



**U.S. OFFICE OF SPECIAL COUNSEL**

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The Special Counsel

August 3, 2015

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

Re: OSC File No. DI-14-3424

Dear Mr. President:

Pursuant to my duties as Special Counsel, enclosed please find the Department of Veteran Affairs' (VA) reports based on disclosures of wrongdoing at the Central Arkansas Veterans Healthcare System, Eugene J. Towbin Healthcare Center (Towbin HC), North Little Rock, Arkansas. The Office of Special Counsel (OSC) has reviewed the reports and, in accordance with 5 U.S.C. § 1213(e), provides the following summary of the allegations and our findings.

Daniel Wheeler, a medical support assistant (MSA) who consented to the release of his name, alleged that Veterans Health Administration (VHA) facilities in the Towbin HC healthcare network did not follow proper scheduling protocols, and that Patient Aligned Care Teams (PACT) were seriously mismanaged.

**The agency substantiated Mr. Wheeler's allegations in part. The initial report determined that Towbin HC PACTs had a backlog of new patients waiting to be seen, inappropriately rejected walk-in patients, and the Towbin HC telephone system was mismanaged. Notwithstanding these conclusions, the initial report noted that the management of PACTs has improved since the time of the original referral and discovered no evidence indicating that deficiencies in the telephone system harmed patients. Mr. Wheeler's allegations concerning schedulers misrepresenting and concealing the length of appointment waiting times to create the appearance of accessible care is the subject of an ongoing agency review and will be addressed in a supplemental report. The initial report recommended the continuation of PACT process improvements, training on use of the telephone system, and that the VA Central Office conduct an assessment of the Towbin HC telephone network to expedite changes in the functionality of the network. A supplemental report that the VA provided indicated that the telephone system that was at issue in this matter was totally replaced. Based on my review, I have determined that the reports meet all statutory requirements and that the findings appear to be reasonable. However, I am closing this matter conditionally, pending receipt of the agency's supplemental report regarding patient waiting lists and scheduling.**

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Mr. Wheeler's allegations were referred to then-Acting Secretary Sloan D. Gibson, to conduct an investigation pursuant to 5 U.S.C. § 1213 (c) and (d). Acting Secretary Gibson asked the Interim Under Secretary for Health to refer the allegations to the Office of the Medical Inspector (OMI) for investigation. Then-Chief of Staff Jose D. Riojas was delegated the authority to review and sign the reports. On April 9, 2015, Mr. Riojas submitted the agency's initial report to OSC, and on June 22, 2015, Michael V. Culpepper, deputy director, Office of Accountability Review, submitted a supplementary report. Mr. Wheeler declined to provide comments to the agency reports. As required by 5 U.S.C. § 1213(e)(3), I am now transmitting the reports to you.<sup>1</sup>

### **I. Mr. Wheeler's Allegations**

Mr. Wheeler alleged that Towbin HC had an excessive backlog of patient PACT appointments. At the time his allegations were referred for investigation, he asserted that appointment wait times were between two to six months. Mr. Wheeler attributed these delays to the fact that some Towbin HC PACTs only treated four to five patients daily. This practice appeared to contravene VHA Directive 2010-027, which requires the agency to create appointments that meet patient needs with no undue waits or delays.

Mr. Wheeler also alleged that PACTs routinely rejected walk-in patients, in violation of agency policy and instead of assessing the acuity of walk-in patients' symptoms, staff frequently informed individuals that the clinic no longer accepts walk-ins, and directed them to the Emergency Department. Mr. Wheeler noted that each PACT had designated times for same-day access, but they were rarely used.

Mr. Wheeler also alleged that deficiencies in the Towbin HC telephone system created barriers to patient access. Mr. Wheeler asserted that appointment reminder letters featured incorrect or out-dated PACT telephone numbers. He noted that in August 2013, information technology administrators changed PACT telephone numbers without updating numbers on automatically generated correspondence sent to patients. In addition, he asserted that the system was outdated and frequently disconnected or rerouted callers attempting to reach providers.

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<sup>1</sup> 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).

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## II. The Agency Reports

The agency substantiated Mr. Wheeler's allegations concerning the PACT backlog. The initial report acknowledged that in the past the patient waiting list had exceeded 500 patients. The initial report explained that in March 2012, Towbin HC management implemented new processes designed to reduce wait times. The initial report noted that since March 2013 Towbin HC has consistently scheduled new patients in fewer than thirty days, and the current availability of appointment times is less than two weeks. With respect to the allegation that PACT teams only treated four to five patients daily, the agency determined that this practice was limited to geriatric PACTs, and was addressed by Assistant Chief of Staff Dr. Matthew Jennings in October 2013. Dr. Jennings informed staff through email directives and in-person meetings that this level of performance was unacceptable and implemented a scheduling template for all PACT teams that dramatically increased the daily number of patients treated. The initial report explained that Dr. Jennings continued to actively monitor teams and document performance since the implementation of these improvements.

The agency substantiated Mr. Wheeler's allegations concerning the improper rejection of PACT patients. The investigation discovered a number of email complaints from Emergency Department (ED) staff reporting that PACTs instructed patients to report to the ED for non-urgent care. In January 2014, Dr. Jennings instructed PACT staff not to send non-urgent patients to the ED, and in March 2014, when the issue persisted, he met with ED and PACT managers to convey specific instructions warning against the inappropriate practice of telling patients to go to the ED. The initial report noted that after this meeting these issues were resolved.

The initial report explained that because Dr. Jennings implemented processes to increase the number of patients treated by PACTs and addressed issues related to the ED, these issues have been resolved. For these reasons, the initial report did not substantiate that management failed to properly oversee PACTs. Investigators reviewed current quality and performance measures and determined that Towbin HC's performance was consistent with nationwide norms for VA medical centers. The initial report recommended a continuation of the changes Dr. Jennings implemented, and a reevaluation of same day appointments to better utilize available providers to increase access.

The investigation substantiated Mr. Wheeler's allegations regarding the telephone system, acknowledging that Towbin HC has a long history of problems with its telephone system. The initial report found that two events associated with the telephone system limited patient access to care. First, in August 2013, new PACT telephone numbers were assigned, but no schedulers or patients were provided with correct numbers, and appointment reminder letters lacked updated numbers. To resolve this problem, clerks were directed to hand-write correct numbers on letters prior to mailing. According to the initial report, this problem was resolved in December 2013, when new numbers were programed into the telephone system.

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The second incident occurred on August 28, 2014, when instead of rerouting only PACT scheduling telephone lines to a centralized call center, as directed by Towbin HC management, IT staff mistakenly rerouted all PACT telephone lines, including those for all doctors and nurses to four telephone terminals in the Towbin HC call center. Because all PACT telephone lines were routed into the call center, patients were rerouted by the system back to the call center by schedulers attempting to transfer them. This more than doubled patient complaints. By the time employees determined the nature of the problem, the IT programmer responsible for the error had retired, making it impossible to quickly address the issue. The problem was finally resolved on November 6, 2014.

In addition, the VA has established benchmarks for call center operations indicating that calls should be answered in less than 30 seconds, and abandonment rates should be less than five percent. The initial report determined that calls to the Towbin HC telephone system were not consistently answered within 30 seconds and abandonment rates exceeded 30 percent.

The initial report further determined that senior Towbin HC leadership was unaware of these problems, and the task of resolving them fell to mid-level staff who had been working on the issues for over two years. The initial report attributed these leadership issues to prolonged vacancies, such as the assistant chief of staff. The initial report also expressed concerns that current IT staff lack the skills and knowledge to correct telephone problems, and indicated that these problems may extend through the entire Central Arkansas Veterans Healthcare System telephone network.

The initial report acknowledged that ongoing issues with the telephone system caused an increase in patient complaints and dissatisfaction. However, the agency was unable to substantiate that these telephone issues contributed to any negative clinical outcomes. The initial report explained that patients had the option of presenting as a walk-in to clinics or the ED. Investigators also examined specific incidents referenced in the original OSC referral and determined that patients were able to obtain medical care via a same day-clinic visit. The initial report recommended training hospital staff on the management and use of the telephone system, and an agency-level assessment of the system to expedite changes and develop remediation plans.

On June 22, 2015, the agency provided a supplemental report indicating that shortly after the initial report had been submitted, Towbin HC started the process of migrating to a totally new telephone system, and additional clerks and telephone experts were retained to ensure the proper transition to this new network. The supplemental report noted that as of June 2015, all stages of migration to this new system had been successful and training was complete.

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#### IV. The Special Counsel's Findings

I have reviewed the original disclosure and the agency reports. Based on the reports and recommendations contained within, the findings of the agency appear reasonable and the agency reports meet all statutory requirements. However, as noted above, I am closing this matter on a conditional basis, pending the agency's review of Mr. Wheeler's scheduling allegations. As required by 5 U.S.C. §1213(e)(3), I have sent copies of the agency reports to the Chairmen and Ranking Members of the Senate and House Committees on Veterans' Affairs. I have also filed copies of the redacted agency reports in our public file, which is available at [www.osc.gov](http://www.osc.gov).<sup>2</sup> OSC has now conditionally closed this file.

Respectfully,



Carolyn N. Lerner

Enclosures

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<sup>2</sup> The VA provided OSC with reports containing employee names (enclosed), and redacted reports in which employees' names were removed. The VA has 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 reports produced in response to 5 U.S.C. § 1213, and requested that OSC post the redacted version of the reports 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 of the reports as an accommodation.