Mr. John Young
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Re: OSC File No. DI-16-4742 – Written Comments on Agency Report

It is disconcerting that out of the numerous allegations that were submitted, the Office of Special Counsel (OSC) only accepted four allegations for investigation regarding the violation of law, rule or regulation; gross mismanagement, and a substantial and specific danger to the public. Of the four allegations that were accepted, the VHA Office of the Medical Inspector (VHA OMI) only substantiated one allegation and partially substantiated a second claim. At minimum, all four of these allegations that the Office of Special Counsel accepted should have been substantiated had the "investigation" been conducted properly. This haphazard investigation only diminishes the credibility of the agency. The results of this investigation only reinforce, if not ensure, that illegal, immoral, and unethical conduct continue at Michael E. DeBakey VA Medical Center (MEDVAMC).

Although it is claimed that the VHA OMI "independently investigates" health care issues, this clearly is not the case where it reports directly to the very agency that directs its investigation. There is an obvious conflict-of-interest where an office reports its findings back to its main headquarters. An incentive within this reporting structure is to downplay the wrongdoings at one of its facilities, as was the case with this poorly conducted investigation. In downplaying these wrongdoings, the agency allows the facility, MEDVAMC, to continue its culture of zero accountability and fraud, waste, and abuse. This is in direct contrast to what Dr. Shulkin, Secretary of Veterans Affairs, has expressed in his numerous press briefings regarding transparency and accountability as well as defeats the intent of the Department of Veterans Affairs Accountability and Whistleblower Protection Act of 2017 that President Trump signed into law in June 2017. It is this very culture of corruption that enables VA "leaders," such as Mr. Christopher R. Sandles, who has received preferential and unfair advantages in violation of Prohibited Personnel Practices to become the Director of the Central Texas VA Health Care System, to continue to be "rewarded" for "serious misconduct" despite on-going questionable actions that impact Veterans, employees, taxpayers, and the public.

The investigation would be described as "imaginative" at worst and "shoddy" at best. Obviously, the investigation was not impartial and instead was biased in favor of MEDVAMC and its past, present, and future dishonest practices of patient care.

There were several flaws in the investigation that the VHA OMI conducted.

Flaw 1: VHA OMI allowed the facility to determine its own witness list. Evidently, there was a self-selection bias since MEDVAMC only selected witnesses who were favorable to the investigation. VHA OMI failed to further investigate and interview other witnesses who were not a part of this self-selected witness list - this is also referred to below where other witnesses named and were provided to VHA OMI to interview. This helps explain why several of the allegations could not be substantiated. It is the best interest of MEDVAMC to hide its own

wrongdoings in order to maintain its “four-star rating” as a medical facility. This inflated ranking and rating encourages unnecessary public funding and undeserved positive publicity.

Flaw 2: VHA OMI did not include the appropriate investigators to conduct the investigation. The investigators were primarily clinical providers, who did not have a true understanding of administrative issues that ultimately impact patient care. The other administrative personnel who were included did not possess the knowledge or skills to determine the validity of the allegations nor did they have the ability to investigate objectively without bias. Witness concerns and questions were deliberately ignored or went unanswered when the competency of the investigators was challenged.

Flaw 3: VHA OMI failed to indicate that it conducted the interviews in "group settings." These group interviews did not allow staff to freely express their individual concerns. Clearly, these arrangements did not provide a psychologically safe and open environment where interviewees could express their concerns due to the real fears that the other interviewees would be reported on and retaliated against – which ultimately occurred. Undoubtedly, this is not how an interview is appropriately conducted, particularly where there are several witnesses who can attest to the allegations first-hand. It appears that the interest of submitting slapdash results is more important than appropriately conducting an objective investigation, particularly where these allegations had been made in calendar year 2016.

Flaw 4: Several of the witnesses shared with other witnesses the content of the interviews and even provided guidance on what the investigators had asked even though they had been informed that the investigation was confidential and signed notices. In some instances, these witnesses also advised other witnesses on how to respond to the investigation. Clearly, this defeats the objective of validating allegations if witnesses are "coached" on their responses by fellow witnesses and/or Executive Leadership.

Flaw 5: VHA OMI used the "Notice of Witness Obligations and Protections" as a tool to threaten witnesses instead of as a tool to inform them of their due process rights. (In some cases, VHA OMI even forgot to request this signed acknowledgments from witnesses before proceeding forward with the interviews. Again, this only demonstrates the "lax" nature in which this investigation was conducted.) Some witnesses had informed VHA OMI that they feared reprisal and retaliation from Executive Leadership due to their participation. However, instead of protecting witnesses from retribution, VHA OMI only perpetuated this fear when it informed the witnesses that their failure to cooperate would result in disciplinary action against the witnesses. Clearly, the VHA OMI does not have vested interest in the protection of witnesses, particularly where retaliation does not impact them directly. It is notable that witnesses and whistleblowers continue to work in a tense environment at MEDVAMC even though VHA OMI may claim otherwise.

Flaw 6: Several witnesses who were referred to during the investigation were excluded from the interview process altogether. Several witnesses were named and referred to VHA OMI, which it disregarded even though it was informed that these staff observed the wrongdoings first-hand. Again, this helps explain why the allegations were not substantiated since "cherry-picking" occurred to reflect the agency in a positive light.

Flaw 7: No Veterans or Veterans groups were interviewed in this process. These stakeholders were excluded from the process altogether even though their quality of care may be impacted. Veterans are the true victims here where their quality of care is at stake but their voices remain unheard. Veterans may only be "selectively" heard after "the damage has been done" - and in some cases, the consequences to our nation's heroes are irreversible where corrective actions come too late or if at all.

Flaw 8: These interviews were conducted in less than a span of two weeks, which clearly cannot capture the extent of the wrongdoings at this facility. It is disputed how an extensive investigation could have been completed in such a short timeframe, particularly where there are nine outlying CBOCs and a medical center involved in the investigation. Some of the CBOCs are located hours away, which would need to be factored into how much time was actually spent conducting the investigation itself.

The flaws must be taken into consideration when reviewing the findings and recommendations that VHA OMI made.

There are several failings in the findings that VHA OMI made.

Allegation 1: The allegation was misinterpreted to include just the CBOCs. Blind scheduling occurs throughout the medical center and CBOCs. However, this allegation was interpreted to just apply to CBOCs. Clearly, if the outer CBOCs are practicing blind scheduling, then the conclusion can also be made that this practice also occurs and is supported by and at the main medical center. The main medical center provides scheduling training through the MSA Academy to all medical center and CBOCs staff.

The investigative report failed to mention that MEDVAMC had been cited for similar concerns regarding scheduling issues in a 2014 OIG investigation where an anonymous whistleblower had reported that Executive Leadership provided instructions to schedule a "certain way" that provide favorable Missed Opportunities Rates. MEDVAMC also failed to mention that it implemented the trainings as a result of these substantiated OIG allegations, not because the trainings were identified as a “best practice.” Yet, these scheduling issues have been allowed to continue to occur up until the date of this report without any repercussions. Instead, MEDVAMC can continue to falsify data and misrepresent wait times to the public without any consequences under these findings. Ultimately, the irony of this is that MEDVAMC attempts to "pull the wool" over the eyes of the public using their own public funds!

Again, no Veterans were interviewed to determine what their experiences were with "blind scheduling." A sample of Veterans could have been interviewed to determine what their scheduling experiences have been. Yet, this was not completed. Numerous Veterans have made both verbal and written complaints and have submitted Congressional inquiries regarding the blind scheduling process. Yet, these complaints were not retrieved for review from the Consumer Affairs office.

It is notable that each of the facilities that Mr. Sandles has transitioned to has had reported issues

with scheduling and/or are rated poorly as one-star facilities, such as VA Loma Linda Healthcare System, VA Greater Los Angeles Healthcare System, and now MEDVAMC. It is also notable that Mr. Sandles oversaw the MSA Academy and its curriculum during this timeframe. Mr. Sandles was aware of these issues for quite some time but "turned a blind eye" and allowed for them to continue to occur in order to produce false perceptions of access.

Allegation 2: This allegation was misinterpreted to just include CBOCs. There are issues with the walk-in process throughout the medical center and CBOCs.

VHA OMI failed to interview MSA staff medical center regarding the walk-in practices of the CBOCs. It would be in the interest of CBOCs staff to not admit to their own wrongdoings since it would only highlight their practices in a negative light. It would also be in the best interest of the CBOCs staff to not jeopardize their own careers since the CBOCs may be the only viable workplaces within the locale.

It is with certainty that had the VHA OMI interviewed the medical center MSA staff regarding walk-in practices at the CBOCs, this allegation, although misinterpreted, would have been substantiated. The medical center facility staff would be able to provide insight regarding the complaints they have received about the CBOCs and their lack of walk-in processes.

VHA OMI also failed to review the number of patient transfers from CBOCs to the main facility to determine the validity of the allegations. Veterans have made many transfer requests from CBOCs to the medical center due to the lack of care patients receive at the CBOCs. Often times, these complaints have arisen because of the lack of walk-in processes.

VHA OMI failed to compare the walk-in process at the CBOCs to that of the medical center. This comparison would have allowed VHA OMI to determine where the differences may lie if walk-in processes existed as claimed. (However, there is no walk-in process at the medical center, which would lead to the conclusion that there is no walk-in process at the CBOCs since the CBOCs follow the processes and procedures of the medical center.) Furthermore, VHA OMI did not reference the date of the so-called "Unscheduled Visits Standard Operating Procedure." The VHA OMI should be aware, as the investigatory unit of VHA patient care, that medical centers will "clean up" issues before the start of an investigation, particularly where they have become aware of the allegations. This investigation is not any different than if The Joint Commission were to conduct a site-visit; it would be in the best interest of MEDVAMC to demonstrate its "best behavior" than to be sanctioned or lose its accreditation. This procedure did not exist prior to this investigation, which patients and medical center staff can attest to had they been interviewed, nor can this procedure be located after this investigation.

VHA OMI also failed to review unscheduled visits and Veteran travel requests. In theory, unscheduled visits within the VISTA system should correlate with the walk-in processes at the CBOCS if they existed since staff would need to document these encounters into patient records. Similarly, unscheduled visits should correlate with the Veteran travel requests if patients were appropriately paid for their travel to the VA center. However, none of these audits were conducted to ensure that this was consistent with the finding that walk-in processes exist at the CBOCs. If this audit had been conducted, it most likely would have opened up "Pandora's box"

to expose that Veterans may not be receiving their proper reimbursements for travel to and from a VA healthcare facility if the unscheduled visits were not being appropriately captured.

Again, no Veterans were interviewed to determine what their experiences have been with the walk-in process at the CBOCs. A sample of Veterans could have been interviewed to determine what their walk-in experiences have been. Yet, this was not completed. Several Veterans have complained about the lack of walk-in processes but they were not included in the interview.

It is notable that Mr. Sandles has been aware of the lack of walk-in processes for quite some time but did not address this in pursuit of his own promotion.

Allegation 3: This allegation was misinterpreted to refer to just CBOCs and that scheduling staff have intentionally disabled automatic call distributor (ACD) systems.

The inaccurate assumption that VHA OMI made presupposes that ACD lines are set up appropriately; however, this is not the case. For ACD lines to be disabled, ACD lines would need to be set up appropriately in the first place. ACD cannot be intentionally disabled if the phone lines are not appropriately set up. VHA OMI failed to determine whether all appropriate areas, particularly clinical areas, were set-up with ACD lines at the CBOCs. There have been instances where CBOCs have not set up ACD lines for certain areas because the tracking of the performance would be unfavorable. VHA OMI failed to investigate why the ACD lines at the CBOCs are set up differently than at the medical center.

Many Veterans have complained that they are unable to reach certain areas of the CBOCs, such as their PACT Teams, and are instead provided with direct extensions to direct office numbers. Yet, Primary Care patients at the medical center may want to speak with a specific MSA or PACT clinic or returning a call from a specific team member and are routed to a Primary Care ACD line. VHA OMI failed to further investigate why this difference exists between the CBOCs and the medical center even though they both follow the same national directives and guidance.

VHA OMI also failed to compare the set-up of the ACD lines of the CBOCs to that of the medical center. VHA OMI failed to investigate why the telephone data for CBOCs is "lumped" for each CBOC whereas the data for the medical center is individual to each care line. However, no comparison was made.

VHA OMI failed to mention that several of the supervisory administrative and clinical support positions are vacant throughout the CBOCs at this time. Because these positions remain vacant, there is no supervisory support to monitor telephone measures as claimed. Staff are not held accountable for telephone performance measures and patients suffer from this lack of accountability.

Again, no Veterans were interviewed to determine what their phone experiences have been with the CBOCs. A sample of Veterans could have been interviewed to determine their telephone experiences have been for the CBOCs. Yet, this was not completed. Several Veterans have complained that they continue to be transferred back and forth between the CBOCs and the medical center, which has been a dissatisfying and frustrating experience.

It is notable that Mr. Sandles has been aware of the phone issues for quite some time but chose not to address them in order to provide the idealistic perception that telephone measures are being met.

Allegation 4: This allegation should be substantiated for both the walk-in and call-in process. However, VHA OMI substantiated that Medical Center Executive Leadership developed a patient scheduling process that violates agency policy by removing required clinical review of patients who call-in for an appointment based on the noted scheduling guidance. This is just one example of the many "shady" instructions that subordinate staff receive to follow from Executive Leadership to "chase performance measures" and to ensure that Senior Executive Service members receive "performance awards (bonuses)."

VHA OMI failed to provide findings for the call-in process as it did for the other allegations. Clearly, VHA OMI did not want to acknowledge the harm that Veterans have already suffered and continue to suffer from the lack of clinical review. Veterans are most likely not aware that they are receiving clinical advice from administrative staff nor would they be pleased to hear that their taxpayer dollars are being wasted due to this "convenient and cheaper" alternative. (For the most part, administrative staff are on a different pay scale than clinical staff and are relatively less expensive when it comes to salary expenses.)

This lack of clinical review via the call-in process not only directly impacts patient care but also prevents data from being appropriately captured and reported to the public. As a result, telephone wait times are underreported and deflated, which inflates the rankings and ratings of MEDVAMC for telephone access and access.

Again, no Veterans were interviewed to determine what their call-in process has been. A sample of Veterans could have been interviewed to determine call-in experiences have been. Yet, this was not completed.

It is notable that Mr. Sandles was in support of this lack of clinical review where the lack of clinical review may lead to an adverse event.

Ultimately, the recommendations that VHA OMI made are of no value since the allegations were not appropriately assessed and instead, misinterpreted to the benefit of MEDVAMC. Even if some of these recommendations were implemented, they would not be successfully sustained at this facility.

In conclusion, this investigation supports the lack of accountability and encourages fraud, waste, and abuse at MEDVAMC. VHA OMI condones the lack of transparency and lack of accountability that has prevented MEDVAMC becoming what it can potentially become, such a federal world-class health care facility. Yet, these same old practices and behaviors have led this facility to where it is now—embroiled in scandal and dishonesty at the expense of Veteran lives, taxpayer funds, and integrity of the agency.

The mission of the VA, "To care for him who shall have borne the battle, and for his widow, and his orphan," cannot be met until VA leaders, such as Mr. Sandles, are held accountable for their serious misconduct and removed from their federal civilian positions. There is a high demand to fill the voids of leadership, professional integrity, and commitment to the highest ideals of public service that the agency currently lacks.

The VA can only be made great again through the re-introduction and instilment of integrity, ethics, and morals back into the agency. VA is the second-largest federal department and should serve as a trailblazer and role model to other federal agencies in its efforts to move toward a culture of accountability and to eradicate the culture of silencing whistleblowers who bring legitimate concerns to the forefront.

Respectfully,

Anonymous Whistleblower

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Re: OSC File No. DI-16-4742 – Addendum to Written Comments on Agency Report

The OSC is strongly encouraged to fully investigate the dubious background of Mr. Sandles, particularly on how he has "progressed" so quickly in his short federal career. Mr. Sandles is on the same career trajectory as another Executive Leader who was recently terminated from federal service in VISN 16.

These "achievements" that Mr. Sandles touts are mired in corruption and wrong-doing and has left a long trail for other hard-working federal employees to clean-up the mess – and is well-known throughout VISN 16. The OSC should further review the numerous and repeated complaints and grievances filed against Mr. Sandles in order to truly see the recurring pattern of oppression, coercion, and other disingenuous actions that he has knowingly committed throughout his federal career. Ultimately, Mr. Sandles' "career progression" has come at the expense of Veteran care.

What is further disappointing and unacceptable to the American public and taxypayers alike is that Mr. Sandles has somehow been promoted to the Medical Director of the Central Texas Veterans Health Care System despite these well-known concerns. Instead of disciplining gross misconduct, Mr. Sandles has been "rewarded" with a promotion within the system – which only perpetuates a vicious circle of fraud, waste, and abuse as well as condones other illegal and immoral actions. This lack of accountability and reward for bad behavior must be fully addressed to meet the demands of Veterans and the public.

The agency has now gained an invaluable tool to improve the needs of Veterans across the United States. With the Department of Veterans Affairs Accountability and Whistleblower Protection Act of 2017 now in place, VA leaders should and can finally be held accountable. Drastic measures need to be taken in order to modernize the VA into an agency that delivers world-class health care. The removal of Mr. Sandles from federal service will serve as an example to other Senior Executive Service appointees and federal employees that serious misconduct will not be tolerated. Moreover, the disciplinary action should be final, not negotiated down to a "slap on the wrist whereby a Senior Executive Service appointee is allowed to maintain his government pay while he completes "special projects" at the regional level on the taxpayers' dime.

Modernization efforts require bold actions and speed in execution. It is only through the actions of "weeding out" unethical officials and making these disciplinary actions transparent that the VA can become a center of patient choice and employer of choice. Corrupt and dishonest officials, such as Mr. Christopher Sandles, serve as barriers that prevent the VA from being an efficient and effective agency that provides high-quality care to Veterans in a patient-centric manner. The removal of these barriers will enable the VA to strategize and produce favorable results and outcomes for our nation's heroes.

Respectfully,

Anonymous Whistleblower