



U.S. OFFICE OF SPECIAL COUNSEL

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The Special Counsel

February 25, 2016

The President
The White House
Washington, D.C. 20500

Re: OSC File Nos. DI-14-2762 and DI-14-3657

Dear Mr. President:

I am forwarding to you two reports based on disclosures from Department of Veterans Affairs (VA) employees at the Edward Hines, Jr., VA Hospital (Hines) in Chicago, Illinois, and the Overton Brooks VA Medical Center (Overton Brooks) in Shreveport, Louisiana. The disclosures were made by Germaine Clarno, a social worker and union president at Hines, and Christopher Shea Wilkes, a social worker at Overton Brooks. The whistleblowers alleged that supervisors directed employees at both hospitals to violate VA scheduling protocols. They further alleged that management's failure to adhere to proper scheduling protocols created a false appearance of acceptable wait times while masking significant delays in veterans' access to care.

After reviewing the whistleblowers' disclosures, I referred the allegations to the VA for investigation. By law, the VA is required to investigate the specific allegations made by the whistleblowers and report back to OSC on its findings. In response to OSC's referrals, the VA submitted summaries of VA Office of Inspector General (OIG) investigations. I am forwarding these cases to you together because of the similarities in both the allegations presented and the VA's response.

The OIG investigations that the VA submitted in response to both referrals are incomplete. They do not respond to the issues that the whistleblowers raised. The OIG investigations found evidence to support the whistleblowers' allegations that employees were using separate spreadsheets outside of the VA's electronic scheduling and patient records systems. However, the OIG largely limited its review to determining whether these separate spreadsheets were "secret."

The OIG's decision to investigate this straw man resulted in inadequate reviews that failed to address the whistleblowers' legitimate concerns about access to care for mental health patients at Hines and Overton Brooks. As discussed below and detailed more fully in the enclosed analyses for both cases, I have determined that the VA's reports do not meet the statutory requirements and the findings do not appear reasonable. See 5 U.S.C. § 1213(e)(1).

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In both cases, facts that the OIG uncovered indicate the need for a broader review of access to care challenges at the hospitals. At Hines, the OIG confirmed that “delays in access to care remain an ongoing issue.” Yet the report does not include any discussion or analysis of actual wait times for mental health or other patients. Nor does it make any recommendations for corrective action to address the ongoing delays, which were at the heart of Ms. Clarno’s disclosures. In addition, the OIG investigation confirms that a senior manager instructed schedulers to manipulate scheduling data to hide the actual wait times experienced by veterans. However, the OIG investigation provides no information on how the manipulations impacted veterans, and it later undermines its own limited findings by stating that the manager’s improper directions to schedulers were “arguably practical.”

At Overton Brooks, the OIG investigation confirmed that the Mental Health Clinic created a spreadsheet that identified 2,700 veterans who needed to be assigned a mental health provider. Again, after confirming the existence of the spreadsheet, the OIG limited its review only to determining whether the spreadsheet was “secret.” Meanwhile, the OIG failed to consider whether the 2,700 veterans in need of a mental health provider reflected the larger concern about access and mental health provider shortages, or what steps could be taken to remedy these challenges.

In addition to the shortcomings in the VA OIG investigations, I am concerned that the VA’s Office of Accountability Review (OAR) determined that the OIG reports “thoroughly” and “fully” addressed the issues raised by the whistleblowers. As both whistleblowers note in their comments to OSC, the focus and tone of the OIG investigations appear to be intended to discredit the whistleblowers by focusing on the word “secret,” rather than reviewing the access to care issues identified by the whistleblowers and in the OSC referrals. Finally, OIG also denied OSC’s request to review a copy of the complete investigation reports, undermining our ability to properly assess the VA’s resolution of these issues.

Moving forward, I am optimistic that new leadership at the VA OIG will steer inquiries in a more appropriate and comprehensive direction. I also expressed my concerns about the ongoing access to care issues at Hines and Overton Brooks to VA leadership. In response, Deputy Secretary Sloan Gibson agreed to review the OIG investigations and OSC’s analyses to determine what steps should be taken to improve access to care at Hines and Overton Brooks. Specifically, the Office of the Medical Inspector will develop a set of recommendations that the facilities will use to develop corrective action plans to address ongoing concerns about veterans’ access to care. I have also requested that VA leadership instruct all of its investigative components to review responses to OSC referrals more carefully. This will help to ensure that the agency complies with legal requirements to fully investigate whistleblower allegations referred by OSC, and avoid delays in identifying and taking corrective actions to address patient care and access concerns.

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As required by 5 U.S.C. § 1213(e)(3), I am providing the agency reports and whistleblower comments in these matters to you and the Chairmen and Ranking Members of the Senate and House Committees on Veterans Affairs.¹ I have also filed copies of the reports and whistleblower comments in our public file, which is available online at www.osc.gov. OSC has now closed these matters.

Sincerely,



Carolyn N. Lerner

¹ The Office of Special Counsel (OSC) is authorized by law to receive disclosure of information from federal employees alleging violation of law, rule, or regulation, gross mismanagement, a gross waste of funds, an abuse of authority, or a substantial and specific danger to public health and safety. 5 U.S.C. § 1213(a) and (b). OSC does not have the authority to investigate a whistleblower's disclosure; rather, if the Special Counsel determines that there is a substantial likelihood that one the aforementioned conditions exists, she is required to advise the appropriate agency head of her determination, and the agency head is required to conduct an investigation of the allegations and submit a written report. 5 U.S.C. § 1213(c) and (g). Upon receipt, the Special Counsel reviews the agency report to determine whether it contains all of the information required by statute and that the findings of the head of the agency appear to be reasonable. 5 U.S.C. § 1213(e)(2). The Special Counsel will determine that the agency's investigative findings and conclusions appear reasonable if they are credible, consistent, and complete based upon the facts in the disclosure, the agency report, and the comments offered by the whistleblower under 5 U.S.C. § 1213(e)(1).

Analysis of Disclosures, Agency Report,
and Whistleblower Comments

OSC File No. DI-14-3657
(Overton Brooks VA Medical Center, Shreveport, Louisiana)

OSC submits the following analysis, agency report, and whistleblower comments based on disclosures of wrongdoing from a whistleblower at the Department of Veterans Affairs (VA), Overton Brooks VA Medical Center (Overton Brooks), Mental Health Services, Shreveport, Louisiana. The whistleblower, Christopher Shea Wilkes, a social worker at Overton Brooks, disclosed that employees in the Overton Brooks Mental Health Clinic engaged in conduct that may constitute a violation of law, rule, or regulation and a substantial and specific danger to public health and safety. In brief, the allegations referred for investigation were as follows:

- Mental Health Services employees at Overton Brooks failed to follow proper scheduling protocols and were not using electronic waiting lists as required; and
- Management's failure to adhere to and enforce agency scheduling policies endangered public health and safety.

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 all of the allegations OSC referred for investigation and the findings do not appear reasonable.

Procedural Background

OSC referred Mr. Wilkes's allegations to Secretary Robert A. McDonald for investigation pursuant to 5 U.S.C. § 1213(c) on December 22, 2014. From that date until June 11, 2015, OSC suspended this case pending a criminal investigation into allegations of scheduling misconduct at Overton Brooks by the VA Office of Inspector General (OIG). On August 27, 2015, then-VA Chief of Staff Robert L. Nabors, II, submitted a report prepared by OIG to OSC on behalf of Secretary McDonald, finding the report fully addressed the allegations OSC referred for investigation. Mr. Wilkes commented on the report pursuant to 5 U.S.C. § 1213(e)(1).

The Whistleblower's Allegations

Mr. Wilkes was the recovery coordinator in Mental Health Services at Overton Brooks from December 2011 through February 2014 and served as the acting assistant chief of Mental Health Services from December 2011 through January 2012. Mr. Wilkes disclosed that scheduling personnel at Overton Brooks are not properly trained on agency scheduling policies and that management does not require employees to follow such policies. Specifically, Mr. Wilkes alleged that, between 2012 and June 2014, schedulers were not using electronic waiting lists as required by VHA Directive 2010-027, VHA Outpatient Scheduling Processes and Procedures (June 9, 2010, updated December 8, 2015) (the directive).

According to the directive at para. 4.c.(19)(b), new patients whose appointments cannot be scheduled in target timeframes must be put on electronic waiting lists (EWL). Employees are to use Recall/Reminder Software to record the appointment needs of established patients requiring follow-

up appointments that cannot be immediately scheduled within target timeframes. VHA Directive 2010-027, para. 4.c.(3)(f)2.a. The directive further provides, “[n]o other wait list formats (paper, electronic spreadsheets) are to be used for tracking requests for outpatient appointments.”

Mr. Wilkes alleged that contrary to this directive, scheduling personnel were not trained to use EWL or the Recall/Reminder Software, and he observed that each scheduler maintained his or her own handwritten paper wait list. Mr. Wilkes indicated that in the spring of 2014, management determined the numerous paper wait lists had become unmanageable and instructed Stephanie Alexander, a nurse in Mental Health Services, to combine all of the paper waitlists into one master list, in the form of an Excel spreadsheet. Once Ms. Alexander compiled the master list, it was determined that there were over 2,700 veterans on the wait list for Mental Health Services, dating back to 2012. According to Mr. Wilkes, because schedulers did not use the EWL and Recall/Reminder Software, the electronic systems did not reflect that there were any patients waiting for appointments in Mental Health Services despite the significant delay in access to care, which endangered public health and safety.

Mr. Wilkes alleged that schedulers were taught and encouraged to manipulate the scheduling of appointments in Mental Health Services because there were not enough prescribing providers to see patients within target timeframes, but facility management wanted the electronic reports to reflect they were meeting the scheduling requirements for performance bonuses.

The Department of Veterans Affairs Report

The VA report summarized an OIG investigation initiated by an OIG hotline complaint that the Mental Health Services operations manager instructed employees in Mental Health not to use the Veterans Health Information Systems and Technology Architecture (VistA) or EWL, and instructed them to keep a “secret” list instead. In this investigation, OIG concluded that there was a spreadsheet used in the Mental Health Clinic identifying approximately 2,700 veterans who needed to be assigned to a Mental Health provider. However, according to the OIG, the list was not used in place of scheduling patients who wanted to be seen or as a substitute for the EWL. In addition, OIG found there was no evidence the operations manager instructed employees to avoid using VistA and EWL or to keep a “secret” list.

The OIG appears to base its findings on 13 witness interviews, an interview of Mr. Wilkes that took place six months prior to the OSC referral, and the review of a list Mr. Wilkes provided, which contained approximately 2,700 veteran names and associated Social Security numbers. OIG notes that there were four additional lists extrapolated from the original list, titled, “Appts Needed,” “Deceased,” “Followed by Another VA,” and “Seen Recent but No follow-up.” The OIG provided no definitive findings or conclusions regarding the purpose and use of these additional lists.

The report included bullet-point summaries of eight unattributed witness statements, which provided alternative, and sometimes conflicting, explanations for the lists. For example, Witness A stated it was “a list of all patients who were seen in the Mental Health Department in the last 3 years... The list was not for patients who had requested appointments. It was a list created to keep patients from falling through the cracks.” Witness B indicated, “The spreadsheet was used as an organizational tool to ensure these patients’ appointments were set and they were assigned a mental health coordinator (a provider needed to see a patient three times before the provider was considered

the patient's mental health coordinator). It was a waiting list for providers, not a list for patients waiting for a specific appointment." Witness D stated "the 'appointments-needed' list consisted of veterans needed [sic] to be reassigned to a new doctor and new treatment team... They could not use the Electronic Wait List (EWL) because the patient did not have a doctor assigned to them. The veterans on the appointments needed list did not have a reason to be seen other than to be assigned to another doctor. And the veteran did not need to be seen in order to be reassigned." Witness F indicated, "according to the notes the witness took during the meeting, [Stephanie] Alexander had said the list consisted of patients that needed to be scheduled for appointments."

OIG conducted follow-up telephone interviews with six employees who denied creating or knowledge of handwritten lists. OIG further indicated there was no mention of handwritten lists created by anybody at any time, although it is unclear whether OIG asked all witnesses about handwritten lists during interviews.

The OIG report and summaries of witness statements do not include information regarding scheduling practices, whether scheduling personnel received proper VistA or EWL training, or whether the electronic scheduling system accurately reflected patient wait times or any delay in patient care. In Chief of Staff Nabors's cover letter, he states, "[e]vidence indicated that there had been inappropriate training several years ago that carried through to present activities," and "[t]here was also evidence of a culture which may have promoted manipulation of wait times, but the culture was not apparent in the recent past or at the current time." The OIG report provided to OSC does not include any discussion of inappropriate training or a culture that promoted the manipulation of wait times.

In their interviews with OIG, numerous witnesses indicated there was a shortage of providers in Mental Health Services. In fact, OIG concluded that there was a list of approximately 2,700 veterans who needed to be assigned a mental health provider. However, the OIG report offers no findings or conclusions regarding whether the shortage of providers caused a delay in access to care, endangering public health and safety, nor does it outline any planned corrective actions to address this outstanding concern.

The Whistleblower's Comments

Mr. Wilkes asserts the report in this matter is a manifestation of the chronic, endemic problems plaguing the VA. He asserts that the report fails to address the issues referred by OSC, and the investigative findings and conclusions are neither reasonable nor complete. He points out that although the report notes several alarming practices at the facility, the agency concludes there is no wrongdoing and offers no corrective action.

Prior to the referral of his allegations to Secretary McDonald by OSC, the VA OIG contacted Mr. Wilkes. At the time, he believed OIG was contacting him as part of an investigation into the improper scheduling practices at the facility, but in fact, OIG was conducting a criminal investigation into how Mr. Wilkes obtained the list and whether he had disseminated the information on the spreadsheet to anyone. As a result, he was not able to provide emails to OIG supporting his assertion that the list in question was a wait list, or provide a list of witnesses who would corroborate his allegations.

According to Mr. Wilkes, OIG narrowly tailored the investigative report issued to reach a result unrelated to his allegations of wrongdoing. The investigation was limited to whether the operations manager instructed employees not to use the EWL or VistA, and whether the spreadsheet was a "secret" list. He asserts that by narrowing the investigation to two specific and less consequential aspects of the problem, the OIG was able to conclude that its investigation did not substantiate Mr. Wilkes's allegations. Further, while neither Mr. Wilkes nor OSC referred to the wait list as "secret," he asserts OIG's use of the term is misleading, because the lists are not "secret" to VA employees. Rather, they are "secret" because under the VA policies, they are not supposed to exist.

The Special Counsel's Findings

The Special Counsel 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 address the allegations OSC referred to the VA. Specifically, the report offers no findings regarding the allegations that scheduling personnel failed to follow proper scheduling protocol and were not properly trained on agency scheduling policies and practices, or that management encouraged the manipulation of electronic scheduling system.

Second, the evidence does not fully support the VA's findings and conclusions. The VA concluded there was a spreadsheet used in the Overton Brooks Mental Health Clinic identifying approximately 2,700 veterans who needed to be assigned a mental health provider. While some witness summaries support that conclusion, other witness statements do not, including explanations that the list consisted of patients that needed to be scheduled for appointments. Further, witness accounts also vary on whether veterans needed an appointment in order to be assigned to a provider, thus making a waiting list for providers synonymous with a waiting list for appointments. The report offers no discussion of how OIG reconciled the varying accounts in reaching its conclusion. In addition, there is no discussion of the propriety of maintaining this type of spreadsheet containing veteran names and Social Security numbers outside of the VA system of patient records.

Last, the report does not sufficiently address Mr. Wilkes's allegation that there was a significant delay in access to care in the Overton Brooks Mental Health Clinic that the VA electronic scheduling system did not accurately reflect, which endangered public health and safety. OIG concludes that the spreadsheet identified 2,700 veterans waiting to be assigned to a provider in the Mental Health Clinic, which, on its face, appears to be evidence of a delay in access to care. Further, witnesses repeatedly indicated there was a shortage of providers, but the VA report provides no determination on that issue.

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

**OSC File No. DI-14-2762
(Hines VA Hospital, Chicago, Illinois)**

OSC submits the following analysis, agency report, and whistleblower comments based on disclosures of wrongdoing from a whistleblower at the Department of Veterans Affairs (VA), Edward Hines, Jr., VA Hospital (Hines), Chicago, Illinois. Germaine Clarno, a social worker at Hines and president of the American Federation of Government Employees (AFGE) Local 781, disclosed that officials at Hines were engaging in actions that may constitute a violation of law, rule, or regulation; gross mismanagement; an abuse of authority; and a substantial and specific danger to public health. In brief, the allegations referred for investigation were as follows:

- Mental Health Service Line staff were improperly directed to record and track patient appointments on a separate Excel spreadsheet instead of the VA's electronic tracking system, in violation of agency policy;
- Scheduling staff in certain units were improperly directed to "zero out" patient wait times in violation of agency policy; and
- Management's failure to adhere to scheduling protocols and the use of improper scheduling practices has created a false appearance of acceptable wait times, while masking significant delays in veterans' access to care.

The investigation conducted by the VA's Office of Inspector General (OIG) substantiated that scheduling staff throughout Hines were instructed to change data and manipulate scheduling in a manner that zeroed out patient wait times and improved the appearance of wait time data at Hines, in violation of Veterans Health Administration (VHA) Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures* (June 9, 2010, updated December 8, 2015) (the directive). OIG found only one manager, patient administrative services (PAS) chief Christopher Wirtjes, responsible for implementing these improper practices.

The investigation further confirmed ongoing use of separate databases, spreadsheets, and other patient tracking tools outside of the VA's official scheduling and patient record systems. However, the OIG investigation focused narrowly on whether any of these alternative scheduling tools were "secret." Despite confirming ongoing delays in access to care at Hines, the agency report did not discuss or address actual wait times, or the impact of such delays on veterans' health. Nor did the report provide any recommendations for corrective action to resolve the ongoing delays. The Special Counsel determined that the agency report does not respond to the allegations of significant delays in access to care at Hines. She also determined that the agency's findings regarding the propriety of widespread use of separate patient tracking tools and accountability for the improper scheduling practices do not appear reasonable.

Procedural Background

Ms. Clarno's allegations were referred on June 5, 2014, to then-Acting Secretary of Veterans Affairs Sloan Gibson to conduct an investigation pursuant to 5 U.S.C. § 1213(c). According to reports then-Chief of Staff Robert L. Nabors, II, provided, OIG conducted an investigation of the whistleblower's allegations and provided its report of investigation to the Office of Accountability

Review (OAR) on January 26, 2015. Secretary Robert A. McDonald also directed OAR to conduct an investigation of the whistleblower's allegations. OAR reviewed the OIG report and related evidence and determined that the OIG report thoroughly addressed the issues that Ms. Clarno raised to OSC. OAR therefore determined that no additional investigation was necessary. On July 28, 2015, the VA submitted a report that OAR prepared summarizing the OIG report. OSC determined that the OAR summary was deficient and not responsive to all of the allegations referred. On August 14, 2015, OSC outlined the deficiencies in the OAR summary and requested that the VA provide the OIG report of investigation to OSC. On September 8, 2015, VA submitted another summary of the OIG report, this time prepared by OIG, as the agency report in response to OSC's referral pursuant to 5 U.S.C. § 1213(c).

The Whistleblower's Allegations

Ms. Clarno has worked at Hines for six years and served as AFGE Local 781 president since 2012. For three years, she was a social worker in the Mental Health Service Line, working with patients enrolled in the Trauma Services Program. The program provides outpatient therapy and support services to veterans diagnosed with post-traumatic stress disorder (PTSD) and other trauma-related conditions. Ms. Clarno explained that patients are initially scheduled for an orientation session, known as a CORE meeting, to learn about PTSD and the program. She stated that patients may then be offered group therapy within two to three weeks; however, most desire individual treatment and typically wait approximately six to nine months for their first individual appointment. Program staff record and track all patient appointments using an Excel spreadsheet maintained in a local public drive, rather than the VHA's official electronic scheduling system, VistA. Ms. Clarno contended that this practice violates the directive. The directive requires the use of the VHA's electronic waiting lists and provides that "[n]o other wait list formats (paper, electronic spreadsheets) are to be used for tracking requests for outpatient appointments."

Ms. Clarno further explained that, in an effort to improve patient wait times, the VA established a national goal of scheduling all new patient appointments within 14 days of the patient's entry into the VA's system. Ms. Clarno learned in 2011 that this 14-day goal was used as a performance measure. She stated that in the Trauma Services Program, managers used the initial CORE meeting to satisfy this goal and were able to document a first appointment within the desired 14-day time frame on a regular basis. However, while it appeared that the program was meeting the goal, in fact, mental health patients were not receiving treatment for six to nine months following that initial meeting. Further, because the scheduling information was maintained on an unofficial spreadsheet rather than in VistA, senior managers did not have access to accurate wait time data.

In 2011, Ms. Clarno raised her concerns regarding the significant wait times for patients with her supervisor, who elevated these concerns to senior management. She stated that no action was taken to address the delays. Current Mental Health Service staff confirmed that scheduling appointments on the Excel spreadsheet and significant wait times for actual treatment continued within the Trauma Services Program. Despite the ongoing delays, Ms. Clarno received an email dated May 6, 2014, from Dr. Bruce Roberts, chief of the Mental Health Service Line, touting Hines's Mental Health Service Line as number one in the country for new patient wait times. Noting that Hines's percentage for initial appointments within 14 days was at 90 percent, Dr. Roberts stated, "This is an indication of the superb access to Mental Health services at Hines." He also referenced the "transparent Excel spreadsheet" used to document each patient's timeline leading up to the initial

appointment. Ms. Clarno contended that these figures provided a false appearance of timely access to mental health care at Hines.

Ms. Clarno further stated that numerous employees throughout Hines reported to her that managers directed them to use improper scheduling procedures, including the Outpatient Clinics, Spinal Cord Injury/Disorder Service, Surgery, Radiology, and Outpatient Medicine. She described one practice used in Outpatient Medicine that violated the directive. When a patient called for an appointment, the scheduler was instructed to advise the patient of the first available appointment date, typically three or more months away. The scheduler would ask the patient if this date was acceptable. Most patients agreed to the date, believing there was no alternative. When the patient accepted that date, the scheduler was instructed to enter the appointment in VistA as the desired date of the patient, rather than the first available date offered. The wait time was then “zeroed out” in the system based on the patient’s “request” for an appointment outside the 14-day time frame. Several employees raised concerns regarding this practice when it was initiated in 2011, but were instructed by managers to follow these procedures.

After learning of scheduling improprieties at the Phoenix VA and receiving reports from employees about similar practices at Hines, Ms. Clarno met with then-Hines director Joan Ricard on May 8, 2014. She advised Ms. Ricard that many employees were reporting practices similar to those reported at Phoenix. That afternoon, Ms. Ricard issued a memorandum to all Hines employees acknowledging that there were “various steps that can make the reported wait times look good without actually improving the timeliness of appointments.” The memorandum stated that such “maneuvers that decrease reported wait times, but do not improve the actual experience of the patient, are not appropriate.” Ms. Clarno contended that Hines leadership knew for years that these improper practices were in use but failed to take appropriate steps to curtail these practices.

The Department of Veterans Affairs Report

According to the VA’s report to OSC that summarizes the OIG report, the OIG investigation focused on allegations “made publicly by the whistleblower” regarding “secret backlog lists,” manipulation of wait times to ensure that staff received large bonuses, and harm to patients. OIG interviewed the whistleblower nine days prior to OSC’s June 5, 2014 referral. The *summary* report reflects that Ms. Clarno discussed all of the allegations outlined in OSC’s referral with OIG investigators. Notably, OSC’s referral included Ms. Clarno’s allegation that the use of separate spreadsheets and tracking tools outside the VHA’s scheduling system violated the directive. According to the OIG summary, OIG focused on whether these lists were “secret,” presumably because Ms. Clarno used that term to describe these separate spreadsheets and lists.

The *summary* report states, “Although delays in access to care remain an ongoing issue at the Hines VAMC, this investigation uncovered no evidence to substantiate the existence of ‘secret’ wait lists.” The OIG investigation confirmed that separate spreadsheets, databases and tracking tools outside of the VA’s electronic scheduling and patient records systems were used by various units throughout Hines, including Mental Health Services. However, OIG stated that it found no evidence that these separate tracking tools were in conflict with the directive or used with the intent to hide delays. OIG repeatedly found that the separate spreadsheets and tracking tools were not secret, because the VISN director, Hines director, managers and employees knew about and/or used them.

In Mental Health Services, the investigation confirmed that since 2008, Trauma Services has used separate databases developed by the program manager to “comprehensively track veterans’ care,” including their referrals, CORE meetings, and treatment. The report states that the databases, maintained on a shared protected drive, are used in addition to VistA, the Computerized Patient Record System (CPRS), and other VA programs. They are not used in their place or to circumvent them. According to the OIG summary, a similar database is used to track treatment by the Intake Center of Mental Health Services. The OIG found that the chief of Mental Health, the Hines director, and the VISN 12 director are aware of these databases; thus, they are not secret.

The report provides a bullet point summary of statements from unidentified witnesses regarding the databases used in Mental Health Services. “Witness 1,” who is the Trauma Services program manager,¹ stated that veterans are immediately scheduled for appointments in VistA “as available.” She asserted that the allegation that her database was intended to artificially lower wait times is “ridiculous;” and that while she was not certain what desired dates were entered in VistA, “patients are being seen in a timely manner, within facility goals, and when they want to be seen.” However, when asked about manipulation of wait time data in VistA, she acknowledged that she was not familiar with the exact manner in which appointments were scheduled. The program manager further described CORE as a group orientation program used to begin the treatment process for PTSD. She stated that she developed CORE without consideration for the mandated wait time goals. She explained that following the CORE orientation, veterans may attend different treatment tracks, some of which prepare veterans for trauma focus and are scheduled in sessions. Thus, veterans may have to wait for a new session, but weekly “therapy meetings” are available to them while waiting.

“Witness 2,” who appears to be the chief of Mental Health Services, also discussed the use of the separate databases by Trauma Services and the Intake Center, noting that they are capable of tracking veterans’ care in ways the “archaic” VistA system cannot. He stated that there was confusion about terms such as “desired date” used in VistA, and “the limitations of that system made it ineffective for managing access and resources.” He noted that the separate databases initially showed access issues, which he addressed. He stated that he is satisfied with access in Mental Health Services. He further noted that CORE was developed to offer group sessions to better serve veterans reluctant to come to treatment.

In addition to Mental Health Services, the OIG investigation confirmed that separate spreadsheets and tracking tools are used by other units throughout Hines. Again, however, OIG only addressed whether these lists were secret. According to the report, several witnesses from “non-Mental Health” units described separate tracking lists, but they did not consider them to be secret. Several witnesses also noted backlogs and delays in scheduling appointments, including specialty consults and procedures. One witness, an MSA supervisor, reported that just before the OIG investigation began, the assistant PAS chief and PAS supervisors knew of a list containing 500-600 new enrollees. Weekend overtime was offered to volunteers to try to schedule appointments for the veterans on this list. The witness noted that the assistant director was involved in this process.

¹The OIG summary does not identify the witnesses by name or title, which is insufficient. Based on the summaries of the testimony of “Witness 1 (Mental Health Trauma Services)” and “Witness 2 (Mental Health Provider),” and by referencing the OAR summary, which provides a list of witnesses by name and position, it is possible to identify these two witnesses and potentially others. It is not possible to identify the numerous MSAs and MSA supervisors or their specific units.

Witnesses further reported that the Surgical Unit began using a patient scheduling log in 2011 for pain treatment appointments. One witness did not agree with the use of this log and believed it caused excess delay in pain treatments, because the log was locked in a drawer and not visible, rather than maintained in an approved computer system. The witness stated that in March 2014, when the investigations of wait times began, the log book was shredded and the information was transferred to an Excel spreadsheet in SharePoint. Another witness, who created this "Patient Tracking List" or "Scheduling List," defended its use, explaining that MSAs lack the working knowledge to efficiently schedule patients for the many pain treatments they require. This witness further stated that the log was not intended to hide wait times, and when it became known that it could be considered a forbidden logbook, it was taken out of use.

The report does not provide an analysis or explanation of OIG's basis for concluding that the separate spreadsheets, databases and tracking tools used in Mental Health Services and throughout Hines are consistent with the requirements and restrictions of the directive. Despite that directive's prohibition of separate paper or electronic lists, regardless of whether they are intended to replace or supplement VHA's official systems, OIG repeatedly stated that the separate tracking tools used at Hines were not secret and found no wrongdoing with their use. However, the report does not provide sufficient evidence demonstrating how appointments are scheduled in VistA in accordance with the directive.

Further, OIG confirmed that there are ongoing delays in access to care at Hines; however, the report does not include any information or analysis of data on actual wait times for treatment in Trauma Services or other units. The report states that the OIG Audit Division conducted an analysis of wait time data and reviewed data analysis reports from Hines management, but there is no discussion of that analysis or the data reports. Further, OIG did not make any findings confirming or disproving the allegation that mental health patients wait six to nine months for their first treatment appointment following the CORE meeting. The report does not explain what data Mental Health Services managers relied on to determine that wait times were acceptable and within the goals. OIG did not make any findings on whether wait times for patients in Mental Health Services or elsewhere are excessive or acceptable.

Additionally, the report does not adequately review of the impact of delays on patient care. It merely states that none of the witnesses had any knowledge of patient deaths or harm. One witness was aware of two patients who chose to go to outside providers because of the delays at Hines. Those cases, one of which involved a surgical delay for kidney cancer due to provider availability, were referred to the OIG Office of Healthcare Inspections for review, and no additional information was provided. The report notes that a review of patient complaints was conducted but does not discuss the findings of that review.²

The OIG investigation substantiated that MSA supervisors improperly directed MSAs to manipulate appointment scheduling and data in a manner that improved the appearance of wait times. The report, through a bullet point outline of unidentified witness testimony, explains the process through which MSAs were instructed to zero-out wait times. Witnesses explained that a data report, known as the "Priscilla Report," generated from VistA, identifies all scheduled appointments that exceed the 14-day wait time between desired and actual appointment dates. The investigation

²The summary prepared by OAR noted that patient complaints were not supportive of the allegations or "indicative of problems which can be associated with intentional schemes to hide wait time data at Hines."

revealed that under the direction of Mr. Wirtjes, MSAs were given the Priscilla Report and directed to “correct errors” by going into VistA and changing the desired date to match the actual appointment date, which reduced the wait time to zero days. Mr. Wirtjes also directed MSA supervisors to instruct MSAs to “make the numbers look good” by scheduling appointments in the manner described by Ms. Clarno, known as the “back out method.” When scheduling appointments, MSAs were instructed to find the next available appointment date in VistA, encourage the veteran to accept that date, then back out of the appointments grid and input that date as the patient’s desired date. Thus, the wait time would be reduced to zero days. Witnesses stated that following news stories of the scheduling improprieties at the Phoenix VA, Mr. Wirtjes claimed MSAs and MSA supervisors had misunderstood his orders.

According to the report, Mr. Wirtjes admitted that he instructed MSAs to use the back out method for scheduling. He conceded that this practice was “not in line with our directive.” However, he denied ordering MSA supervisors or MSAs to go into VistA and change desired dates to match appointment dates. He agreed that changing the desired dates resulted in better wait time numbers at Hines, but blamed this on the MSAs’ and MSA supervisors’ misunderstanding of his directions. OIG found that these practices “arguably” violated the directive.

OIG concluded, however, that there was no evidence that managers above Mr. Wirtjes had knowledge of the improper scheduling practices. The report states that OIG reviewed email correspondence between 2010 to 2015 from Hines and VISN 12 leadership showing their acknowledgement of and intolerance for gaming strategies and intentional falsification of wait time data. The emails also showed “ongoing dialogue” between Hines providers and management on issues such as “stressing that wait times cannot be hidden,” MSA input errors and desired date reliability, frustration with the limitations of the computer systems, and the need for more resources to truly address access issues. Further, managers were aware of an April 2010 “Inappropriate Scheduling Practices” memorandum by William Schoenhard, then-deputy under secretary for health for operations and management, mandating immediate facility reviews and elimination of all inappropriate scheduling practices and gaming strategies for decreasing the appearance of excessive wait times. The evidence suggests that leadership and senior management had knowledge of at least the potential for these practices. Nevertheless, the report does not adequately explain the evidence to support OIG’s conclusion that no one above the PAS chief had any knowledge of the improper scheduling practices at Hines. Nor does the report reflect that OIG considered whether leadership neglected their oversight responsibilities to ensure that these practices were not in use.

OIG determined that the improper scheduling practices and manipulation of data resulted in “decreased wait time data sets.” Thus, although the report does not provide a clear conclusion, the investigation appears to confirm that management’s failure to adhere to proper scheduling protocols created a false appearance of acceptable wait times while masking delays in access to care. Despite the evidence presented, the summary provided by OAR states that this allegation was not substantiated. As noted, OIG did not provide any information on actual wait times or the extent and impact of the delays on patient care, nor were any recommendations made to address the ongoing delays.

With respect to corrective actions taken or planned, the report states that the PAS chief received a proposed 14-day suspension. OIG did not provide any recommendation for corrective action. For “actions taken or planned as a result of the investigation,” the report identifies the

memorandum issued on May 8, 2014, by then-Hines director Joan Ricard regarding improper scheduling practices. As noted, that memorandum was a part of Ms. Clarno's disclosure. The report also references management's approval of overtime during the weekend of May 3, 2014, to clear backlogs of hundreds of unscheduled appointments and pending consults before OIG investigators arrived.

The Whistleblower's Comments

Ms. Clarno provided comments on the agency's report. Her comments included concerns regarding inconsistencies, the lack of a thorough investigation, omission of pertinent information, and bias toward her. She emphasized that the directive prohibits the use of any other wait list formats, including paper and electronic spreadsheets, for tracking requests for outpatient appointments. She noted that there are two VHA systems used for scheduling and charting, VistA and CPRS, through which providers are able to track and monitor veterans' appointments. She asserted that the only justification for using a separate means for tracking treatments/appointments would be to keep information separate from VistA, which allows for manipulation. She further stated that employees are pressured to meet timeliness goals and are therefore motivated to create systems outside of VistA and CPRS to meet those goals, rather than actually improve the experience of the veterans.

Ms. Clarno pointed out that although the OIG investigation confirmed her allegation of the use of separate databases to track patient referrals and treatment, VA did not substantiate a violation of VHA Directive 2010-027. Similarly, she noted that the investigation substantiated that MSAs were directed to change data within VistA and use "gaming strategies" to decrease the appearance of wait times. However, OAR claims that it did not substantiate the allegation that failure to adhere to scheduling protocols and the use of improper scheduling practices created a false appearance of acceptable wait times while masking delays in access to care.

In addition, Ms. Clarno commented that management throughout the VHA, including in the Hines's Director's Office, had full knowledge of these improper practices. She noted that Ms. Ricard admitted in her May 8, 2014 memorandum that there were wait time issues at Hines, and Ms. Ricard stated they were "monitoring the metrics to assure timely care." Ms. Ricard also outlined examples of how scheduling can be manipulated, noting the "pressure to improve reported results." Ms. Clarno noted that this memorandum was issued the day after she met with Ms. Ricard regarding the secret or separate wait lists that employees were reporting to her. Ms. Clarno further pointed out that VHA Directive 2010-027 provides that: the VISN director is responsible for the oversight of enrollment, scheduling, processing, consult management, and wait lists; the facility director is responsible for ensuring standardized systems are in place to balance supply and demand; and facility leadership must be vigilant in the identification and avoidance of inappropriate scheduling activities.

Ms. Clarno also explained the use and meaning of the term "secret" in referring to the separate spreadsheets and databases used at Hines to track patient care in violation of the directive. She stated that staff and leadership use this term in reference to waiting lists that the Central Office did not approve, were created internally, and not openly available to stakeholders or veterans. She asserted that focusing on the term "secret" distracted from the purpose of the investigation by focusing on discrediting the whistleblower. She noted other comments in the OIG summary that she believes demonstrate bias toward the whistleblower.

Finally, Ms. Clarno emphasized that accurate and reliable data on supply and demand are critical to providing treatment that is “patient centered and timely.” She noted that orientation groups, similar to CORE sessions, are a mechanism used to give the appearance that veterans are receiving treatment in a timely manner; however, this data is neither reliable nor accurate. Ms. Clarno expressed frustration in her persistent efforts to bring these serious allegations to the attention of Hines leadership and disappointment in the investigation OIG conducted.

The Special Counsel’s Findings

The Special Counsel determined that the agency report does not meet the statutory requirements, nor do the agency’s findings appear reasonable. As discussed above, the report does not provide a sufficient review of the evidence, and the evidence does not support the findings and conclusions. Moreover, the report demonstrates that the OIG investigation was not responsive to the serious allegations of significant wait times and delays in veterans’ access to care at Hines. The report confirms that “delays in access to care remain an ongoing issue at Hines,” yet it does not include any analysis of actual wait times or adequately assess the impact of such delays on patient care. Critically, the report does not make any recommendations for corrective action or reflect that any action was taken following the investigation to address the ongoing delays. Further, the report shows a failure to hold Hines management and leadership accountable for widespread use of improper scheduling practices that violated VA policies and rules and falsely improved the appearance of wait times at Hines. Finally, the content and tenor of the report OIG prepared demonstrate hostility toward Ms. Clarno, apparently for having spoken publicly, as well as an attempt to minimize her allegations.