Analysis of Disclosures, Agency Report, and Whistleblower Comments

OSC File No. DI-14-2763
(Olin E. Teague Veterans' Medical Center, Temple, 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), Olin E. Teague Veterans' Medical Center (Temple VAMC), Temple, Texas. The whistleblower, who chose to remain anonymous, disclosed that employees in the Temple VAMC Radiology Department engaged in conduct that may constitute a violation of law, rule, or regulation; and a substantial and specific danger to public health. In brief, the allegations referred for investigation were as follows:

- The Radiology chief regularly canceled and rescheduled appointments that would have otherwise shown an extended wait time.
- The Radiology chief directed radiologists to cancel and reschedule appointments when he was unavailable to avoid showing an extended wait time.

The VA report states that the investigation did not substantiate the whistleblower's allegations. However, as outlined below, the Special Counsel determined that the agency report is not responsive to the allegations referred for investigation and that its findings do not appear reasonable.

Procedural Background

OSC referred the whistleblower's allegations to then-Secretary Eric K. Shinseki for investigation pursuant to 5 U.S.C. § 1213(c) on May 30, 2014. From then until November 17, 2015, OSC suspended the case pending the VA Office of the Inspector General's (OIG) criminal investigation into allegations of scheduling misconduct at the Temple VAMC. On December 4, 2015, then-VA Chief of Staff Robert L. Nabors, II, submitted the OIG's report to OSC on behalf of Secretary Robert A. McDonald. The whistleblower commented on the report pursuant to 5 U.S.C. § 1213(e)(1).

The Whistleblower's Allegations

The Temple VAMC Radiology Department handles radiology services for the Temple VAMC, the Waco VAMC, and the Austin Outpatient Clinic (Austin), Austin, Texas. These facilities are part of the Central Texas Veterans Health Care System (CTVHCS). The Radiology Department is headed by Dr. Gordon Vincent.

The whistleblower explained that if a patient requires a radiology procedure, the patient's provider enters the order in the VA's Computerized Patient Record System (CPRS), the agency's electronic health records database. CPRS contains a specific "pad" functionality to record these orders. The order is marked according to its urgency and is automatically sent to the Radiology Department for scheduling. The whistleblower stated that orders marked as "routine" should be

scheduled within a certain timeframe, typically 30 to 60 days. If an order results in a scheduled appointment and the order is then canceled, then the appointment is also canceled.

The whistleblower disclosed that the Radiology Department often experiences long patient wait times for appointments, particularly for advanced procedures such as CT scans and MRI exams. The whistleblower alleged that Dr. Vincent cancels orders in CPRS, which also cancels any associated scheduled appointment, to make these wait times appear shorter. Using the name of the original provider, Dr. Vincent then places a new request for the procedure, creating a new date for the request. This restarts the wait time for that patient. For example, if an order is entered into CPRS but the earliest available appointment is 60 days in the future, Dr. Vincent would cancel the order and then reenter the request using a new entry date 30 days from the available appointment date, under the same name as the original requester. This makes the wait time appear to be 30 days instead of 60 days.

The whistleblower alleged that Dr. Vincent also assigned other radiologists to handle a "cancel/reschedule" file when he was out of the office. Radiology order requests that Dr. Vincent planned to cancel and reschedule were kept in a folder in the scheduling area at the Temple Medical Center. Radiologists were directed to retrieve the file in CPRS and cancel and reorder the requests in the records. The whistleblower alleged that this practice was ongoing for approximately two years.

VHA Directive 2010-027, VHA Outpatient Scheduling Processes and Procedures, para. 2.a. (June 9, 2010) states, "It is the VHA's commitment to provide clinically appropriate quality care for eligible Veterans when they want and need it. This requires the ability to create appointments that meet the patient's needs with no undue waits or delays." The directive also states that wait times for specialty care clinics are monitored. Para. 4.c.(3)(b) notes that providers should document orders in CPRS and explain the rationale and timeframes for diagnostic tests before the patient leaves the examination room. The directive emphasizes the importance of the timeframe set by an ordering provider when requesting a radiology appointment. Finally, para. 4.c.(2) indicates that work performed in response to such orders triggers a data transmission to a Patient Care Encounter (PCE) database. The PCE database maintains wait time data on specialty services, including radiology studies.

The whistleblower maintained that by canceling and reordering radiological tests, Dr. Vincent compromised the facility's ability to meet the agency's stated goal of providing care in a timely manner and may have undermined the clinical goals of the ordering provider. This could have negative effects on patients waiting to receive a radiology appointment. The whistleblower surmised that Dr. Vincent's actions may have been an attempt to reduce wait times via the PCE database in order to reflect better timeliness outcomes for the facility.

Canceling orders may also be a violation of the requirements of VHA Handbook 1907.01, Health Information Management and Health Records (September 19, 2012). Handbook 1907.01, para. 25.f.(3) states, "No edit, reassignment, deletion, or alteration of any documentation after the manual or electronic signature has been completed can occur without the approval of the Health Information Management professional or the Privacy Officer." The whistleblower explained that

CPRS does allow an authorized provider to alter the provider name entered in a record in certain circumstances. For example, a radiologist ordering lab work may change the provider name in CPRS from his or her name to the name of the provider who requested the original procedure. This ensures that the requesting provider receives the results of the test, since the radiologist cannot follow up on abnormal test results. However, it does not appear that the Handbook anticipates the cancellation of orders in the manner undertaken by Dr. Vincent. Further, Dr. Vincent's practice of signing newly recreated orders as the original provider may also violate the electronic signature requirements of the Handbook. For example, para. 25.f.(1) states that local policy must provide security measures to verify the authenticity of user electronic signatures. It appears, based upon the allegations, that Dr. Vincent is using other providers' signatures to cancel and reorder patient radiology orders.

The Department of Veterans Affairs Report

The VA submitted a report drafted by the OIG. The report indicates that the OIG's underlying investigation was initiated by a hotline complaint from a confidential whistleblower, a former employee at a different facility within the CTVHCS. It was not in response to OSC's referral to the Secretary. The hotline complaint alleged that the Radiology chief asked or ordered physicians to move desired dates for requested imaging procedures beyond 30 days so that the procedures would appear to be completed within 30 days of the desired dates. The hotline complaint also alleged in memoranda to physicians outlining Radiology backlogs, the chief asked physicians to schedule imaging procedures within timeframes of more than 30 days. The chief also regularly sent emails to physicians reporting on the Radiology backlog. The OIG determined that these allegations included the allegations forwarded by OSC and conducted a single investigation into both cases.

As part of its investigation, the OIG interviewed the hotline complainant, Dr. Vincent, the chief of staff, the chief technologist, and seven staff radiologists. It does not appear that the OIG interviewed any ordering physicians. The OIG also reviewed the Radiology chief's personnel documentation for the years 2011 through 2013, a random sample of discontinued consults from between January 2010 and July 2014, and email accounts of the Radiology chief and chief technologist. The investigation included a review of the medical records of a patient whom the hotline complainant identified.

The VA did not substantiate the whistleblower's allegations. The report relies largely upon Dr. Vincent's assertions that he only cancels appointments at the request of patients and that he always includes a note in CPRS explaining the reason for the cancellation. The report also relies upon the statements of the radiologists, six of whom denied ever canceling appointments in order to shorten wait times. A fifth radiologist, who serves as the acting chief of Radiology when Dr. Vincent is absent, stated that in 2010 or 2011, Dr. Vincent gave him a file of appointments to be canceled, but that he did not change the desired dates on the orders. The report does not indicate whether this is the same file that the whistleblower alleged was located in Radiology front desk area. The report briefly addresses the OIG's review of discontinued consults, which did not produce information of evidentiary value because it was "impossible to determine the reason for the discontinuations."

The Whistleblower Comments

The whistleblower stated that the OIG's investigation based on the hotline complaint did not include the whistleblower's allegations. The whistleblower outlined the steps taken when a provider requests a radiological examination for a patient, noting that radiologists do not generally cancel an examination if additional information was required before the image could be approved. The whistleblower reiterated the allegation that, on at least two occasions, Dr. Vincent provided a folder containing scheduled examinations that he wanted canceled. Dr. Vincent directed that the examinations be canceled using the name of the original provider and then requested again using the current date. The whistleblower asserted that this occurred only on days when Dr. Vincent was in the office. One of the radiologists whom the OIG interviewed stated that while investigators asked whether he had canceled and rescheduled appointments—he said he had not—they did not ask whether Dr. Vincent had ever asked him to cancel and reschedule.

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. First, the OIG investigation and report do not fully address the allegations OSC referred to the VA. Specifically, the report offers no findings regarding the allegation that Dr. Vincent uses other providers' signatures in CPRS in violation of agency policy. The investigation did not include a review of the log-in data for CPRS or a review of which providers were canceling consults and the frequency of cancellation. Further, the report indicates that investigators focused heavily on the hotline complainant's allegation that desired dates were not properly recorded at the time appointments were made and that Dr. Vincent documented this manipulation via emails and memoranda. These allegations, however, are separate from the allegations OSC forwarded and do not necessarily overlap with OSC's referral.

Second, the VA's findings and conclusions do not appear to be fully supported by the evidence. For example, the report specifically notes that Dr. Vincent always includes an explanatory note when he cancels and reschedules a consult. The report also states that an analysis of discontinued consults was inconclusive because it was impossible to determine the reason for the discontinuations. The report does not reconcile these two statements, but the absence of explanatory information in a random sample of discontinued consults casts doubt on Dr. Vincent's accuracy and the OIG's findings. The report also fails to specify whether discontinued consults are analogous to canceled and rescheduled consults; how many consults were reviewed; how the consults were chosen; how many total consults were canceled; the time period of the review; or what information the review included. There is also no discussion of whether investigators reviewed who logged into CPRS to discontinue, cancel, or reschedule consults, or which provider ultimately signed newly scheduled consults.

OSC's referral included specific information regarding a folder of appointments to be canceled that was placed at the Radiology front desk. The VA's report indicates that a single radiologist discussed a folder he received from Dr. Vincent in 2010 or 2011, but it is not clear from the report whether this is the same folder. There is no indication that investigators followed

up on this allegation with the radiologist, or that they specifically discussed the folder with other witnesses. Investigators did not interview front desk staff about the folder, nor does it appear that a physical inspection of the front desk area was conducted.

Finally, the VA's report focuses heavily on the hotline complainant's vague allegations. This includes significant discussion of emails and memoranda related to desired dates, including a reference to an email exchange published by *The Daily Beast*, which is unrelated to OSC's referral and is never explained by the report. Investigators reviewed email traffic related to desired dates, but OSC's referral does not mention the phrase "desired dates," nor is the manipulation of desired dates the focus of the allegations OSC referred. Similarly, the report notes that the hotline complainant provided information on a specific patient, but the report does not explain who the patient was, how the patient was negatively affected, or how the patient's records relate to OSC's referral.