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The Special Counsel

August 2, 2016

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

Re: OSC File No. DI-15-5392

Dear Mr. President:

Pursuant to my duties as Special Counsel, I am forwarding an unredacted Department of Veterans Affairs' (VA) report based on disclosures of wrongdoing at the Phoenix VA Health Care System, Phoenix, Arizona. The whistleblower, Dr. Elaine Ramos, who consented to the release of her name, alleged that Medical Support Assistants at the Southeast Community Based Outpatient Clinic (SE CBOC) engaged in misconduct with respect to patient scheduling procedures. I have reviewed the report and, in accordance with 5 U.S.C. § 1213(e), provide the following summary of the agency report, whistleblower comments, and my findings.[1]

Dr. Ramos' allegations were referred to Secretary Robert McDonald for investigation pursuant to 5 U.S.C. § 1213. The VA's Office of the Medical Inspector investigated the matter. Interim Chief of Staff Robert D. Snyder was delegated the authority to review and sign the report. On February 29, 2016, Mr. Snyder submitted the agency's report to the Office of Special Counsel (OSC). Dr. Ramos commented on the report on March 21, 2016. On May 26, 2016, the VA provided additional information regarding the status of proposed corrective actions.

The investigation substantiated that some schedulers at the SE CBOC, without informing patients, rescheduled and cancelled appointments through a prohibited practice known as blind scheduling. In addition, the report found that the Phoenix VA Health Care

[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).

System was not using the most recent VA policy guidance on scheduling processes and that SE CBOC employees had not received training on these revised procedures. The report did not substantiate that the clinic's employees inappropriately triaged patients presenting at the SE CBOC during mental health crises. However, the report acknowledged that the SE CBOC Mental Health Clinic did not implement proper standard operating procedures to assist with this process. The report also substantiated additional allegations provided by Dr. Ramos during an interview with investigators. She asserted that a psychiatrist failed to examine an admitted patient and implement a treatment plan within twenty-four hours of admission, thus constituting a violation of agency policy.

In response to these substantiated allegations, the agency provided training and education updates for employees on scheduling policies and continued to conduct scheduling audits. With respect to the psychiatrist who failed to admit a patient, the report recommended the initiation of a Focused Professional Practice Evaluation to determine if her conduct fell below an acceptable standard. The evaluation was performed on March 29, 2016 and concluded that the psychiatrist was a skilled and thorough physician, notwithstanding the incident Dr. Ramos described. Additional information provided by the VA indicated that this individual subsequently resigned and left VA service on June 9, 2016.

In examining Dr. Ramos' unsubstantiated allegation concerning patient triage, investigators reviewed the electronic health records of all unscheduled patients who presented at the SE CBOC during the allegedly improperly conducted triages. The investigators determined that the clinic's employees screened all individuals for suicidal and homicidal ideation. According to the report, a mental health provider or registered nurse then saw each individual. However, the report found that the SE CBOC Mental Health Clinic lacked written guidelines, policies, or procedures to address these unscheduled patients. In response, the agency developed and implemented appropriate procedures for the clinic.

Dr. Ramos commented that the report mistakenly attributed scheduling improprieties to insufficient staffing. She asserted that the SE CBOC was fully staffed with schedulers during the time at issue in her allegations but that managers stated they would not implement updated policies, despite being aware of them. She disputed the report's findings regarding patient triages, stating that these conclusions differed from her recollection of the day-to-day operation of the clinic.

I have reviewed the original disclosure, the agency report, and Dr. Ramos' comments. While Dr. Ramos called into question the reasoning and conclusions of the investigation, the report indicates that the agency took measures to confirm that the SE CBOC retrained employees and implemented proper policies to ensure appropriate access to care. For these reasons, I have determined that the report meets all statutory requirements, and the findings appear to be reasonable.

As required by 5 U.S.C. § 1213(e)(3), I have sent copies of the agency report and Dr. Ramos' comments to the Chairmen and Ranking Members of the Senate and House Committees on Veterans' Affairs. I have also filed a redacted copy of the agency report and Dr. Ramos' comments in our public file which is available at www.osc.gov.[2] OSC has now closed this file.

Respectfully,

Carolyn N. Lerner

Enclosures

[2] 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.