Analysis of Disclosures, Agency Report, and Whistleblower Comments

OSC File No. DI-14-2947
(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. Virgie Hardeman, a union steward and former nurse, disclosed that facilities within the Central Texas Veterans Healthcare System, including at the Temple VAMC, did not follow proper scheduling protocols. In brief, the allegations referred for investigation were as follows:

- Scheduling staff were directed to manipulate patient wait time data, in violation of agency policy.
- Management was aware of the ongoing data manipulation, but took no action to correct it.
- Management's failure to enforce agency scheduling policies endangered public health and safety.

The investigation by the VA Office of the Inspector General (OIG) did not substantiate that improper scheduling occurred at the Temple VAMC. However, the report contains serious deficiencies. Therefore, as outlined below, the Special Counsel determined that the agency report is not responsive to the allegations OSC referred for investigation and that the VA's findings appear unreasonable.

Procedural Background

OSC referred Ms. Hardeman's allegations to then-Secretary Eric K. Shinseki for investigation pursuant to 5 U.S.C. § 1213(c) on December 22, 2014. At VA's request, OSC suspended the case pending the VA OIG's criminal investigation at the Temple VAMC. The VA OIG completed its investigation on November 16, 2015. On February 12, 2016, Interim Chief of Staff Robert D. Snyder submitted the OIG's report and findings to OSC. Ms. Hardeman commented on the report pursuant to 5 U.S.C. § 1213(e)(1).

The Whistleblower's Allegations

Ms. Hardeman alleged that employees at the Temple VAMC were directed to improperly schedule patient appointments in violation of agency policy. Ms. Hardeman explained that the VA Central Office (VACO) was notified in 2010 that local staff across the Veterans Health Administration (VHA) were manipulating wait time data in order to meet performance metrics. In response, Deputy Under Secretary for Health Operations and Management William Schoenhard issued a memorandum on April 26, 2010, prohibiting such manipulation. The April 26 memo included an attachment describing various prohibited methods of data manipulation.

Ms. Hardeman alleged that several of these methods were very common at the Temple VAMC, especially after the memo was released.

The April 26 memo recommends determining whether the facility maintains a fully-booked schedule for 30 or more consecutive days while meeting wait-time performance measures. The memo noted that this would suggest that the facility's wait-time data were being falsified, because if a facility is fully booked 30 or more days into the future, it is unlikely that new patients could be scheduled and seen within 30 days of their desired appointment date. Ms. Hardeman disclosed that this was regularly the case at the Temple VAMC, including after the release of the memo. The memo further notes, "not including the patient in scheduling the appointment" is another sign of data manipulation. Ms. Hardeman alleged that patients were rarely included in the scheduling of appointments. Finally, Ms. Hardeman alleged that it was common practice at the Temple VAMC to send patients who could not be seen within 14 days of their desired date to the Fee Basis system, which would remove them from the data reporting. Ms. Hardeman alleged that the facility had hundreds of Fee Basis consults in "scheduled" or "complete" status that were not complete and dated back over a year.

The VA OIG previously conducted an investigation into allegations of data manipulation at the Temple VAMC and issued a report of its findings on January 6, 2012. That report substantiated that appointments were not being properly scheduled and that patients were waiting many months to be seen. The report also found that hundreds of Fee Basis consults were incomplete, dating back to 2009. The OIG recommended that the facility director ensure that all staff follow VA policies for scheduling and monitor compliance. Ms. Hardeman alleged that despite the OIG's report and recommendations, the facility continued to improperly schedule patient appointments. For example, Ms. Hardeman stated that as of June 2014, patients scheduled in the gastroenterology clinic were being scheduled solely according to clinic availability, and almost all of the appointments indicated that they were scheduled within zero days of the patients' desired dates, despite wait times ranging from 30 to 70 days.

Ms. Hardeman further alleged that Temple VAMC claimed in an application for the Robert W. Carey Performance Excellence Award, which it received, that the facility discovered that front line staff had incorrectly used desired dates when scheduling appointments but corrected the problem.

The Department of Veterans Affairs Report

The VA submitted a report drafted by the OIG that did not substantiate Ms. Hardeman's allegations. Mr. Snyder's cover letter to the report indicates that the OIG's investigation into OSC File No. DI-14-2520 (North Central Federal Clinic, San Antonio, Texas, and Austin Outpatient Clinic, Austin, Texas) was expanded to include Ms. Hardeman's allegations at the Temple VAMC. According to the report, OIG investigators interviewed seven witnesses and reviewed documentation of employee performance appraisals and email data. The report contains brief summaries of the witnesses' testimony and a short discussion of the investigators' review of performance documentation belonging to the chief of the Medical Administration Service (MAS). Investigators determined that the chief's performance ratings were not based on

achievements related to patient wait times. The report does not indicate that it reviewed documentation for any other employees.

The OIG also notes that the investigators' review of employee email data did not uncover any directives to employees instructing them to falsify appointment data. The report does not provide any additional details about this review.

Based upon its investigation, the OIG determined that no scheduling manipulation was occurring at the Temple VAMC and that no corrective or disciplinary action was required.

The Whistleblower Comments

Ms. Hardeman stated that several of the employees responsible for scheduling manipulation had been reassigned or had left the facility by the time the OIG's investigation was initiated, calling into question the completeness of the interviews. Ms. Hardeman also highlighted several submissions to the facility's anonymous "Speak to the Director" program that provided detailed descriptions of management's involvement in the manipulation of desired dates between 2012 and 2014.

Ms. Hardeman also contests the OIG's assertion that investigators interviewed the employees whom Ms. Hardeman identified as having relevant information. Rather, Ms. Hardeman stated, only two of the seven employees she identified were interviewed, and because of the impromptu scheduling of her own and other interviews, the witnesses were not able to gather or provide their documentation for the investigators. Specifically, Ms. Hardeman identified three Compensation and Pension employees who could provide relevant information to investigators, but they were not contacted. Ms. Hardeman also stated that investigators told her that they would be returning for additional interviews and that witnesses could provide documentation then, but no such opportunity was actually provided.

Ms. Hardeman included commentary from one of the witnesses who was interviewed in the investigation. Charles Kubrich, an MSA, stated that he also believed the investigators would be returning for additional interviews and that he could provide documentation then. He indicated that this was discussed at length during his interview, but that investigators never returned.

Mr. Kabrich also explained to investigators in detail how patients with appointments scheduled by their providers were forced into taking earlier appointments or having their appointments canceled without rescheduling to make room for veterans approaching their two-year wait times and for active duty patients from Fort Hood. Mr. Kabrich told investigators that this forced patients who had already had an extensive wait for an appointment back to the beginning of the waiting list, and yet gave the facility credit for clearing their appointment backlog. Mr. Kabrich expressed disappointment that the OIG concluded he had no evidence of wait time manipulation, while failing to discuss this information.

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. Mr. Snyder's cover letter and the agency report both emphasize the second-hand nature of Ms. Hardeman's knowledge of the allegations, without addressing information provided to OSC. In short, the report appears to be an attempt to discredit Ms. Hardeman and to dismiss the seriousness of her allegations.

Further, despite the length of time it took the OIG to complete its criminal inquiry, the investigation was quite limited in scope. This is concerning, in no small part, because OIG was simultaneously investigating both OSC's original referral regarding the Temple VAMC, which I noted in my referral letter to the Secretary in Ms. Hardeman's case, and similar allegations at the North Central and Austin facilities, which Mr. Snyder mentions in his cover letter to the report. Considering the breadth of these investigations and the length of time between our referral and receipt of the agency's reports, it is curious that only seven witnesses were interviewed, and that only one employee's performance documents were reviewed.

The report contains no discussion of Ms. Hardeman's allegation that hundreds of Fee Basis consults were in "scheduled" or "complete" status but were not actually completed and that they dated back over a year, an issue that would bear directly upon the health and safety of patients.

The report also fails to fully address Ms. Hardeman's assertions that the facility was previously found to be manipulating its scheduling processes. The report contains no substantive discussion of the April 26 memo or its effect on scheduling following the OIG's 2012 report, despite its discussion of an MSA supervisor who acknowledged that desired dates were improperly recorded as first available dates "in the past." The report provides no dates or context for this, and it does not appear that investigators followed up. The supervisor also denied instructing schedulers to manipulate wait time data, but there is no explanation provided for why schedulers were previously manipulating data if they were not instructed to do so. Further, it does not appear that investigators reviewed Ms. Hardeman's documentation showing that employees were, in fact, asked to manipulate desired dates between 2012 and 2014.

The report also limited its review of performance documentation to only one employee, the MAS chief. This issue was not raised in the referral and is not determinative of a motive for data manipulation, nor does it answer the question of whether any manipulation actually occurred. Regardless, if the OIG believes that this is an important factor in determining whether improper scheduling was occurring, more than one individual's documentation would need to be reviewed to gain a full understanding of the situation at the Temple VAMC.

Interestingly, the medical administrative officer indicated to investigators that he could only discuss the scheduling practices of his service, totaling approximately 236 scheduling employees. The report, however, indicates there are 735 total employees at the Temple VAMC who are responsible for scheduling, but it does not appear that investigators discussed these allegations with or interviewed witnesses from any other service.

Further, while the report briefly touches upon the OIG's review of email data, it contains no additional information on this review: who conducted it, whose emails were included, what time period was reviewed, or what search terms were used.

It is not possible to determine that the OIG's findings in this matter are reasonable when the agency's report contains such significant gaps in crucial information. The OIG's determination that no scheduling manipulation occurred is not supported by the information contained in the report, and it does not appear, based upon the quality of the report, that the OIG treated Ms. Hardeman's allegations seriously.