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WASHINGTON, D.C.
DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON DC 20420

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The Honorable Carolyn N. Lerner
Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW
Suite 300
Washington, DC 20036

RE: OSC File No. DI-14-2947

Dear Ms. Lerner:

I am responding to your letter of December 22, 2014, regarding allegations made by a whistleblower (Ms. Virgie Hardeman) regarding the Department of Veterans Affairs (VA), Olin E. Teague Veterans' Medical Center, Temple, Texas (Teague VAMC) which is part of the Central Texas Veterans' Health Care System. The whistleblower alleged the following:

- Scheduling staff were directed to manipulate patient wait times data, in violation of agency policy;
- Management was aware of the ongoing data manipulation but took no action to correct it;
- Management's failure to enforce agency scheduling policies endangered public health and safety.

An investigation was initiated based on information provided by a Medical Support Assistant at the North Central VA Federal Clinic, San Antonio, Texas, on or about May 7, 2014. The allegation was that the San Antonio and Austin, Texas facilities did not follow proper appointment scheduling protocols. In particular, the individual alleged that scheduling staff were improperly directed to make patients' desired dates for appointments to be the same date as the first available date, and to avoid utilizing the electronic waiting list. The investigation was expanded to address additional similar complaints received during the investigation, including allegations relating to the Teague VAMC.

The Secretary has delegated to me the authority to sign the enclosed report and take any actions deemed necessary as referenced in 5 United States Code §1213(d)(5).

In response to your letter concerning these allegations, the VA Office of Inspector General (OIG) conducted an investigation of the allegations made by Ms. Hardeman. OIG interviewed Ms. Hardeman, and she informed them that she did not schedule

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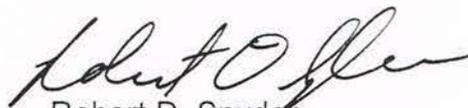
patients in the course of her duties and had no direct knowledge of any supervisors or managers ordering other VA employees to schedule appointments improperly. She said she was acting on behalf of other employees in contacting OIG, OSC, and the Teague VAMC Director's office with the allegations. Ms. Hardeman said she believed that management had told Temple VAMC employees to schedule appointments a certain way in order to make it appear that patients, who were being seen at the Teague VAMC, had a shorter wait time than they actually did. However, she had no personal knowledge of this and did not provide OIG any direct evidence. She did not identify any specific patient whose health or safety was harmed by the scheduling practices at the Temple VAMC. Ms. Hardeman did provide OIG the names of employees she said would have knowledge of the allegations of improper scheduling practices and manipulation of wait times.

OIG prepared the enclosed report of their investigation. OIG's investigation did not substantiate the allegations. OIG interviewed seven Teague VAMC employees, including the employees that Ms. Hardeman said had information about scheduling practices and wait times manipulation. In addition, OIG reviewed documentary evidence relating to the Performance Appraisal Program of employees responsible for training and supervising Medical Administration Service schedulers and reviewed employee email data for the Teague VAMC. OIG concluded that they did not identify any violations of law, rule, or regulation and made no recommendations for corrective action.

I have reviewed OIG's report and find that it fully addresses the allegations we were asked to investigate in your letter of December 22, 2014. Therefore, I am submitting their report in response to that referral.

Thank you for the opportunity to respond.

Sincerely,



Robert D. Snyder
Interim Chief of Staff

Enclosure

**REPORT FOR THE OFFICE OF SPECIAL COUNSEL PURSUANT TO THE
PROVISIONS OF TITLE 5 UNITED STATES CODE § 1213
RESULTS OF INVESTIGATION BY THE VA OFFICE OF INSPECTOR GENERAL IN
RESPONSE TO ALLEGATIONS OF VIOLATION OF LAW, RULE, REGULATION,
TEMPLE, TEXAS VA MEDICAL CENTER**

OSC FILE DI-14-2947

1. Summary of the information with respect to which the investigation was initiated.

An investigation was initiated based on information provided by a Medical Support Assistant at the North Central Department of Veterans Affairs (VA) Federal Clinic (North Central VAFC), San Antonio, Texas, on or about May 7, 2014. The allegation was that the San Antonio and Austin, Texas facilities did not follow proper appointment scheduling protocols. In particular, the individual alleged that scheduling staff were improperly directed to make patients' desired dates for appointments to be the same date as the first available date, and to avoid utilizing the electronic waiting list (EWL). The investigation was expanded to address additional similar complaints received during the investigation, including allegations relating to the Olin E. Teague VA Medical Center, in Temple, Texas (Temple VAMC).

The Temple, Texas investigation related to allegations raised by Ms. Virgie Hardeman, a Temple VAMC employee, to the Office of Special Counsel (OSC). The allegations to be investigated included:

- Scheduling staff were directed to manipulate patient wait time data, in violation of agency policy;
- Management was aware of the ongoing data manipulation but took no action to correct it;
- Management's failure to enforce agency scheduling policies endangered public health and safety.

2. Description of the conduct of the investigation.

- a. Interviews: The VA Office of Inspector General (OIG) investigators interviewed the Complainant, Program Support Assistant, Trainer; the Chief, Medical Administration Services (MAS); and the Supervisor, Medical Support Assistant, at the Temple, Texas VAMC.
- b. Records review: Performance plans, appraisals, awards, and email accounts of the Program Support Assistant, Trainer, and the Chief, MAS.

3. Summary of the evidence obtained from the investigation.

- Ms. Hardeman has worked for VA for 36 years. She currently works as a

licensed vocational nurse (LVN) in the Emergency Department (ED) at Temple VAMC and is also a union steward with the American Federation of Government Employees (AFGE) local union 2109 at Temple VAMC. Ms. Hardeman did not schedule patients while working as an LVN in the ED at Temple VAMC.

Ms. Hardeman had no direct knowledge and/or evidence of any supervisor or manager, including the VAMC Director, specifically ordering VA employees to schedule appointments improperly or against VA policy. Ms. Hardeman said she was acting on behalf of other Temple VAMC employees when she contacted VA OIG, OSC, and the Temple VAMC Director's Office around May 2014 to report that the scheduling of appointments was not being done properly.

Ms. Hardeman said she believed that management had told Temple VAMC employees to schedule appointments a certain way, in order to make it appear that patients who were being seen at Temple VAMC had a shorter wait time than they actually did. However, she had no personal knowledge of this and did not provide any direct evidence. She did not identify any specific patient whose health or safety was harmed by the scheduling practices at the Temple VAMC.

- We also interviewed a clerk, a Medical Support Assistant identified by Ms. Hardeman, as possibly having knowledge of the manipulation of wait times at the Temple VAMC. The individual stated that he did not routinely schedule appointments, except for lab appointments for VA patients and does not schedule appointments for clinics. One of his duties includes contacting clinics at Temple VAMC and requesting that appointments be made for patients who are on Ward 3K. The individual did not have any knowledge of or provide any evidence of manipulation of wait times.
- We interviewed the Physician Assistant identified by Ms. Hardeman as possibly having knowledge about inappropriate scheduling practices and/or gaming strategies being used at the Temple VAMC. Although the Physician Assistant alleged that wait times were altered in the past so that supervisors could receive monetary bonuses and promotions, he offered no evidence to support his allegation. He opined that scheduling procedures improved and that hospital management was taking steps to correct previous scheduling problems. Finally, the Physician Assistant advised that he was not aware of improper scheduling processes currently being used at the facility.
- The Medical Support Assistant, Trainer, MAS, Temple VAMC stated that he taught new MAS employees the way to schedule appointments, per Veterans Health Administration (VHA) Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures*. He was aware that the Temple VAMC was not using the EWL list because he claimed the Chief of MAS, directed that the EWL would not be used. See below for additional discussion. He taught the staff that the Veteran's desired date is captured and not changed, and then the appointment is scheduled based upon what is available. He stated, however, that he does not instruct employees that the desired date should be coded as the first available date.

- Chief, MAS, Temple VAMC stated that supervisors and staff would discuss meeting the 14-day performance measure but said that nobody encouraged anyone to manipulate the desired date. She stated that Central Texas Veterans Health Care System does not use the EWL because it does not have a need to use the EWL. She explained that the EWL was used for Veterans who are outside of 90 days, and it was their goal not to have patients scheduled for appointments outside 90 days. As such, there was no need in most of the locations to use the EWL because the Veterans are not having to wait that long. She denied giving an instruction not to use the EWL and stated that the instruction was to know what the EWL is and if a Veteran's name gets on the EWL, that it is properly worked with to ensure that the Veteran is not mistakenly left off that list and not given an appointment. She said if there was a problem scheduling the patient that the instruction was to get with the provider and their supervisor and make sure that it is known that there is nowhere to put this patient in 90 days.
- Supervisor, Medical Support Assistant, Temple VAMC told us that she researched the scheduling directives in 2011. She knows the rules associated with scheduling and followed the scheduling directive. There was a time when the desired date was being recorded as the first available date, while still taking into account the provider's orders. The scheduler would let the patient know what the first available date was, and if they agreed, that date would be recorded as the desired date. She denied ever instructing her schedulers to manipulate patient wait times. She stated that the scheduling policy is very confusing and believes that many of the schedulers' mistakes were not intentional and were made because the employee was scheduling too quickly.
- A Medical Administrative Officer, MAS, Temple VAMC, stated he could talk about what occurs with MAS schedulers and how his employees are trained but cannot explain about the other services' schedulers, who make up 68 percent of the scheduling staff. At the Temple VAMC, there are 735 individuals with scheduling keys, and MAS is responsible for 236 of those individuals. The EWL was not utilized because MAS always believed that there was sufficient access. If he had known there were access issues, the EWL would have been utilized. Unfortunately, some employees misunderstood the message and believed that the EWL could not be used for any reason.
- A review of VA Forms 0750, Performance Appraisal Program, for fiscal years (FY) 2011, 2012, and 2013 for the, Program Support Assistant, Trainer, Temple VAMC showed that the position description indicated he is responsible for the following:
 - Having knowledge of MAS policy and procedures;
 - Knowledge of VA regulations, directives, policies, procedures, memoranda, and manuals;

- Training new employees in all components of MAS;
- Identifying MAS problem areas and developing training to combat the identified problems; and
- Providing refresher training to schedulers.

The review revealed that he was performing his position without a data validator for FY 2013. A data validator is an individual who provides statistical, analytical, and evaluative data to assist the MAS supervisors in teaching, training, and monitoring their employees in the performance of their duties. For FY 2012, he provided new employee training on VHA Directive 2010-027 and provided additional training to scheduling staff on the desired date.

- A review of VA Form 3482e, Executive Career Field (ECF) Performance Appraisal Program, VHA, for FYs 2011, 2012, and 2013 for the Chief, MAS, Temple VAMC showed that her performance appraisals and self-assessments for FY 2012 and 2013 contained metrics and statements associated with patient wait times. For FY 2012 and 2013, the rating narratives do not contain any indication that her performance ratings were based on any claimed achievements associated with patient wait times.
- A review of VA employee email data for the Temple VAMC did not uncover any emails from any VA employee that indicated an individual or group of individuals were being instructed to manipulate or falsify patient appointment data.

4. A listing of violations or apparent violations of law, rule, or regulation.

The VA OIG's investigation did not identify any violations of law, rule, or regulation at the Temple VAMC.

5. A description of any action taken or planned as a result of the investigation.

No action was taken or is planned to be taken because the allegations were not substantiated.