the investigators had reviewed the matter appropriately, his allegations would have been substantiated.

IV. The Special Counsel's Findings

I have reviewed the original disclosure, the agency report, and the whistleblower's comments. I am satisfied that the agency's investigation was sufficient, and while Mr. Overly's allegations may, in fact, be valid, based on the VA's report and recommendations contained within, the findings of the agency appear reasonable and the agency report meets all statutory requirements.

As required by 5 U.S.C. §1213(e)(3), I have sent copies of the agency report and the whistleblower's comments to the Chairmen and Ranking members of the Senate and House Committees on Veteran's Affairs. I have also filed copies of the redacted agency report and whistleblower comments in our public file, which is available at www.osc.gov. OSC has now closed this file.

Respectfully,

Carolyn N. Lerner

Enclosures