My response and comments on the agency report OSC File No. DI-13-4425 and DI-14-3017 are as follows:

If the Cheyenne/Fort Collins VAMC can claim they were "not a risk to public health and safety," then I use the same argument for the punishment they doled out to me.

My geographical reassignment on March 12, 2013 and suspension on June 17, 2013 was for varied motives designed for an improper purpose, and had no legitimate business purposes, other than punishment and intimidation to coerce me into manipulating appointment data, and to clear out the front desk at the Fort Collins Clinic. After I was reassigned, my job vacancy was filled with two MSAs who would manipulate the appointment data from the Cheyenne VAMC.

I challenge the legitimacy of the geographical reassignment in two ways:

1. My reassignment did not promote the efficiency of the service. It created a huge hole at the front desk at the Fort Collins Clinic, and there was NO vacancy at the Cheyenne VAMC, in USA Jobs, or any internal job vacancy memo. Interestingly, I was not required to put in any job resumes or applications with the reassignment to the Cheyenne VAMC, nor were the two Cheyenne MSA's required to fill out any job applications via USA Jobs for their reassignment to the Fort Collins Clinic.

However, upon my return off of Military Orders on Sept 30, 2014, when I requested to return to my original job duty station at the Fort Collins Clinic, I was instructed by HR to a USA Jobs application process, and had to post a new resume, Veterans preference letter, Veterans Disability letter and DD214, as if I was brand new to the Federal Job Application Process! The job application ended on Oct. 3, 2014, and to this date, Nov 3, 2014, I have not heard back from the Cheyenne VAMC HR department regarding my return to the Fort Collins VA Clinic.

2. I attack the bona fides of a reassignment order. I was reassigned to job vacancy that didn't exist. I did not refuse, because I was told it was temporary and for training. Yet that was lie, because my Fort Collins locality pay ended two weeks after my reassignment, and I never received any specialized instructed training while at the Cheyenne VAMC. Not only was there no job vacancies at the Cheyenne VA at the time of my reassignment but TWO MSA's had to leave their jobs vacant while they worked at the Fort Collins Clinic. This does not promote efficiency of the service, and should be an invalid reassignment.

The only reason I was reassigned from Fort Collins VA Clinic to the Cheyenne VAMA was to move employees down to the Fort Collins clinic to manipulate the appointment data. My reassignment was for an improper purpose, now clearly evident in the OSC File No DI-13-4425, page 6, Allegation 3, Paragraph 5, the Prospective Wait time Trend Chart.

I also, at this time, challenge my 2 week unpaid suspension and all allegations against me.

Using the new evidence found in the OSC file No. DI-13-4425 and DI-14-3017, the allegations stacked against me and used against me in my suspension, are invalid, and are all at the fault of the Cheyenne VAMC.

1. My suspension was supported by the Medical Director, Cynthia McCormack and the Assistant Director, Paul Roberts to cover up the fact that I was not manipulating the patient wait times, that prevented them from their bonuses, which are based on the metrics of the 2-week wait time for appointments.

2. They (Cynthia McCormack and Paul Roberts) stacked the charges, allowed unsigned, unsubstantiated reports of contact, charged me with delaying patient care by a list unscheduled appointments that were cancelled after I was reassigned to the Cheyenne VAMC, and non- PACT team cancelled appointments made after my reassignment, illustrated a pervasive internal mentality to throw the book at me and frighten me into playing their game of cooking the books for the 2-week appointment wait time.

3. The suspension was a threat from the Front Office, that I had better start playing their game—or expect more trumped up charges and suspensions in the future. I requested ADR but the agency refused both mediation and facilitation.

This hostile environment is what led me to file the whistleblowers complaint against the Cheyenne VAMC. The Cheyenne VAMC thought they were above reproach, beyond the laws, regulations and policies of the VHA for scheduling practices. The Cheyenne VAMC broke practically every rule of the scheduling policy, yet is unscathed, while I received a two week suspension in the midst of all the chaos.

The Agency's response for supplemental information on July 24, 2014 addressed three issues from the original report on Feb. 25, 2014.

Their responses clearly exonerate my suspension disciplinary action as follows:

1. The email about two Cheyenne employees who had manipulated the data entries—no criminal prosecution. Their disciplinary action was not reported, why is that? If no "crime" was committed, then I should not have been prosecuted either.
2. Cheyenne/Fort Collins another Phoenix
   Their response, " . . .at the time that the Medical Center had directed altering the recording of desired dates beginning in March 2013:
   Let me make it very clear, the Medical Center did not "direct" altering desired dates beginning on March 2013 (that was the exact time of my reassignment from Fort Collins to Cheyenne). The Cheyenne VAMC directed altering desired dates from the very first day I was hired, starting January 2012!

3. Out of the 8 patients death, the MOST interesting was number 8, the 24 yr old who DIED waiting for an appointment at the Fort Collins clinic! From his date of completing the enrollment paperwork, (Nov 2012) to when he had an appointment made in JAN 2013 for an April 2013 appointment, (4 months away), he was a no-show, and I imagine "blind scheduling" took place and another appointment was made for him, 2 months away—he died before he got the second appointment, yet NO investigation-no follow up on the no-show? What ARE the no-show guidelines and policy? Fact: There were NO policies or directives in place for No-Shows.

4. On Nov 7, 2013, I emailed my supervisor, "Is there a VHA Policy on "one time no-shows" for consults, and his response was:

   It is not in writing yet (being developed), but discontinue the consult with a statement relating it is due to the NS. It will be referred back to the practitioner automatically. I use this quite often, but if it due to bad weather conditions, family emergency, etc, but the Vet some slack and reschedule. If they just do not show and no reason given, discontinue is what I've been doing. The only practitioners I know of that want to review no shows are in Ophthalmology, Urology, Surgery and some Orthopedic-due to medical conditions. The others are happy to discontinue. Might want to check with your practitioners for now and ask their opinions. That will do until the facility directive has been published.

5. Finally, if the report found no evidence the data manipulation constituted a risk to public health and safety, then my suspension allegations of "delayed patient care" also was not a risk to public health and safety.
   (I was charged with delaying patient care due to three factors:
   1) The rescheduled appointments could not be made due to appointment blocking in the VISTA software, which is a violation of VHA policy.
   2) Some of the rescheduled appointments were not from my PACT team. PACT team did not review charts of the cancelled appointments.
   3) Some of the cancellations were made *after* my reassignment to Cheyenne VAMC! I was not aware of them.

6. Allegation 1: The OMI substantiated the allegation that providers do not always conduct patient follow up appointments when cancelled. This left the entire job of rescheduling, first cancelled, first next appointment, without regards to health conditions.

7. Allegation 2: The OMI substantiated the allegation scheduling patient appointments more than 90 days in advance was not permitted, in violation of agency policy. This prevented me from scheduling the patients I was accused of "delaying patient" care.

8. Allegation 3: The OMI substantiated consults, return and long-term appointments are not scheduled in accordance with agency policy. The OMI found that we were given erroneous on the job instruction for recording the Desired Date, therefore what I was trained to do was inaccurate, yet the Cheyenne VA still went ahead and suspended me, for something they taught me to do!

9. Allegation 4: The OMI substantiated the CHY VAMC failed to properly train staff on scheduling policies yet, made allegations against me that I was delaying care!

10. *In conclusion, a direct quote from the OSC File No. DI-13-4425 dated February 25, 2014: Medical and Clinic staff reported and OMI found evidence to support that in the past, MSA's were unable to perform all their require functions due to the scheduling system restrictions, unavailability of appointment slots for some providers and staffing shortages.* And that is why my reassignment AND suspension should be removed from my employee file. I did nothing wrong but follow the instructions I was taught.

I am satisfied that my whistleblower complaint has made some changes (on paper) to better care for our veterans and improve their health care conditions.

Now it is time for the Cheyenne/Fort Collins to make some changes to improve one more veteran working conditions, me. I am a veteran and an employee of the VA, and am asking to be made whole again, after this VA scandal that shook the nation, and shook my own personal household when I was unjustly punished and subject to geographical work reassignment based on no legitimate and honest business purposes and my 2 week unpaid suspension , which was based on my inability to schedule appointments, due to *due to the scheduling system restrictions, unavailability of appointment slots for some providers and staffing shortages.*