**Analysis of Disclosures, Agency Report, and Whistleblower Comments**

**OSC File No. DI-14-2520**
**(North Central Federal Clinic (North Central), San Antonio, Texas, and Austin Outpatient Clinic (Austin), Austin, Texas)**

OSC submits the following analysis, agency report, and whistleblower comments based on disclosures of wrongdoing from an employee at the Department of Veterans Affairs (VA), North Central Federal Clinic (North Central), San Antonio, Texas, and Austin Outpatient Clinic (Austin), Austin, Texas. Phillip Turner, a medical support assistant (MSA) who consented to the release of his name, disclosed that the Veterans Health Administration (VHA) facilities in San Antonio and Austin do not follow proper scheduling protocols. In brief, the allegations referred for investigation are as follows:

- Scheduling staff were improperly directed to "zero out" patient wait times, in violation of agency policy.
- Staff were directed to avoid using the Electronic Waiting List (EWL) for patients awaiting appointments.
- The failure of management to adhere to agency scheduling policies endangered public health and safety.

The investigation by the VA Office of the Inspector General (OIG) substantiated systemic improper scheduling at these locations but did not address the allegation that improper scheduling may have endangered public health and safety. Further, the VA OIG did not recommend any additional actions be taken in response to its findings. Because of this, as outlined below, the Special Counsel determined that the agency report is not responsive to the allegations referred for investigation by OSC.

*Procedural Background*

OSC referred Mr. Turner's allegations to then-Secretary Eric K. Shinseki for investigation pursuant to 5 U.S.C. § 1213(c) on May 7, 2014. At VA's request, OSC suspended the case pending the VA OIG's criminal investigation into allegations of scheduling misconduct at the North Central and Austin Clinics. The VA OIG completed its investigation and submitted its findings to the VA Office of Accountability Review (OAR) on May 6, 2015. On January 11, 2016, then-Chief of Staff Robert L. Nabors, II, submitted a summary of the OIG's investigation and findings to OSC on behalf of Secretary Robert A. McDonald. Mr. Turner commented on the report pursuant to 5 U.S.C. § 1213(e)(1).

*The Whistleblower's Allegations*

**Improper Scheduling**

Mr. Turner alleged that MSAs in the Mental Health Clinic at North Central and in the Primary Care Clinic at Austin were verbally directed during training, and by lead clerks and supervisors, to ensure that patient wait times at both facilities were recorded as being as close to zero days as possible.

Pursuant to VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures* (June 9, 2010), para. 4.c.(4)(b)3., the patient must define the desired date for a return appointment. Mr. Turner explained that the desired date must be recorded in VISTA, the VHA's electronic tracking system. Per the directive, once the desired date is set in the system, even if that date is unavailable, it may not be altered to reflect the date of an appointment the patient accepts. Mr. Turner alleged that officials at the North Central and Austin facilities instructed MSAs to record patient appointments as both the desired date and the accepted date in order to avoid the frequent appearance of being unable to schedule patients on their desired dates. Mr. Turner disclosed that MSAs were directed to enter VISTA to check the patient's desired date and, if the date was unavailable, to exit out of the scheduling system, then enter back in, navigate to the date of the first available appointment, and use that date as both the desired date and appointment date. As a result, the system showed that the patient had no wait between the desired date and the date of the actual appointment.

The same practice also extended to patients whom providers referred for follow-up appointments, according to Mr. Turner. For example, a provider could direct that a patient return for follow-up care within 30 days, which would be recorded as the desired date. If the patient could not be seen on that date, the MSA would then schedule the patient for the first available opening. However, Mr. Turner reported that MSAs at North Central and Austin were directed to instead use the appointment date as the desired date. If the appointment date was 60 days after the initial appointment, the patient actually waited 30 days for a follow-up appointment; however, this was not reflected by the data entered into VISTA.

Mr. Turner noted that one method management used to ensure that appointment dates entered into VISTA appeared timely was to send back appointments that were late by more than 14 days and ask MSAs to "correct" them. For example, on April 18, 2014, Mr. Turner spoke with a patient who called to cancel his morning appointment for that day. The patient requested that he be rescheduled for an afternoon appointment on the same day, which Mr. Turner recorded as the desired date in VISTA. However, there was no availability for the afternoon, so Mr. Turner scheduled the patient to return on May 16, 2014. On April 22, 2014, Mr. Turner received an email from management analyst Rachel Martinez informing him that there was an error in the system for this appointment and directing him to correct it. The only problem Mr. Turner could identify with the entry was that VISTA reflected a correct wait time of more than 14 days. Similarly, Mr. Turner stated that he was directed to zero out wait times when he worked at Austin by Bonnie Carroll, Medical Administration Service (MAS) supervisor; Robert Marrero, MAS supervisor; Angelika Smith, lead clerk; and Danny Fountain, trainer. He received the same

direction at North Central from Ms. Martinez and Edward Medina, a Department of Defense employee.

Mr. Turner noted that ensuring patients were seen within two weeks of their desired appointment date was identified in agency training manuals as a performance measure and thus could affect an employee's bonus. Further, inappropriate scheduling practices resulted in flawed wait time data and may have had a direct effect on patient health. Because there was no accurate data trail to track scheduling delays, it was impossible to identify patients who required time-sensitive follow-up appointments but did not receive them.

**Failure to Use Electronic Wait List**

Mr. Turner also alleged that MSAs at North Central and Austin were never instructed to use the agency's Electronic Waiting List (EWL). In fact, he alleged, scheduling staff at Austin were specifically instructed not to use the EWL.

The EWL was created to keep track of patients who are waiting for an opening in the appointment calendar. If a patient cancels his or her appointment, the next patient on the EWL should be offered the newly opened appointment time. As noted in VHA Directive 2010-027, para. 2.(e)(11), the EWL is generally used to keep track of patients with whom the clinic does not have an established relationship. Pursuant to para. 4.c.(18), when appointments become available, the facility has at least three days to contact patients. Openings are to be offered either to patients on the EWL, or to those who have appointments scheduled more than 30 days past their desired date. Mr. Turner alleged that staff at North Central and Austin never did this, as they were instructed otherwise. The failure to use an EWL may pose a substantial and specific danger to public health because patients who should have been included on the EWL did not receive more timely appointments when they become available.

**Cover-Up of Improper Scheduling Policies**

After he heard about the alleged scheduling improprieties at the VAMC in Phoenix, Arizona, Mr. Turner became concerned that his facilities were not following proper scheduling protocols. As a result, on April 24, 2014, Mr. Turner emailed his concerns to Dr. Veronica McClean, his direct supervisor at Audie L. Murphy VAMC, as well as to several of his current and former co-workers. Shortly thereafter, his e-mail was shared with the directors in both the Central Texas and South Texas Veterans Health Care Systems. Mr. Turner was informed on May 1, 2014, that North Central supervisors met with staff in all clinics to direct them to cease zeroing out their patient wait times, despite having been previously directed to do the opposite.

In addition, after Mr. Turner emailed his coworkers, he was called into a meeting with David Heier, the building manager and directed to immediately stop emailing regarding his scheduling concerns. Although Mr. Heier is not in Mr. Turner's chain of command, Mr. Heier indicated that he was sharing a direct order that he received from the director. Mr. Turner was also instructed by Dr. Miguel Ybarra, acting chief of psychology, to attend additional training. Mr. Turner believed that the direction to stop discussing his concerns, in combination with

management's instruction to staff to stop zeroing out appointments, indicated an attempt by the agency to cover up its involvement in improper scheduling practices.

*The Department of Veterans Affairs Report*

The VA submitted a report, which the OIG drafted and OAR reviewed, that substantiates Mr. Turner's allegations and finds that inappropriate scheduling practices were systemic, occurring not only at North Central and Austin but also at the Kerrville VAMC in Kerrville, Texas. The OIG did not address Mr. Turner's allegation that these scheduling failures could have negatively affected patient health and makes no recommendations for future action.

According to the report, investigators reviewed personnel information for unidentified VA employees and determined that none of them received bonuses or awards for meeting patient wait time goals. The report does not make a finding as to whether management officials were responsible or culpable for the widespread improper scheduling. The cover letter to the report, however, indicates that unidentified VA supervisory employees were replaced.

The report also does not make a finding as to Mr. Turner's allegation that the facilities attempted to cover up their improper scheduling practices. The report does, however, address allegations that OSC did not refer, such as the existence of a hard-copy wait list and the destruction of documentation related to patient wait time data.

*The Whistleblower Comments*

Mr. Turner stated that, despite the ample evidence he provided, the agency's investigation was inadequate and not objective. He was frustrated with the failure to hold employees accountable for their actions and stated that the investigation served only to reinforce his belief that the system is corrupt.

*The Special Counsel's Findings*

I have determined that the agency report does not meet the statutory requirements, nor do the agency's findings appear reasonable. The OIG investigation and report do not fully address the allegations OSC referred to the VA. Specifically, and most important, the report offers no findings regarding the allegation that inappropriate scheduling may have negatively affected patient health, despite the OIG's own determination that inappropriate scheduling not only occurred, but was "systemic." While the VA substantiated scheduling violations, the impetus for Mr. Turner's disclosure and my referral of his allegations was not the violations themselves. Rather, it was the fact that the manipulation of scheduling at these locations could have directly and negatively affected the health and safety of every patient scheduled for an appointment at North Central, Austin, and, apparently, Kerrville. The OIG's complete failure to address this allegation and to explain why it did not investigate patient health is not reasonable.

In addition, while the investigation substantiated the existence of improper scheduling, the OIG made no finding as to whether any individuals purposely directed staff to schedule

inappropriately, which was Mr. Turner's specific allegation. The OIG offers no names or titles of individuals who were found to have given such directions, or who failed to provide sufficient and proper training for schedulers and their supervisors. The report makes no recommendations of disciplinary action for the responsible individuals, continued training for schedulers and staff, or continued oversight by the Veterans Integrated Service Network or VHA. In fact, the report makes no recommendations whatsoever, despite Mr. Nabors's assertion in his cover letter that he agreed with the report's recommendations and directed the VAMC director to carry them out. This is unacceptable. While I understand the OIG's finding that these problems were institutional, institutions are made up of individuals. It is not reasonable to conclude that because the problems were widespread, it is impossible to find the responsible individuals. While the report's cover letter appears to indicate that the VA took some corrective or disciplinary actions in response to the OIG's report, the actions and individuals are not specified, and neither the report nor the cover letter sufficiently addresses these concerns.