



U.S. OFFICE OF SPECIAL COUNSEL

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The Special Counsel

July 28, 2015

The President  
The White House  
Washington, D.C. 20500

Re: OSC File Nos. DI-13-4425 and DI-14-3017

Dear Mr. President:

Pursuant to my duties as Special Counsel, enclosed please find an agency report based on disclosures made by employees at the Department of Veterans Affairs (VA), Cheyenne VA Medical Center (Cheyenne VAMC), Cheyenne, Wyoming, and Fort Collins VA Clinic (Fort Collins), Fort Collins, Colorado,<sup>1</sup> alleging that employees engaged in conduct that constituted a violation of law, rule, or regulation, and a substantial and specific danger to public health. The whistleblowers, one of whom chose to remain anonymous, alleged that employees at Fort Collins failed to follow proper protocols when scheduling patient appointments.

**The VA substantiated the whistleblowers' allegation that patient appointments at Fort Collins were not scheduled according to agency policy. Specifically, the Clinic "blind scheduled" appointments for veterans after an initial appointment had been canceled, in violation of VA policy. In addition, the Clinic manipulated the "desired date" for appointments to falsely show that veterans waited for care for shorter periods of time than actually was the case. However, the agency determined that no patients were harmed due to the delay in care within the Cheyenne VAMC system. The VA has taken the Office of the Medical Inspector's (OMI) recommended corrective actions to improve its scheduling practices, including disciplining six individuals responsible for the misconduct. These were among the first officials to be held culpable for the widespread manipulation of patient scheduling data in the VA. Unfortunately, the agency's ultimate conclusion that the improper scheduling practices did not pose a danger to patient health or safety is unsupported. Thus, I have determined that this finding is not reasonable.**

The anonymous whistleblower's allegations were initially referred on October 25, 2013, to then-Secretary of Veterans Affairs Eric K. Shinseki to conduct an investigation pursuant to 5 U.S.C. § 1213(g)(2). The Secretary delegated the authority to sign the VA's report of investigation to then-Chief of Staff Jose D. Riojas. On February 28, 2014, Mr.

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<sup>1</sup> Fort Collins is administered by the Cheyenne VAMC and is part of the Cheyenne VAMC health system.

Riojas submitted the agency's report to OSC based on an investigation OMI conducted. On April 2, 2014, OSC again referred the allegations to Secretary Shinseki for an investigation pursuant to 5 U.S.C. § 1213(c) and (d) due to ongoing concern that the issues were not fully resolved. On June 30, 2014, OSC submitted to Secretary Shinseki a companion referral of these allegations, made by Lawrence Little, a medical support assistant (MSA) at Fort Collins, who consented to the release of his name. OSC received a report pursuant to § 1213(c) and (d) from Interim Under Secretary for Health Carolyn Clancy on July 16, 2014, and a supplemental report on October 3, 2014. The anonymous whistleblower submitted comments on the reports pursuant to § 1213(e)(1); Mr. Little declined to comment. As required by 5 U.S.C. § 1213(e)(3), I am now transmitting the reports and comments to you.<sup>2</sup>

### **I. The Whistleblower's Disclosures**

The anonymous whistleblower disclosed that MSAs at Fort Collins were not properly trained on agency scheduling policies and that management did not require that such policies be followed. Specifically, the whistleblower disclosed that the regular practice at Fort Collins was to "blind schedule" follow-up appointments after an initial appointment had been cancelled. When a re-scheduled appointment was not available until several months in the future, the MSAs would print out a letter with the patient's new appointment date and time and mail it. If the patient was unable to keep the appointment listed on the notification letter, the patient was expected to call back to reschedule it, but MSAs did not directly confirm that the veteran would be able to make it to the "blindly" scheduled appointment date. The whistleblower noted that upon cancellation of a clinic, providers frequently failed to request a list of canceled patients from the MSAs in order to review the patient charts for urgent medical needs requiring a provider follow-up telephone call.

In addition, the whistleblower noted that the Cheyenne VAMC and Fort Collins scheduling software prevented MSAs from scheduling patients more than 90 days into the future. The whistleblower explained that the software includes a "Recall/Reminder" function for appointments past the 90-day window. This allows a postcard to be sent to the patients requesting that they call the facility to schedule their appointments. The whistleblower alleged that this system is fully dependent upon the patients for scheduling, and that not all patients call to schedule a visit. MSAs are not directed to call the patients and follow up if the patients fail to schedule a return appointment after receiving the postcard. Thus, patients with

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<sup>2</sup> The Office of Special Counsel (OSC) is authorized by law to receive disclosure of information from federal employees alleging violation 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) and (g).

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).

urgent or critical needs may not receive the care they require because they have not had an appointment scheduled for them before leaving the facility.

According to the whistleblower, as of September 2013, the Cheyenne VAMC and Fort Collins were relying upon Veterans Health Administration (VHA) Directive 2009-070, *VHA Outpatient Scheduling Processes and Procedures* (December 17, 2009) when making scheduling decisions. This Directive was rescinded in June 2010 and replaced by VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures* (June 9, 2010). The rescinded policy provided that schedules should be open three to four months into the future for scheduling. However, VHA Directive 2010-027 para. 4.c.(3)(e)1., which had been in effect for over three years, prohibits facilities from blocking the scheduling of future appointments by limiting the maximum timeframe into the future that an appointment can be scheduled.

Further, para. 4.c.(19)(j) of the current directive requires that medical records be reviewed to ensure that urgent medical problems are addressed in a timely fashion when a clinic is canceled or a patient fails to arrive for a scheduled appointment.<sup>3</sup> The whistleblower noted that these directives were never provided to Fort Collins MSAs, nor were Fort Collins MSAs trained on these policies. The whistleblower alleged that several other sections of VHA Directive 2010-027 were also regularly violated by Fort Collins and Cheyenne VAMC staff. For example, para. 4.c.(3)(e)4. of the directive requires the use of the “Recall/Reminder” software to manage appointments scheduled beyond the mandated three-to four-month scheduling window. The whistleblower alleged that this software feature is only used when patients are checked out, at which point a provider may notate the patient’s file for follow-up in six months. The feature was never used to assist in rescheduling canceled clinics. Paragraph 4.c.(3)(f)1. requires that clinical consultation appointments be scheduled as soon as possible on the day the consult is ordered, before the patient leaves the referring provider team area. However, the whistleblower alleged that this never occurred; rather, the consult order would first go through the specialty clinic, and the specialty clinic would then contact the patient to schedule an appointment.<sup>4</sup>

The directive further requires, in para. 4.c.(4)(b)1., that for return appointments of established patients, providers document the return date for the patient in the Computerized Patient Record System, preferably through an order.<sup>5</sup> The whistleblower alleged that it was extremely rare for providers at Fort Collins to document a specific date for a return appointment. Rather, providers wrote in notes for the patient to return in a certain number of months, or follow-up within a certain timeframe, without providing a certain date.

Additionally, para. 4.c.(4)(b)3. states that the patient must define the desired date for a return appointment. The whistleblower explained that the MSA must record the desired date in the scheduling system. Per the directive, once the desired date is set in the system it may not be altered to reflect the date of an appointment the patient accepts if the desired date

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<sup>3</sup> This requirement is also found in the rescinded directive, 2009-070.

<sup>4</sup> This requirement is similarly stated in the rescinded directive.

<sup>5</sup> This requirement is similarly stated in the rescinded directive.

is unavailable. Thus, both the desired date and the accepted appointment date are memorialized in the scheduling system. The whistleblower alleged that MSAs at Fort Collins and the Cheyenne VAMC were instructed to instead record the date of the patient's appointment as both the desired date and the accepted date, in order to avoid the appearance of frequently being unable to schedule a patient on his or her desired date.

Finally, para. 4.c.(18) directs that, when appointments become available and the facility has at least three days to contact patients, the available appointments be offered to patients on the waiting list for an appointment, or who have appointments scheduled more than 30 days past the patient's desired date. The whistleblower alleged that staff at the Cheyenne VAMC and Fort Collins never followed this provision of the directive and were never made aware that such a requirement existed.

## **II. The VA's 5 U.S.C. § 1213(g)(2) Report**

In its original report, the agency substantiated the allegation that at least one provider in Fort Collins failed to review the charts of patients whose appointments were canceled. The investigation determined that in one instance, a nurse practitioner who was on leave in November and December 2012 failed to review her patient charts before her absence. During that period, the primary care needs of her patients were not met, and MSAs canceled appointments for those patients who they could not contact to reschedule. All of the MSAs confirmed to investigators that they blind scheduled patients if they could not be reached. The report acknowledged that blind scheduling violates VHA policy, but found that most patients who were blind scheduled kept their appointments.

The investigation also determined the nurse practitioner in question had a total of 975 patients on her Recall/Reminder discrepancy list, which according to the report means that those patients were not able to schedule follow-up appointments. The report further states that Fort Collins as a whole had a total of 2,832 patients on its Recall/Reminder discrepancy list. The Ambulatory Care associate chief of staff indicated to investigators that the difficulty in scheduling primary care appointments was due to a shortage of providers, and stated that eight new providers were currently in the hiring process.

The investigation further found that Fort Collins staff were restricted from scheduling appointments more than 90 days into the future, but found that the guidance contained in the agency policy was conflicting. Thus, because the policy was "difficult to interpret," the Office of the Medical Inspector did not substantiate that a violation of the policy occurred.

In addition, the investigation found that MSAs were not properly trained on how to record desired dates, specifically that all the MSAs interviewed reported a direct link between the desired date and the appointment date. The interviewees also reported that they had been instructed to ensure that the desired date was within 14 days of the appointment date. Many reported that they had been counseled when the appointment date was more than 14 days from the desired date, and were told to change the desired date to ensure compliance with the 14-day requirement. Additionally, several MSAs reported to investigators that training from the Cheyenne VAMC Business Office included instructions to record the desired date and

appointment date as the same date. In addition, the MSAs stated that when an appointment needed to be canceled, they were instructed to change the desired date to within 14 days of the new appointment date. MSAs also did not daily monitor or review of the Recall/Reminder discrepancy list. All of these actions were in direct contradiction of agency policy.

The Office of the Medical Inspector reviewed Fort Collins's data from November 15, 2012, to November 1, 2013, to determine the prospective wait time at Fort Collins for established patients. The data indicated that in March 2013, patient wait times decreased dramatically to be nearly 100 percent in compliance with the 14-day goal. MSAs indicated that this change coincided with a March 2013 direction from the Business Office to review the appointment schedule for availability, inform the patient of that availability, and then enter the desired date as the appointment date. The decrease also coincided with a March 2013 decision by Cheyenne VAMC leadership to resolve scheduling and morale issues at Fort Collins by detailing two employees to Fort Collins to replace two MSAs who were being permanently reassigned from the Fort Collins to Cheyenne. The detailed employees reported that they fixed the scheduling issues at Fort Collins by changing desired dates to ensure that they fell within the 14-day goal. With regard to the data, the MSAs expressed frustration with scheduling, indicating that providers had no availability for up to eight weeks, in direct contradiction to Fort Collins's data showing 90 percent compliance for scheduling within 14 days. MSAs also noted that if their appointments were greater than 14 days from the desired dates, they would be placed on a "bad boy" list. Despite these findings, the Office of the Medical Inspector could not substantiate that improper scheduling and extended wait times had a negative impact on patient care, because "no specific patient information [was provided] about an adverse effect on medical care...."

The agency's original report made a number of recommendations to the Cheyenne VAMC regarding its findings. These included ensuring that all scheduling is done in compliance with VHA directives, such as following up with patients after canceled appointments, monitoring patients off the Recall/Reminder discrepancy list, and discontinuing blind scheduling. The report also recommended that staff receive retraining on proper scheduling. The report included recommendations to the VHA to revise its directive to make the requirements more clear, to consider conducting an assessment of the Cheyenne VAMC and Fort Collins to determine their program needs, and to consider conducting a VHA-wide audit of scheduling practices to determine the validity of wait-time data.

### **III. Mr. Little's Allegations and the VA's 5 U.S.C. § 1213(c) Report**

Due to continuing concerns about the VA's response to the § 1213(g)(2) referral, OSC referred the anonymous whistleblower's allegations under 5 U.S.C. § 1213(c), with a request for updates on the responsive actions taken by both the VHA and the Cheyenne VAMC. OSC subsequently referred companion allegations made by MSA Lawrence Little. Mr. Little's allegations were substantially the same as those originally referred under § 1213(c) and § 1213(g)(2); however, he also provided email correspondence dated June 19, 2013, from David Newman, Cheyenne VAMC telehealth coordinator. In the email, Mr. Newman notes that the facility is measured by whether appointments meet the 14-day goal

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and provides instructions for scheduling appointments in compliance with the goal. He instructs staff to advise the patient of the first available date, and if that date is accepted by the patient, to enter that date as the desired date of the patient. He states in the e-mail that, "Yes, it is gaming the system a bit." Nevertheless, he explains that when they exceed the 14-day measure, "the front office gets very upset, which doesn't help us." Mr. Newman offers staff assistance to "fix" already scheduled appointments by canceling and rescheduling the appointments with a desired date within the 14-day time window, so that staff members can "get off the bad boys list."

Mr. Little also provided an email dated August 26, 2013, from Eric Hart, then-Fort Collins clinic manager, forwarding the text of an email he received from MSA supervisor James Murphy addressing "incorrectly scheduled appointments." Mr. Murphy's email to Mr. Hart advises that schedulers continue to use the desired date function improperly, and that the vast majority of appointments reflect wait times greater than the 14-day "time limit." Mr. Murphy states that he and Business Office Chief Theresa Garduno had "corrected literally thousands"—at least 2,700—of these appointments over the past month-and-a-half and were continuing to do so. He reiterates the direction to record the first available date accepted by the patient as the patient's desired date. Mr. Little explained that by simply reviewing the scheduling data, without conferring with the MSAs or patients, Mr. Murphy and Ms. Garduno would have no way of knowing whether the information was accurate and thus had no basis to correct it. In our referral of Mr. Little's allegations, we noted that his additional information demonstrated and supported the allegations that Cheyenne VAMC and Fort Collins management gave improper instruction to staff on scheduling practices in violation of agency policies and procedures in an effort to conceal actual wait times.

In its response to these referrals, VA submitted a report pursuant to 5 U.S.C. § 1213(c) and (d). The report did not address the referral of Mr. Little's allegations. However, the agency provided updates on the status of the recommendations made in its first report. According to the report, the Cheyenne VAMC took steps to ensure that providers follow up on all patient cancellations, to ensure compliance with VHA scheduling directives and distribute the directives and policies to all employees, to develop a standard operating procedure for the Recall/Reminder discrepancy list, and to immediately discontinue blind scheduling. The Cheyenne VAMC also retrained MSAs on proper scheduling procedures, among other actions.

The agency also reported that the VHA scheduling policy was in need of updating, and estimated that revisions to the policy would move into the approval process in September 2014. Further, in April 2014, then-Secretary Shinseki directed the VHA to complete a nationwide audit of scheduling staff and their understanding of VA scheduling policy, and to identify inappropriate scheduling practices and wait list management. The audit led to the launch in May 2014 of the "Accelerating Access to Care Initiative," a nationwide program to ensure timely access to care. As part of the initiative, VA identified and contacted veterans waiting for care and began addressing issues impeding veterans' access to care. Approximately 100,000 veterans were identified as experiencing long wait times, and individual clinics undertook assessments to improve access.

The report also noted that the Office of the Medical Inspector was undertaking a clinical review of all cases associated with Fort Collins to determine whether any deaths occurred while patients were waiting for care and to determine whether a delay in care was associated with harm to a patient waiting for an appointment.

#### **IV. The VA's Supplemental Report**

The VA submitted a supplemental report to OSC in October 2014 to address Mr. Little's allegations, as well as to answer additional questions about the outcome of its investigation. In the supplemental report, the agency asserted that it reviewed Mr. Little's allegations and the supporting emails that he provided. However, the agency determined that Cheyenne VAMC and Veterans Integrated Service Network leadership did not direct the manipulation of wait time data, but did find that some in management "exercised ineffective oversight with respect to the input and reporting of such data." The agency proposed disciplinary action against six individuals involved in the matter, but did not initially provide their names, titles, or the discipline proposed against them. The agency later indicated that all six employees received disciplinary actions varying from admonishment to suspension, including one retirement pending a proposed removal.

The supplemental report also outlined the health and safety review undertaken as a result of the whistleblowers' allegations. Reviews were conducted by the VHA Central Office and the Cheyenne VAMC. The VHA review assessed the data related to Fort Collins' new enrollee appointment requests from January 1, 2005, through November 30, 2013. The data did not separate Fort Collins' data from the Cheyenne VAMC or its other clinics. VHA cross-referenced the data with any recorded deaths occurring during the time period between March 2013 (when the wait time manipulation began) and November 30, 2013. The results showed that eight veterans died during that time frame. The report provided a brief description of each patient's outcome, concluding that there was no evidence that the deaths of the eight patients were the result of a delay in care.

The Cheyenne VAMC reviewed the use of the Recall/Reminder discrepancy list. Reviewers looked at all patients on the discrepancy list to identify the status of their appointments, and reviewed the records of those patients without an appointment to ascertain whether follow-up care was provided elsewhere. If a patient was found to be in need of care, a MSA attempted to call him to schedule an appointment. If the MSA was unable to reach the patient after two attempts, a letter was mailed to the patient. If the patient did not respond, a nurse was assigned to review the patient's records to determine their needs. Fort Collins staff were directed to reach out to the patient's emergency contacts to connect with the veteran if the nurse review determined that the patient required more than routine care. As a result of these actions, the agency stated that the Fort Collins Recall/Reminder discrepancy list decreased 98 percent by August 1, 2014.

The Cheyenne VAMC also conducted an audit of the records of 724 patients who were hospitalized in non-VA facilities between September 2, 2011, and July 11, 2013. The facility's quality management staff reviewed the cases to determine whether the patients' hospitalizations were related to their canceled appointments. The review found no

relationship between the hospitalizations and unmet needs as a result of canceled appointments.

#### **V. The Whistleblower's Comments**

The anonymous whistleblower submitted comments on the agency's reports.<sup>6</sup> The whistleblower challenged the reports' assertion that data manipulation began in March 2013, and stated that improper scheduling was occurring from at least January 2012. The whistleblower also raised concerns about the individual patient profiles included in the supplemental report, in particular a 24-year old patient who was enrolled as a patient in October 2012 and indicated he would like an appointment. His enrollment was completed in January 2013, but he did not receive an appointment until April 2013, for which he was a no-show. The report notes that he was rescheduled for a new appointment in June 2013, but passed away on April 17, 2013. The whistleblower noted that it is likely the patient's June appointment was blind scheduled, and pointed out that the patient waited four months to receive an initial appointment. The whistleblower noted that the facility did not have guidelines for patient no-shows in place at the time to follow up with the patient, and called into question the failure by the agency to investigate further into the circumstances of the patient's care and death.

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#### **VI. The Special Counsel's Findings**

I have reviewed the original disclosure and the agency reports. Based on that review, I have determined that the reports contain all of the information required by statute. However, I do not find reasonable the VA's conclusion that there was no substantial and specific danger to public health or safety as a result of the scheduling improprieties that caused delays in access to care. While I acknowledge that OMI and Cheyenne VAMC conducted reviews of relevant patient deaths and hospitalizations, I disagree that deaths and hospitalizations are the only measures for determining whether patients were harmed or could have been harmed by scheduling delays and the manipulation of wait time data. While the VA has taken great strides in the last year to fully account for identified misconduct, and the impact it has on the safety of veterans, the approach taken in this report is a step backward. In making this determination, the VA finds that employees and management engaged in serious wrongdoing—in this case, failing to properly follow up on and schedule patient appointments—but simultaneously determines that these serious shortcomings have no negative impact on patient care. While the VA has taken responsive corrective actions in this case, including disciplinary action against wrongdoers, it is troubling that the agency continues to be unwilling to acknowledge that the confirmed wrongdoing posed a possible danger to patients at Fort Collins and Cheyenne.

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<sup>6</sup> Mr. Little declined to comment.

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As required by 5 U.S.C. § 1213(e)(3), I have sent copies of the unredacted reports and whistleblower comments to the Chairmen and Ranking Members of the Senate and House Committees on Veterans' Affairs. I have also filed copies of the redacted reports and whistleblower comments in our public file, which is available online at [www.osc.gov](http://www.osc.gov).<sup>7</sup> OSC has now closed this file.

Sincerely,



Carolyn N. Lerner

Enclosures

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<sup>7</sup> The VA provided OSC with a 5 U.S.C. § 1213(g)(2) report containing employee names (enclosed), and a redacted report in which employees' names were removed. The VA cited Exemption 6 of the Freedom of Information Act (FOIA) (5 U.S.C. § 552(b)(6)) as the basis for its redactions to the report produced in response to 5 U.S.C. § 1213, and requested that OSC post the redacted version of the report in our public file. OSC objects to the VA's use of FOIA to remove these names because under FOIA, such withholding of information is discretionary, not mandatory, and therefore does not fit within the exceptions to disclosure under 5 U.S.C. § 1219(b), but has agreed to post the redacted version as an accommodation.