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Whistleblower Comments

OSC File No. DI – 17 - 0045

August 1, 2017

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The Honorable Carolyn N. Lerner

Special Counsel

U.S. Office of Special Counsel

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RE: OSC File Nos. DI – 16-5834 & DI – 17-0045

Report by the VA Office of the Medical Inspector (OMI) dated April 5, 2017 -

"The whistleblowers alleged that the Physical Therapy (PT) Department used the Outlook calendar to avoid excessive wait times for appointments."

"VA substantiated none of the allegations, finding that the PT Department maintained all appointments in the Veterans Health Information Systems and Technology Architecture (VISTA appointment system, according to Veterans Health Administration (VHA) policy, and only used Outlook as an aid in finding open times in the therapists' schedules."

This is in response to the report dated 04/05/2017 regarding the investigation performed by the VA Office of the Medical Inspector (OMI) to address whistleblower allegations that the report lists as "a PT Supervisor instructed her administrative staff to manipulate the patient scheduling system in an effort to hide wait times at the Edith Nourse Rogers Memorial Veterans Hospital (the Medical Center) in Bedford Massachusetts."

Although the statement above is true, it is not the basis of the whistleblower's complaint as it is impossible to prove due to several factors. The events occurred in 2015 and 2016 and was done by delayed input of entering Veterans appointments beyond a two week period into VISTA. The

appointments were put in the therapists Outlook calendar but not entered into VISTA so they would not show on reports. This delay caused errors including either two Veterans being booked at the same time on one Physical Therapist's (PT) schedule or one Veteran being booked at the same time with another department's appointment (such as dental) because the appointment did not appear in VISTA when the other department looked for an opening to book the Veteran for an appointment. Unfortunately, written evidence of this is not available and several staff involved in these actions no longer work for the Sensory and Physical Rehabilitation (SPRS) department/VA or will not reveal their involvement due to fear of harassment and retaliation from management. As the whistleblowers do not have a team of investigators and attorneys to research, query, and prepare the evidence, we have supplied as much as possible while still completing our obligations and duties for the Veterans we serve.

The specific allegations of the whistleblowers listed in the report are also stated incorrectly and therefore, the facts and findings provided to support that the alleged events or actions took place are irrelevant. The whistleblowers had contacted the Office of Special Counsel (OSC) by phone and email after their initial phone interviews had occurred by OMI to express concern regarding the appearance of bias with a VA agency investigating the VA Medical Center based on the questions and response of the OMI investigators during the initial process. Bias was also demonstrated by the OMI investigators during the in-person interview process during the on-site visit in January 2017. This whistleblower attempted to educate the OMI investigators during her face-to-face interview, with NAGE Union President ([redacted]) also present, regarding the true allegations that had been filed versus the "scheduling issues" they were attempting to address. The OMI investigators were resistant to looking deeper into the true allegations and continued to revert to problems with the "scheduling process". One staff member was upset after being interviewed and stated, "They kept asking me the same questions over and over again as if they expected me to change my answer." The above information was relayed to the OSC by this whistleblower as the on-site visit was taking place.

The OMI investigators concentrated on the scheduling process, use of the Outlook calendar for scheduling purposes, and clinically indicated dates (CID's) during their site visit. This is evidenced in their main allegation stated on their cover letter by Vivieca Wright Simpson, Chief of Staff = "The Whistleblowers alleged that the Physical Therapy (PT) Department used the Outlook calendar to avoid excessive wait times for appointments." It is also evident in the executive summary and the specific allegations on page ii of the report which states "allegations that a PT Supervisor instructed her administrative staff to manipulate the patient scheduling system in an effort to hide wait times". The specific allegations are as follows:

1. [redacted], PT Supervisor, improperly instructed PT department administrative employees not to enter patient appointments into agency scheduling systems in violation of Veterans Health Administration (VHA) policies;
2. [redacted] directed that employees use a shared Outlook calendar for scheduling patient appointments to conceal lengthy wait times;
3. [redacted] instructed employees to improperly manipulate clinically-indicated dates (CID), in violation of agency policy, in an effort to hide patient wait times.

Unfortunately, the OMI investigation appears to have overlooked the basis of the whistleblowers' allegations which is that the Veterans were not being offered the Veterans Choice Program despite having to wait greater than 30 days for PT evaluation and/or treatment appointments after the initial PT evaluation. This was an ongoing problem throughout 2015 and 2016. Once the VA was notified by the OSC in December 2016 that a claim had been filed for Abuse of Authority, then changes started to be made but little had been done prior despite staff and patient complaints about the lengthy wait times and poor access to treatment. Staff do not file formal complaints for fear of retaliation which has been the typical response by management in the past. Veterans do not file for fear of retaliation in the form of further reduction to access of services or reduction of their service connection and benefits.

The OMI report admits to the greater than 30 day wait for Veterans to access PT evaluation and treatment several times including the following under conclusions for Allegation 2 on page iii :

"There is evidence that wait times for PT services exceeded the 30 day standard, which was recognized by the Medical Center leadership and resulted in recruiting and hiring four additional PT's."

The Veterans affected by the lengthy wait for PT appointments should have been offered the Veteran's Choice Program per VA Directive 1230 and were not. This whistleblower has numerous records of this that were provided to the OMI investigators during the on-site visit in January 2017. I can provide these specific Veteran records to the OSC as allowed under the Special Privacy topics (whistleblower) under the VA Privacy and HIPAA focused training.

Under the Findings section on page 3 of the report, it states that Veterans who are new patients to the PT department must get appointments within 30 days and that in order to comply with the requirements for the Veterans Choice Program (Choice), the Medical Center implemented process changes in the PT department in April 2015. "If VA is unable to schedule an appointment within this

time frame, the MSA (medical support assistant) is required to place the Veteran on the Veteran's Choice List (VCL)." The report then lists statistics about the number of Veterans placed on the VCL in FY 2015, 2016, and 2017. It does not mention the Veterans that were not placed on the VCL despite having been given numerous records of such cases. In fact, on page 4 of the report, it states "we reviewed lists of Veterans provided by the whistleblowers and all were in Vista in scheduled appointments. The report omits that these appointments were not within the 30 day required timeframe and the Veterans were not offered the Choice program as mandated per VA Directive 1230. As stated before, this whistleblower can provide numerous cases demonstrating this from 2015 – 2016 as provided to the OMI investigators. I will gladly reproduce this documentation for the OSC as allowed per the VA Privacy and HIPAA focused training.

The report mentions a shortage of staff which has been an ongoing issue but this does not excuse management's responsibility in the lack of placing Veterans on the VCL and being offered the Choice program due to having an over 30 day wait to access PT services. Four additional PT's were hired and began working for the Medical Center from March to July 2016. Two of these PT's replaced staff that had left between December 2015 and February 2016. Only 1 PT is working full-time in the Outpatient setting and the other 3 PT's work primarily in Inpatient and assist with walk-in patients and an occasional Outpatient if needed. The additional staffing was also necessary due to new inpatient units at the Medical Center including Hospice and GPU (geripsych unit). Under the Findings for Allegation 2 on page 5 of the report, it states "despite an increase in the number of PT's in the last 2 years, the VISTA appointment system reflects only 1 PT and one PTA (Physical Therapy Assistant). This is irrelevant as the 1 PT in VISTA was for the Outpatient PT Clinic where all outpatient Veteran appointments were scheduled which was changed to individual Outpatient PT provider clinics in March 2017 for better productivity accounting and tracking.

If indeed the lengthy wait times were due to a shortage of staff, then management should take responsibility and take on a regular caseload of patient care to decrease the wait times. In many PT facilities, supervisors are required to be 25-50% + productive with patient care. Not only does the PT Supervisor at the Medical Center not have a regular caseload of patients, but she has accrued overtime/comp time for working late and on the weekends without providing patient care. The PT Supervisor has used this comp time during the week reducing the staff available to see Veterans including walk-in patients and some have been declined treatment due to this. There have been instances when Veteran treatment sessions were canceled due to a PT/PTA needing to go home ill, the PT Supervisor leaving for the day, and [redacted], PTA whistleblower was not utilized to see the

Veterans despite his offering and being available to do so. The whistleblowers are not privy to the documentation to provide proof of this but have witnessed it often and an investigative agency would be able to obtain the proper documentation to evidence the amount of overtime/comp time the PT Supervisor has accrued and utilized and lack of patient care/productivity to support it. This whistleblower has emails that the PT Supervisor sent on the weekend from the Medical Center and feels this is further Abuse of Authority.

Specific Allegation 2 on page ii of the OMI report states that [redacted] directed that employees use a shared Outlook calendar for scheduling patient's appointments to conceal lengthy wait times. Our allegation was not that she directed employees to use a shared calendar but that they were instructed not to put them in CPRS/VISTA if they were scheduled beyond 30 days so that it would conceal the lengthy wait time. This is evident in the example provided on page 6 of the report. "The whistleblowers provided one example of a Veteran with 5 appointments in VISTA and a copy of an Outlook calendar printed the same day (10/20/2016) indicating 2 additional appointments on January 3 and 6, 2017. The last two appointments in January were not on the printout from VISTA. The report provides further details stating 2 of the 5 appointments in VISTA were with other departments, not with PT, and justifying the lack of the 2 PT appointments in January being on the VISTA schedule as consistent with the Scheduling SOP (standard operating procedure) item 4 = "patients will be given 2 visits at a time max 4." If this were the case, then at least 1 of the Veteran' PT appointment in January should have been scheduled in VISTA. By not listing the Veteran's PT appointment in January in VISTA, other departments would not realize the Veteran has the appointment and could schedule an appointment for a different service line at the same day and time. This was happening often during 2015 – 2016 due to the PT appointments not being put in VISTA beyond 15-30 days so the wait times were not evident.

Several emails by PT's demonstrate the lengthy wait times as early as July 2, 2014. The OMI report refers to an email on page 7 that was provided by this whistleblower during the investigation. The report highlights that it was "from a PT regarding the use of one of the PTA's as a scheduler, making the PTA unavailable to do treatments. This PT stated the use of the PTA for this purpose resulted in no open appointment slots for treatment for 2-6 weeks." The bias of the investigation is evident in this instance as the actual email (word for word) stated the following:

"It is difficult to monitor patients. Patients are scheduled and coming in for the evaluation and then there are no open slots for treatments for 2 – 6 weeks. Also with Katie doing scheduling there are less open slots to slide patients into. There are a lot of cancellations but we do not have a waiting list to give appointments to those who are waiting for treatment. We might be seeing more evals but I feel

some veterans are not getting any treatment. Or the treatment can not possibly be effective if not seen on a consistent basis. Also I am renewing a lot of certifications because of the scheduling limitations.

This is my experience and I have a few veterans that are pretty upset."

It is interesting that the OMI report states the PT Supervisor was attempting to hire temporary help while awaiting approval and posting for the permanent scheduling clerk position in order to free up the PTA to do more treatments. [redacted], PTA and one of the whistleblowers, had offered to assist with Outpatient treatments many times when he had availability due to decreased Inpatient caseload. He was told he could not assist with Outpatient despite being willing and available. This whistleblower had also inquired if [redacted] could treat Outpatient Veteran's during the times when his Inpatient caseload was low but was told he could not without a reason as to why. This is evident in an email between this whistleblower and management. This denial of allowing [redacted] to assist with Outpatient Veteran treatments affected access and wait times. The PT Supervisor canceled Outpatient Veteran appointments at times in instances where the PT/PTA had to leave suddenly versus utilizing [redacted] to treat them.

The lengthy wait time for Veterans to get PT appointments was addressed again in an email by this whistleblower dated October 24, 2016. The OMI report refers to this on page 7 but relates it to "scheduling preferences of 1 PT for re-evaluations" affecting schedule access. The report fails to mention the exact wording in the email =

"When I met with [redacted] on 10/20/2016, we discussed that my patients were having a 4 - 6 week delay in getting follow-appointments after I evaluated or re-assessed them. I had suggested at that time that [redacted], PTA would be able to see my patients for treatment to clear the backlog as he is not fully booked on the inpatient side and has seen my patients for outpatient treatment in the past. [redacted] is able and willing to perform outpatient treatments. This would allow veterans to get in sooner for treatment and have their full treatment session to have the proper care they deserve. I was told at that time that this would not be an option but was not given a clear reason as to why.

Unfortunately, to have the veterans given a shorter session without receiving the full treatment not only goes against the ICARE values and my POC but is a disservice to the veterans and not acceptable."

ICARE = Integrity, Commitment, Advocacy, Respect, Excellence

POC = plan of care

The bias of the VA OMI investigators is evident again in the example above.

During 2015 – 2016 there was a shared Outlook calendar for a "shared treatment room" = room 227E in building 78 on the 2nd floor. Room 227E is a smaller enclosed room within the larger PT gym space = room 227. The larger room 227 is utilized mainly for inpatient PT treatments and wheelchair clinic. Room 227E is used by PT, OT (Occupational therapy) and speech therapists to perform evaluations and treatment in a quiet, private space. It is the only room that this PT can use to evaluate and treat the Veterans that I see with the privacy and respect they deserve. Unfortunately, I do not have my own treatment room with a computer and treatment table as all other outpatient PT's have who work in building 82.

We were just notified last week (07/25/2017) in an email from the PT Supervisor that the Outlook calendar will no longer be utilized for scheduling. As stated in the email – "there is a new scheduling package that combines VISTA with a screen similar to Outlook. This is only for MSA access. Going forward Outlook will not be used for scheduling." The staff's response has been one of disbelief as every clinician uses the Outlook calendar on an hour to hour, day to day and week to week basis to get a snapshot of who they are seeing, perform chart reviews for the patient, and quickly see any changes made in their schedule. Without the Outlook calendar, the clinicians will have to do a 10-step process in VISTA to obtain less information than we were formally able to perform in one step to see our daily/weekly Outlook calendar. We received another email today (07/31/2017) from the PT Supervisor stating "Outlook is not current as we have transitioned to the new scheduling package. We are currently in the process of getting viewing access for the staff and finishing training for the MSAs." Why would the Outlook system be discontinued before staff had access and were fully trained? An MSA commented that it takes longer to book in the new system and it does not have the full information in the calendar format as Outlook had to allow clinicians to monitor their patient caseload and provide safe and efficient care. One staff member wrote a full page response questioning this action as it will make our jobs more difficult with greater room for errors and to what end?

An employee puts their job on the line as a whistleblower. This prevents staff and Veterans from coming forward and/or telling the truth and filing complaints. It is well known and evidenced often in the VA system. This whistleblower has been harassed and retaliated against often since filing the claim with the OSC. In February to April 2017, during the reasonable accommodation process, a Human Resources (HR) staff member and my PT Supervisor stated that "I could not do the essential functions of my job due to my inability to use the chemical cleaning wipes" due to a documented medical condition.

This is documented in the emails which provided details of the meetings. In April 2017, I provided documentation from my medical doctor and the Job Accommodation Network stating details of my medical condition, restrictions, and typical handling in these cases and I have not heard further regarding a Reasonable Accommodation from HR or my PT Supervisor.

Further harassment, retaliation and Abuse of Authority is evident by the Admonishment I was given by my PT Supervisor on 06/27/2017 which has been placed in my VA personnel file. She had given me a Proposed Admonishment on 05/31/2017 with charges of Delay of Patient Care and Failure to Follow Instruction. I had provided her with a 3 page response on 06/15/2017 defending my position that the charges were based on my actions on 05/01/2017 to ensure safety for a Veteran patient and staff. Management would normally praise a staff member for ensuring safety of patients and staff and not only did I get an admonishment but it was without any verbal warning prior. This seems highly unusual considering I have been given two Outstanding and one Excellent review during the three annual reviews I have had since I began my employment with the VA. I would like the Admonishment added to my OSC claim as further Abuse of Authority. The Proposed Admonishment included 17 pages of supporting documentation including several Reports of Contact and Q & A (question and answer) meeting notes. The extent of time the PT Supervisor put in to prepare it had a much greater impact in delaying patient care and would have been better utilized in giving more Veterans quicker access to treatment. During a brief discussion with [redacted], Chief of SPRS, and Margaret Gallagher afterward, they both stated that the patient would now be on the over 30 day list due to my actions and I responded that administrative reports should not be prioritized over safety of patients and staff.

I am morally upset by the state of the VA. Many hardworking staff willing to fight for the rights of the Veterans are retaliated against and others decide to leave. We have had multiple staff members of the SPRS department leave over the past 1-2 years. Some of these included Veterans and others left within 3-4 months of being hired. There are multiple cases being handled by the NAGE Union. It is a broken system where brushing things under the rug and damage control are applauded. We have jobs because of the Veterans who put their lives on the line fighting for our freedom and now have mental and physical deficits due to this. Many in upper and middle management seem to take this for granted and prevent the Veterans from getting the proper and timely care they deserve. My father is a WWII Veteran and I am saddened to think about the care he would receive should he need it.

[redacted]

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August 1, 2017

I am submitting this response in hopes that a re-investigation can be performed which addresses the true allegations. This should not be performed by the Office of the Medical Inspector as it is a VA agency and has already demonstrated bias by omitting key points to spin the results in favor of management.

We have received many emails recently about Secretary Shulkins desire to change the VA to a culture of accountability. In the Eagle Tribune article dated 07/18/2017 regarding the Manchester VA, it quotes Shulkin as stating "I have been clear about the importance of transparency, accountability and rapidly fixing any and all problems brought to our attention." I hope the outcome of this case will demonstrate this and not only will problems be fixed but management will be held accountable for past and present actions including bullying, harassment, and retaliation toward staff.

Thank you,

[redacted]

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