DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON DC 20420

September 8, 2015

The Honorable Carolyn N. Lerner
Special Counsel
U.S. Office of Special Counsel
1730 M Street NW, Suite 300
Washington, DC 20036

RE: OSC File No. DI-14-2762

Dear Ms. Lerner:

I am responding to your letter regarding allegations made by a whistleblower at the Edward Hines, Jr. Veterans Affairs Medical Center (VAMC) in Chicago, Illinois. The whistleblower alleged that "Hines management has failed to adhere to VA patient scheduling policies" and "has directed staff to use improper scheduling procedures in an effort to conceal excessive wait times for patient appointments." The VA Office of Inspector General (OIG) conducted an investigation into the whistleblower's allegations and provided a report, dated January 21, 2015, to the Office of Accountability Review (OAR) on January 26, 2015. The OIG subsequently prepared the enclosed Report for the Office of Special Counsel Pursuant to the Provisions of Title 5 USC §1213. That report is now submitted as the Department's report in lieu of the report provided to the Office of Special Counsel (OSC) on July 28, 2015. The Secretary delegated to me the authority to sign the enclosed report and take any actions deemed necessary under 5 United States Code (USC) § 1213(d)(5).

The Secretary directed OAR to conduct an investigation concerning the whistleblower's allegations. In turn, OAR reviewed the OIG report and related evidence, and determined that the OIG report thoroughly addressed the issues raised by the whistleblower in her letter to OSC. Therefore, no additional investigation was required by OAR. OAR substantiated that Medical Support Assistants (MSAs) throughout the VAMC were changing data within the VistA system under the direction of MSA supervisors who asserted these orders originated from the Patient Administrative Services (PAS) Chief. OAR has confirmed that management at the facility and Veterans Integrated Service Network is taking appropriate administrative action against the Hines PAS Chief for violations of Veterans Health Administration (VHA) Directive 2010-027, VHA Outpatient Scheduling Processes and Procedures. Based on the OIG report, OAR also prepared the report which was submitted to OSC on July 28, 2015. As the OIG conducted an investigation of the whistleblower's allegations and has now prepared a report to the OSC pursuant to 5 USC §1213, that report is now submitted as the Department's response in lieu of the previous report.

I have reviewed the findings of the report and agree with the actions taken to address those findings. We will update this response when the administrative actions described above are complete.

Thank you for the opportunity to respond.

Sincerely,

Robert L. Nabors II
Chief of Staff

Enclosure

REPORT FOR THE OFFICE OF SPECIAL COUNSEL PURSUANT TO THE PROVISIONS OF TITLE 5 UNITED STATES CODE § 1213

RESULTS OF INVESTIGATION BY THE VETERANS AFFAIRS (VA) OFFICE OF INSPECTOR GENERAL OF ALLEGATIONS OF MISCONDUCT REGARDING SCHEDULING PRACTICES AT THE HINES, ILLINOIS, VA MEDICAL CENTER

1. **Summary of information with respect to which the investigation was initiated.**

Allegations made publicly by the Whistleblower were the focus of the investigation at the Hines, IL Veterans Affairs Medical Center (VAMC) conducted by the Department of Veterans Affairs, Office of Inspector General (VA OIG). The complainant primarily alleged that the Hines VAMC Mental Health division maintained "secret backlog lists." The Whistleblower also alleged that she had been told that wait times were manipulated to ensure that the staff received large bonuses and that patients were harmed. The Whistleblower was interviewed by the VA OIG prior to the whistleblower disclosure dated June 5, 2014, that the Office of Special Counsel sent to the VA Secretary with allegations from the same Whistleblower. Therefore, the investigation focused on the complaints she raised during her interview with the VA OIG.

2. **A description of the conduct of the investigation.**

In conducting this investigation the VA OIG interviewed the Whistleblower, Hines VAMC, Medical Support Assistants (MSAs), MSA Supervisors, Patient Administration Services (PAS) managers, administrative staff, clinical staff and senior level VAMC and Veterans Integrated Service Network (VISN) 12 leadership. A key word search and review of approximately 245,000 official emails from selected relevant Hines VAMC and VISN 12 employees has been conducted. A review of available Letters of Inquiry issued to Hines VAMC MSAs has been conducted. A review of complaints taken by the Hines Patient Advocate Office was conducted. The OIG Audit Division conducted relevant wait time data analysis on desired date/appointment date metrics in addition to reviewing data analysis reports from Hines VAMC management.

After several unsuccessful attempts to schedule an interview, the Whistleblower was interviewed on May 27, 2014, and provided the following.

- When Veterans diagnosed with Posttraumatic Stress Disorder (PTSD) or Traumatic Brain Injury (TBI) were referred to the Trauma Services section of Mental Health, they were not able to receive treatment in a timely manner, many times waiting many months for treatment.

- In response to the mandate from VA Central Office that patients receive care within 14 days, the Psychologist and Trauma Services Program Manager developed the CORE program. Upon receiving referrals to Trauma Services, MSAs schedule the veterans for CORE, which is a 2-day orientation program explaining PTSD. While this counts as "treatment within 14 days," the Whistleblower stated it is not really treatment.
- This individual then manages a Microsoft Excel spreadsheet on a shared network drive, upon which she tracks Veterans. When appointments open up, she gives the Veterans' information and appointment dates to MSAs and has them make the appointments in VistA. In this manner, although Veterans may wait many months to be seen by a psychologist, it appears as though they are not waiting long for treatment.
- The Whistleblower stated she has seen this spreadsheet, that it was discussed at staff meetings, and that generally she was told that the spreadsheet was in response to the central office 14-day wait time mandate, and the fact that putting the appointments in VistA would show longer wait times.
- When she and other staff raised objections and complained about access problems in Mental Health, they were told that was just the way it was, and that they would get used to it.
- The Whistleblower provided two emails in support of her claims. One was from Bruce Roberts, Chief of Hines Mental Health, dated May 6, 2014, about which the Whistleblower alleged Roberts admitted to using Kelly's Excel spreadsheet to manipulate wait times. The other was from Director Joan Ricard, dated May 8, 2014, which the Whistleblower alleged explained the manipulation of wait times and admonishes employees to report wait time truthfully.
- The Whistleblower asserted that wait times were artificially lowered in this manner so that upper management would receive large bonuses. She believed low wait times is one of three critical elements in their yearly performance evaluations, and that some have received "five-figure" bonuses.
- Whistleblower's attorney stated that about one week prior he spoke to a Hines VA doctor who reported Excel spreadsheets similar to the one used in Trauma Services (Mental Health) were widely used throughout Hines, and that the matter was discussed in a staff meeting held several years ago and attended by VISN 12 Director, Dr. Murawsky.
- The Whistleblower had no first-hand direct knowledge of any other scheduling manipulations or improprieties at Hines. She had no first-hand direct knowledge of any patient deaths or drastic changes in patient conditions related to wait times or scheduling manipulation at Hines. She claimed to have been contacted by 20 to 25 people who claim to have knowledge of additional scheduling

manipulations, and/or deaths occurring at Hines, but she refused to provide their names.

- The Whistleblower stated she would only release additional information if given a written document stating that she would not be held responsible for violating HIPAA.
- The Whistleblower denied having any additional emails, documents, or other evidence to provide.

The Whistleblower and her attorney were contacted towards the completion of the investigation and asked to provide any additional evidence or information not previously made available to OIG to ensure a thorough investigation of allegations. Neither the Whistleblower nor her attorney responded to the request.

Secret Waiting Lists

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 at Hines VAMC. In regards to the Whistleblower's primary allegations of Mental Health treatment delays and usage of any "secret lists" associated with Mental Health programs, there is no evidence to suggest the tracking tools or group introductory sessions utilized by that department were in conflict with the aforementioned scheduling directives or used with intent to hide delays in treatment. It appears the Trauma Services database was used to assist in the tracking of modern Mental Health treatment in a way that worked around deficiencies in antiquated VA scheduling software.

Mental Health

Witness 1 (Mental Health, Trauma Services)

- The program manager of Trauma Services, created a database to aid in tracking Veterans' treatments beginning in approximately 2008.
- The database actually consists of three separate databases, one for referrals, one for CORE, and one for treatment.
- The database is used in addition to VistA, CPRS, and other VA programs. It is not used in their place, or used to circumvent them in any way.
- CORE is an orientation program used as a clinical tool to begin the process of treatment for PTSD. The witness created the program while at a different VA facility; with no consideration for VA Central Office-mandated wait time goals.
- When a Veteran is referred to Trauma Services, an appointment is made for immediate outreach and consult. Once contacted, the Veteran is scheduled for CORE. While CORE is a group orientation, individual sessions are provided for those with special considerations, scheduling conflicts, etc. The program is

staffed by several of the nine psychologists and one social worker assigned to Trauma Services. During the assessment portion of the orientation, Veterans meet individually with staff members who take immediate treatment action if necessary. After CORE, Veterans may attend different treatment "tracks," including preparation for trauma focus, and trauma focus. While those who desire to go straight to trauma focus may do so, several different programs are designed to prepare patients for trauma focus. Since these are scheduled in sessions, a Veteran may have to wait until a new session starts, but weekly therapy meetings are available to them while waiting.

- The witness stated that while she would always like more staff, she feels staffing levels are currently sufficient to provide meaningful care within the VA Central Office wait time goals. The aforementioned program structure was specifically designed to address specific problems relating to the treatment of PTSD including reluctance to seek and remain in treatment.
- The database is used to comprehensively track Veterans' care, in a way currently not possible with VistA, CPRS, and other VA programs. The database is held on a shared protected drive, to which all clinicians in her section have access. Chief of Mental Health, Dr. Robert Bruce is aware of its existence, as is the National Center for PTSD. It is not secret.
- Concurrently, Veterans are immediately scheduled for appointments in VistA as available. No Trauma Services clinicians have scheduling access. Clinicians complete scheduling sheets for each Veteran and submit them to PAS MSAs Mark Rumentzas and Tom McHugh (assigned to Mental Health) and Program Support Assistant Gwen Richmond for entry into VistA. The witness is vaguely familiar with allegations of desired and appointment date manipulations within the VistA system to lower wait times. When asked if MSAs in Trauma Services were engaged in this type of manipulation, she stated she was not specifically familiar with the exact manner in which they scheduled appointments. She asserted that the allegation that the database was intended as a manner in which to artificially lower waits times is "ridiculous." She went on to explain that the VistA system is not reflective of the nature of on-going Mental Health treatment, and the concept of desired date is not really applicable in the context. While she is not certain of what desired dates MSAs are entering in VistA, she maintained Veterans are being seen in a timely manner, within goals, and when they want to be seen.
- When the VA OIG Special Agent mentioned that her database was referenced in an email from Bruce Roberts dated May 6, 2014, [provided by the Whistleblower], the Witness advised hers is not the database to which he was referring in the email. Rather, he was referring to a similar database used by the intake section of the Mental Health Service Line.

Witness 2 (Mental Health provider)

- Since his hiring at Hines, the witness has been concerned with access, and ensuring that Veterans have immediate treatment options.
- In pursuit of increasing access, the witness oversaw the development of the Intake Center and databases capable of tracking Veterans' care in ways the archaic VistA system was not able.
- The databases used by Mental Health to track treatment have evolved, and the ones currently used by Trauma Services and the Intake Center were developed by Kelly Phipps Maieritsch. They are not secret.
- The databases are not used instead of the VA scheduling system. Any MSAs working to schedule Mental Health appointments have always been instructed by Mental Health staff to be truthful and accurate in their data entry.
- The witness noted that there had been confusion about "desired date," "create date" and other terms used in the VistA system, and that the limitations of that system made it ineffective in managing access and resources.
- The databases were successful and initially showed access issues, which were addressed by Dr. Roberts.
- Currently, the witness is satisfied with access in Mental Health.
- The CORE program was created by Kelly Phipps Maieritsch and approved by Dr. Roberts. It was not created in response to a performance measure, but instead was developed as a tool to offer group sessions to better serve Veterans reluctant or apprehensive to come in for Mental Health treatment.
- If a patient in CORE or any other area of the hospital is found to need immediate intervention and treatment, they receive treatment immediately.
- Prior to going public with the Whistleblower's allegations, CBS news was granted an interview with Dr. Roberts. When the story ran soon after, Mental Health was not mentioned, leading Dr. Roberts to believe his rebuttal to the Whistleblower's allegations had been successful. On June 11, 2014, or June 12, 2014, CBS reporter Wyatt Andrews contacted Dr. Roberts "off the record" and after explaining that he had excluded the allegations against Mental Health in his previous story, told Dr. Roberts he had more questions about Joan Ricard. It was felt that Andrews was implying some type of quid pro quo, and did not respond, but the request was forwarded to the Director's office.
- Many of the staff in Mental Health are very upset because the Whistleblower has suggested that the very programs implemented by Mental Health to increase access and improve treatment were in fact designed to hide access issues. The witness asserted this is not the case.

Witness 3, (VAMC Director)

- Believes the Whistleblower was referring to the Mental Health tracking tool as the "secret list," but maintained there are no secret lists at the Hines VAMC.

Witness 4, (VISN Director)

- Regarding the Whistleblower's allegation of "secret lists," he believes the Whistleblower was referring to Mental Health's tracking tool, which he was aware of.

Non-Mental Health

Although the Whistleblower's allegations focused primarily on the Mental Health unit, she stated that she thought similar practices were occurring throughout the VAMC. The VA OIG investigation also addressed whether there were "secret" waiting lists in other areas.

Witness 5 (MSA, non-Mental Health)

- In regards to "secret lists," the witness believes there is no such thing. He believes computerized listings of pending consult appointments, which often become backlogged, could be misconstrued as such. He believes there is no ill intent in doing this; rather, system scheduling limitations gives them no other alternative.

Witness 6 (MSA Supervisor, non-Mental Health)

- The witness has never heard of any kind of secret list, and surmised that the Whistleblower may be referring to either the Electronic Wait List, recall reminder list, the pending consults list, or the Mental Health section's "Calendar List," none of which are secret.

Witness 7 (MSA Supervisor, non-Mental Health)

- When asked about "secret lists," the witness advised she was not aware of any such lists. Approximately three or four weeks ago, PAS did find out there was a lengthy New Enrollee Appointment Request (NEAR) list in eligibility, which has now been "cleared up."

Witness 8 (MSA, non-Mental Health)

- The witness does not know anything about secret lists or what that may be referring to.

Witness 9 (MSA Supervisor, non-Mental Health)

- The witness has never heard of any secret wait lists or backlog lists.
- Just before this investigation began, Joan McKenzie-Hobbs and PAS supervisors knew of a list containing 500 to 600 new enrollees, and Saturday overtime was offered to volunteers to come in and try and get Veterans on this list scheduled. Assistant Director Kenny Sraon was very involved in this process

Witness 10 (PAS Supervisor)

- It's possible some may perceive the Pending Consults listing to be the "secret" wait list; however, it is a legitimate, tracked computerized list.

Witness 11 (Physician, Primary Care)

- The witness has no knowledge of "secret" wait lists, but stated pending consults are not typically scheduled in a timely manner.

Witness 12 (Nursing, Outpatient)

- The witness believes Surgical Prep used some sort of patient tracking list, but otherwise does not know of any "secret lists" or anything inappropriate.
- In the past the witness has seen a backlogged procedures list in GI Lab, i.e. patients waiting for colonoscopy procedures, but she doesn't feel this is a secret list or otherwise inappropriate.

Witness 13 (Clinical Administration, non-Mental Health)

- In 2013, nurses on the Surgical Floor used patient scheduling logs. The witness did not agree with the use of these logs and was vocal about her opposition.
- The scheduling logs contained PII (patients' last names and the last four digits of their social security numbers) which she felt was a security concern. The log also included a calendar date for when a procedure was to be performed. She believed it to be a wait list or schedule log that was kept for patients waiting for pain treatment until an appointment was available. When an appointment was available they had an MSA schedule the appointment.
- She believes this method caused excess delay in pain treatments because the log was not visible and was locked in a drawer instead of being placed in an approved computer system.
- The logbook was maintained by two nurses. (Witnesses 14 below.)
- In approximately March 2014, when waiting time investigations became known, the logbook was taken out of use and "shredded." The information began to be

put in an Excel spreadsheet in SharePoint, which she helped implement in approximately April 2012.

Witnesses 14 and 15 (Nursing, non-Mental Health)

- Witness 14 created the log described by Witness 13, which she referred to as a "Patient Tracking List" or "Scheduling List," in approximately 2011. The witnesses stated that it is not a waiting list, and it is not secret. [Witness 15 is Witness 14's supervisor.]
- Pain treatment schedules vary weekly, depending on provider availability and providers' specialties in administering injections, etc. MSAs do not have the working knowledge to efficiently schedule patients for the multitude of treatments they require. Therefore, when nurses work a patient needing treatment into an appointment slot based on the provider availability, they then immediately have an MSA schedule the treatment in VistA.
- This is the only practical way to get patients in for pain treatment that really needs it at the time they need it.
- When Witness 13 objected to the log, it was transferred to the computerized log in the SharePoint system. Witness 12 stated it was known that logbooks were not to be used; however, this book was viewed as necessary for the efficiency of treating the Veterans.
- Witness 14 stated that Witness 11 did not grasp what this log was, in addition to its practicality.
- The log was never utilized for the purpose or intention of hiding wait times, and once it became known that this could be considered a forbidden "logbook," it was taken out of use.

Witnesses in the non-Mental Health areas talked about a spreadsheet informally referred to as the "Priscilla Report." We found that the report, which was generated at the VAMC, identified all scheduled appointments that fell outside the established acceptable 14-day wait time. It was not a "secret report."

Bonuses

The Whistleblower asserted that wait times were artificially lowered so that upper management would receive large bonuses. She believed low wait times is one of three critical elements in their yearly performance evaluations, and that some have received "five-figure" bonuses. The OIG received a similar complaint from Senator Mark Kirk regarding bonuses including an allegation that $16.6 million was paid in bonuses since 2011. We did not substantiate that anyone received a "five-figure" bonus or that bonuses were specifically tied to waiting times. We also did not substantiate that $16.6 million was paid in bonuses since 2011. The VISN Director told the investigators:

- The bonus system does not provide much financial incentive to hide data and Hines is not different from other VISN 12 facilities in bonus amounts, etc.
- His bonus and Director Ricard's are determined via a point system by the Corporate Senior Executive Office in Washington D.C., and he does not believe high access numbers in a large facility like Hines would be a significant factor.
- The bonus amounts released to the press and Senator Kirk reflect all retention incentives, etc., not just performance awards. He stated of the $16 million alleged, $9.5 million was in salary incentives and retention bonuses (which are widely known and necessary), not performance awards. Overall ratings drive performance awards, and access is such a small fraction it does not influence overall awards.

Intentional and/or malicious falsification of wait times

Although the Whistleblower did not provide any specific complaint or evidence regarding falsification of wait times, the VA OIG investigation addressed the issue. On June 30, 2014, approximately 245,000 VA official emails were obtained by the OIG Forensic Laboratory for the following VA officials:

Karandeep (Kenny) Sraon
Joan Ricard
Christopher Wirtjes
Joan McKenzie-Hobbs
Donna Fagan
Daniel Zomchek
Priscilla Hartel
Brian Hertz
Jeffrey Murawsky
Jack Bulmash

There were no emails found that were indicative of intentional and/or malicious falsification of wait time data within the Hines VAMC. To the contrary, multiple emails from 2010 to the present by Hines and VISN 12 leadership clearly show the acknowledgement of and intolerance to gaming strategies and intentional falsification of wait time data. They also show ongoing dialogue between Hines providers and management stressing that wait times cannot be hidden, supporting their belief that MSA input errors and desired date reliability was in question, frustrations with the limitations of software systems, and that more resources were needed to truly address access issues.

During interviews, various MSA and PAS staff referenced a report referred to as the "Priscilla Report."

Testimony regarding the "Priscilla Report" included:

- The MSA Leads then distributes the lists [Priscilla Report] as applicable to the MSA's with instructions to "fix errors" in the scheduling. "Fix errors" means that MSAs are to go back into the VistA system, cancel the appointment in question,

then immediately re-make the appointment with a desired date showing the same as that of the appointment date, which decreases the wait time to zero. After the MSAs make the requested changes, she reports the changes back to her supervisor. If the changes are refused, she does not get further involved. She explained that the column on the far right of the spreadsheet was the difference in number of days between the Veteran's desired date of appointment and the date the appointment was created, i.e. entered into the computer system. She stated any "zero" in this column was an error by the MSA who entered the appointment, and she was tasked with having the MSAs go back to "fix" the errors as stated above. (Witness 16)

- The new Chief, PAS directed the weekly (or so) review of the Priscilla Report, and the "correction" of "errors" by changing the desired dates to the actual appointment dates. In one such meeting, he told MSA staff that the Hines numbers were "in the red"; that Hines was the only medical center in the VISN getting "dinged," and that other facilities were entering appointments using a desired date that matched the appointment date, as long as the Veteran agreed to the appointment. This was referred to as the "back out method." The witness did note that those appointments whose "create date" is the same as the desired date are indeed frequently occurring errors resulting from MSAs going through the system too fast. (Witness 7)
- She attended the meeting which occurred in July or August 2013, during which the Chief, PAS told MSA supervisors that they were to start using the 'back out method." Most MSA supervisors were unhappy with this, and the Chief, PAS instructed them to "make the numbers look good" by trying to get the Veteran to agree to the next available appointment. Another PAS supervisor told her verbally on different occasions to have MSAs on the "Priscilla Report" remake appointments in VistA so that the desired dates match the appointment dates. The PAS supervisor pushed MSA supervisors to utilize a Letter of Inquiry for MSAs who were frequently on the Priscilla Report. However, the witness never utilized a Letter of Inquiry. (Witness 9)
- The "Priscilla Report" is officially known as an IRM Data Run, automatically generated in the VistA system, which she imports into an Excel spreadsheet and emails to a group comprising managers overseeing MSA leads and other various supervisors. The purpose of the report is to identify patient wait times that are in excess of 14 days. Wait time is calculated as the time between the patient's desired appointment date (or a doctor's consult date) and the date of the actual appointment scheduled. The witness noted that these are unrealistic standards that VAMC cannot meet. (Witness 17)
- The "Priscilla Report" is a list generated to identify all scheduled appointments that fall outside the established acceptable 14-day wait time. This report is used

to identify "clerical" errors made by MSAs. Contrary to the Chief, PAS, the witness stated the MSAs are then asked to contact the Veteran to clarify the desired date and change it in the system. (Witness 18)

- The witness' current duties include support and oversight to PAS Section Chiefs, who oversee MSA supervisors and MSAs. The witness feels that the changing of desired dates by MSAs as a result of the "Priscilla Report" and other data pointed out to her by two providers was an attempt to correct errors made by MSAs wherein desired dates were the same as create dates. If this was the case, MSAs were supposed to make comments in the system to reflect why this was the case. The witness was not aware of any intentional manipulation of data to decrease wait times. If the witness had felt that were the case, she would not have condoned it. The witness recently initiated an audit of the wait time numbers, where approximately 1200 patients' wait times were reviewed for accuracy. Her data showed that from February 2013 to May 2014, 27% of patient wait times exceeding 14 days were due to MSA scheduling errors, 59% were due to legitimate access issues, and 14% were due to MSAs not inputting required comments in the VistA system to account for the desired date matching the create date. (Witness 19)

Witnesses testified that after the issues at the Phoenix VA broke, the Chief, PAS held a meeting with all MSAs and told them that their supervisors had taught them the wrong way to schedule appointments. He also had a meeting with the MSA supervisors in which he told them that they had misunderstood his orders.

The Chief, PAS disputed statements by others regarding his instructions:

- He has utilized the "Priscilla Report," which is generated to identify the number of appointments exceeding the 14-day established acceptable wait time period between desired appointment date and actual appointment date. The intent of this list is not to manipulate numbers in order to shrink the percentage of appointment wait times exceeding 14 days, but rather to identify "clerical errors" made by MSAs when scheduling appointments.
- As PAS Chief, he re-implemented old methods of scheduling wherein an MSA could select "next available" appointment, then view the grid of available appointments. They could then "back out" of the appointments, which would allow them to input the desired date after viewing the grid of available appointments and getting the patient to agree to an available date. Often, due to a system default, the MSAs mistakenly end up entering the create date as that of the desired date, which would only be accurate for a walk-in same day appointment. If this is the case, the MSA is required to enter a notation in the comment field, stating this is the case and is not a mistake.

- When he became PAS Chief, the MSA supervisors under him "misunderstood" his intent and directions in these methods of scheduling practices, and the purpose and use of the "Priscilla Report." He has since learned that they thought he directed them to correct these "errors" by going back into VistA and make the desired date and appointment dates match. He never told anyone to go back and change dates. He did not realize they were doing so, and his intent with the "Priscilla Report" was only to educate MSAs.
- He stated he thought the scheduling practices under the prior Chief, PAS, i.e. not letting MSAs back out of the grid, was too restrictive. In approximately September 2013, he met with the MSA supervisors and instructed them to view appointments as part of the discussion with the Veteran, and if the Veteran didn't care and agreed to another available date, that becomes the desired date (transcript p. 77-78). He later realized this was too liberal and was in the process of updating these directions just prior to this investigation.
- Allowing MSAs to back out of the grid and get the patients to agree to another date was a mistake and "not in line with our directive." He agreed that wait time data, i.e. desired dates, were being changed which resulted in better "wait time" numbers at the Hines VAMC, but blamed the MSAs' and MSA supervisors' misunderstandings of the situation.
- Although he found out weeks prior to the investigation that MSAs were changing desired dates subsequent to the "Priscilla Reports," he did nothing to stop this. He denied receiving results of "Priscilla Report" "fixes," as well as reporting "fixes" up his chain of command.
- He steadfastly denied instructing MSA supervisors or anyone down the chain of command to purposely alter dates in the VistA system in response to the Priscilla Report.

In regards to scheduling processes by MSAs throughout the Hines VAMC, it has been shown that MSAs were changing data within the VistA system under the direction of MSA supervisors, who asserted these orders originated from the Chief, PAS. Although the existence of MSA clerical errors due to antiquated confusing scheduling software appears valid, the Chief, PAS denied giving orders for MSAs to go back into VistA and change data subsequent to wait time IRM Data Reports being issued (Priscilla Reports). The results of these changes, whether by design or by unintentional and indirect effect, resulted in decreased wait time data sets. The interpretation of scheduling processes, in specific regard to desired date interpretation and negotiation of desired date with Veterans, appears to vary across the MSAs interviewed. The Chief, PAS admitted to implementing scheduling methods in which the MSAs could encourage agreement from Veterans for alternate desired dates closer to the scheduled appointment dates. While arguably practical, this violates VHA Scheduling Directive 2010-027. There is no

evidence to suggest management above the Chief, PAS had knowledge of these practices.

Alleged Deaths Due to Waiting Times

Although the Whistleblower told the investigators that she was contacted by 20 to 25 people who claim to have knowledge of additional scheduling manipulations, and/or deaths occurring at Hines, she refused to provide the names of the individuals who contacted her and did not provide any other information regarding this issue. None of the witnesses interviewed by the VA OIG investigators had any knowledge of patient deaths or harm. The one witness stated he was aware of two patients who had chosen to go to outside providers. One chose to go to an outside provider due to a delay in surgical availability for kidney cancer and the other due to a delay in coordination of a care plan at Hines VAMC; however, he stated they were not directly attributable to scheduling manipulation or processes, but rather provider/surgical availability. These cases were referred by the VA OIG investigators to the VA OIG Office of Healthcare Inspections for review.

3. **A summary of the evidence obtained during the investigation**.

The evidence is summarized above in Section 2.

4. **A listing of any violation or apparent violation of any law, rule, or regulation.**

The VA OIG determined that there was arguably a violation of VHA Directive 2010-027, VHA Outpatient Scheduling Process and Procedures.

5. **A description of any action taken or planned as a result of the investigation.**

The Chief, PAS has received a proposed 14-day suspension for implementing inappropriate scheduling practices, failing to take timely action to end such improper practices, and failing to provide clear instruction to subordinates regarding scheduling procedures. That action is pending a decision by the Deciding Official.

On May 8, 2014, the VAMC Director issued a memorandum to all employees notifying them that taking steps to make waiting times look good without actually improving the timeliness of appointments was inappropriate. The Director asked employees to follow the rules and to report unethical scheduling practices to the VAMC Compliance Officer. Also, during the weekend of May 3, 2014, VAMC management approved overtime for MSAs to work overtime to clear backlogs and pending consults. Witnesses told the OIG investigators that shortly after the matter was reported to the media, the Chief, PAS

advised the staff that he had been misunderstood and that he did not mean that they should go back to "questioned" scheduling methods. (Witnesses 6, 7, 10, and 20)

DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON DC 20420

September 8, 2015

The Honorable Carolyn N. Lerner
Special Counsel
U.S. Office of Special Counsel
1730 M Street NW, Suite 300
Washington, DC 20036

RE: OSC File No. DI-14-2762

Dear Ms. Lerner:

I am responding to your letter regarding allegations made by a whistleblower at the Edward Hines, Jr. Veterans Affairs Medical Center (VAMC) in Chicago, Illinois. The whistleblower alleged that "Hines management has failed to adhere to VA patient scheduling policies" and "has directed staff to use improper scheduling procedures in an effort to conceal excessive wait times for patient appointments." The VA Office of Inspector General (OIG) conducted an investigation into the whistleblower's allegations and provided a report, dated January 21, 2015, to the Office of Accountability Review (OAR) on January 26, 2015. The OIG subsequently prepared the enclosed Report for the Office of Special Counsel Pursuant to the Provisions of Title 5 USC §1213. That report is now submitted as the Department's report in lieu of the report provided to the Office of Special Counsel (OSC) on July 28, 2015. The Secretary delegated to me the authority to sign the enclosed report and take any actions deemed necessary under 5 United States Code (USC) § 1213(d)(5).

The Secretary directed OAR to conduct an investigation concerning the whistleblower's allegations. In turn, OAR reviewed the OIG report and related evidence, and determined that the OIG report thoroughly addressed the issues raised by the whistleblower in her letter to OSC. Therefore, no additional investigation was required by OAR. OAR substantiated that Medical Support Assistants (MSAs) throughout the VAMC were changing data within the VistA system under the direction of MSA supervisors who asserted these orders originated from the Patient Administrative Services (PAS) Chief. OAR has confirmed that management at the facility and Veterans Integrated Service Network is taking appropriate administrative action against the Hines PAS Chief for violations of Veterans Health Administration (VHA) Directive 2010-027, VHA Outpatient Scheduling Processes and Procedures. Based on the OIG report, OAR also prepared the report which was submitted to OSC on July 28, 2015. As the OIG conducted an investigation of the whistleblower's allegations and has now prepared a report to the OSC pursuant to 5 USC §1213, that report is now submitted as the Department's response in lieu of the previous report.

I have reviewed the findings of the report and agree with the actions taken to address those findings. We will update this response when the administrative actions described above are complete.

Thank you for the opportunity to respond.

Sincerely,

Robert L. Nabors II
Chief of Staff

Enclosure

REPORT FOR THE OFFICE OF SPECIAL COUNSEL PURSUANT TO THE PROVISIONS OF TITLE 5 UNITED STATES CODE § 1213

RESULTS OF INVESTIGATION BY THE VETERANS AFFAIRS (VA) OFFICE OF INSPECTOR GENERAL OF ALLEGATIONS OF MISCONDUCT REGARDING SCHEDULING PRACTICES AT THE HINES, ILLINOIS, VA MEDICAL CENTER

1. **Summary of information with respect to which the investigation was initiated.**

Allegations made publicly by the Whistleblower were the focus of the investigation at the Hines, IL Veterans Affairs Medical Center (VAMC) conducted by the Department of Veterans Affairs, Office of Inspector General (VA OIG). The complainant primarily alleged that the Hines VAMC Mental Health division maintained "secret backlog lists." The Whistleblower also alleged that she had been told that wait times were manipulated to ensure that the staff received large bonuses and that patients were harmed. The Whistleblower was interviewed by the VA OIG prior to the whistleblower disclosure dated June 5, 2014, that the Office of Special Counsel sent to the VA Secretary with allegations from the same Whistleblower. Therefore, the investigation focused on the complaints she raised during her interview with the VA OIG.

2. **A description of the conduct of the investigation.**

In conducting this investigation the VA OIG interviewed the Whistleblower, Hines VAMC, Medical Support Assistants (MSAs), MSA Supervisors, Patient Administration Services (PAS) managers, administrative staff, clinical staff and senior level VAMC and Veterans Integrated Service Network (VISN) 12 leadership. A key word search and review of approximately 245,000 official emails from selected relevant Hines VAMC and VISN 12 employees has been conducted. A review of available Letters of Inquiry issued to Hines VAMC MSAs has been conducted. A review of complaints taken by the Hines Patient Advocate Office was conducted. The OIG Audit Division conducted relevant wait time data analysis on desired date/appointment date metrics in addition to reviewing data analysis reports from Hines VAMC management.

After several unsuccessful attempts to schedule an interview, the Whistleblower was interviewed on May 27, 2014, and provided the following.

- When Veterans diagnosed with Posttraumatic Stress Disorder (PTSD) or Traumatic Brain Injury (TBI) were referred to the Trauma Services section of Mental Health, they were not able to receive treatment in a timely manner, many times waiting many months for treatment.

- In response to the mandate from VA Central Office that patients receive care within 14 days, the Psychologist and Trauma Services Program Manager developed the CORE program. Upon receiving referrals to Trauma Services, MSAs schedule the veterans for CORE, which is a 2-day orientation program explaining PTSD. While this counts as "treatment within 14 days," the Whistleblower stated it is not really treatment.
- This individual then manages a Microsoft Excel spreadsheet on a shared network drive, upon which she tracks Veterans. When appointments open up, she gives the Veterans' information and appointment dates to MSAs and has them make the appointments in VistA. In this manner, although Veterans may wait many months to be seen by a psychologist, it appears as though they are not waiting long for treatment.
- The Whistleblower stated she has seen this spreadsheet, that it was discussed at staff meetings, and that generally she was told that the spreadsheet was in response to the central office 14-day wait time mandate, and the fact that putting the appointments in VistA would show longer wait times.
- When she and other staff raised objections and complained about access problems in Mental Health, they were told that was just the way it was, and that they would get used to it.
- The Whistleblower provided two emails in support of her claims. One was from Bruce Roberts, Chief of Hines Mental Health, dated May 6, 2014, about which the Whistleblower alleged Roberts admitted to using Kelly's Excel spreadsheet to manipulate wait times. The other was from Director Joan Ricard, dated May 8, 2014, which the Whistleblower alleged explained the manipulation of wait times and admonishes employees to report wait time truthfully.
- The Whistleblower asserted that wait times were artificially lowered in this manner so that upper management would receive large bonuses. She believed low wait times is one of three critical elements in their yearly performance evaluations, and that some have received "five-figure" bonuses.
- Whistleblower's attorney stated that about one week prior he spoke to a Hines VA doctor who reported Excel spreadsheets similar to the one used in Trauma Services (Mental Health) were widely used throughout Hines, and that the matter was discussed in a staff meeting held several years ago and attended by VISN 12 Director, Dr. Murawsky.
- The Whistleblower had no first-hand direct knowledge of any other scheduling manipulations or improprieties at Hines. She had no first-hand direct knowledge of any patient deaths or drastic changes in patient conditions related to wait times or scheduling manipulation at Hines. She claimed to have been contacted by 20 to 25 people who claim to have knowledge of additional scheduling

manipulations, and/or deaths occurring at Hines, but she refused to provide their names.

- The Whistleblower stated she would only release additional information if given a written document stating that she would not be held responsible for violating HIPAA.
- The Whistleblower denied having any additional emails, documents, or other evidence to provide.

The Whistleblower and her attorney were contacted towards the completion of the investigation and asked to provide any additional evidence or information not previously made available to OIG to ensure a thorough investigation of allegations. Neither the Whistleblower nor her attorney responded to the request.

Secret Waiting Lists

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 at Hines VAMC. In regards to the Whistleblower's primary allegations of Mental Health treatment delays and usage of any "secret lists" associated with Mental Health programs, there is no evidence to suggest the tracking tools or group introductory sessions utilized by that department were in conflict with the aforementioned scheduling directives or used with intent to hide delays in treatment. It appears the Trauma Services database was used to assist in the tracking of modern Mental Health treatment in a way that worked around deficiencies in antiquated VA scheduling software.

Mental Health

Witness 1 (Mental Health, Trauma Services)

- The program manager of Trauma Services, created a database to aid in tracking Veterans' treatments beginning in approximately 2008.
- The database actually consists of three separate databases, one for referrals, one for CORE, and one for treatment.
- The database is used in addition to VistA, CPRS, and other VA programs. It is not used in their place, or used to circumvent them in any way.
- CORE is an orientation program used as a clinical tool to begin the process of treatment for PTSD. The witness created the program while at a different VA facility; with no consideration for VA Central Office-mandated wait time goals.
- When a Veteran is referred to Trauma Services, an appointment is made for immediate outreach and consult. Once contacted, the Veteran is scheduled for CORE. While CORE is a group orientation, individual sessions are provided for those with special considerations, scheduling conflicts, etc. The program is

staffed by several of the nine psychologists and one social worker assigned to Trauma Services. During the assessment portion of the orientation, Veterans meet individually with staff members who take immediate treatment action if necessary. After CORE, Veterans may attend different treatment "tracks," including preparation for trauma focus, and trauma focus. While those who desire to go straight to trauma focus may do so, several different programs are designed to prepare patients for trauma focus. Since these are scheduled in sessions, a Veteran may have to wait until a new session starts, but weekly therapy meetings are available to them while waiting.

- The witness stated that while she would always like more staff, she feels staffing levels are currently sufficient to provide meaningful care within the VA Central Office wait time goals. The aforementioned program structure was specifically designed to address specific problems relating to the treatment of PTSD including reluctance to seek and remain in treatment.
- The database is used to comprehensively track Veterans' care, in a way currently not possible with VistA, CPRS, and other VA programs. The database is held on a shared protected drive, to which all clinicians in her section have access. Chief of Mental Health, Dr. Robert Bruce is aware of its existence, as is the National Center for PTSD. It is not secret.
- Concurrently, Veterans are immediately scheduled for appointments in VistA as available. No Trauma Services clinicians have scheduling access. Clinicians complete scheduling sheets for each Veteran and submit them to PAS MSAs Mark Rumentzas and Tom McHugh (assigned to Mental Health) and Program Support Assistant Gwen Richmond for entry into VistA. The witness is vaguely familiar with allegations of desired and appointment date manipulations within the VistA system to lower wait times. When asked if MSAs in Trauma Services were engaged in this type of manipulation, she stated she was not specifically familiar with the exact manner in which they scheduled appointments. She asserted that the allegation that the database was intended as a manner in which to artificially lower waits times is "ridiculous." She went on to explain that the VistA system is not reflective of the nature of on-going Mental Health treatment, and the concept of desired date is not really applicable in the context. While she is not certain of what desired dates MSAs are entering in VistA, she maintained Veterans are being seen in a timely manner, within goals, and when they want to be seen.
- When the VA OIG Special Agent mentioned that her database was referenced in an email from Bruce Roberts dated May 6, 2014, [provided by the Whistleblower], the Witness advised hers is not the database to which he was referring in the email. Rather, he was referring to a similar database used by the intake section of the Mental Health Service Line.

Witness 2 (Mental Health provider)

- Since his hiring at Hines, the witness has been concerned with access, and ensuring that Veterans have immediate treatment options.
- In pursuit of increasing access, the witness oversaw the development of the Intake Center and databases capable of tracking Veterans' care in ways the archaic VistA system was not able.
- The databases used by Mental Health to track treatment have evolved, and the ones currently used by Trauma Services and the Intake Center were developed by Kelly Phipps Maieritsch. They are not secret.
- The databases are not used instead of the VA scheduling system. Any MSAs working to schedule Mental Health appointments have always been instructed by Mental Health staff to be truthful and accurate in their data entry.
- The witness noted that there had been confusion about "desired date," "create date" and other terms used in the VistA system, and that the limitations of that system made it ineffective in managing access and resources.
- The databases were successful and initially showed access issues, which were addressed by Dr. Roberts.
- Currently, the witness is satisfied with access in Mental Health.
- The CORE program was created by Kelly Phipps Maieritsch and approved by Dr. Roberts. It was not created in response to a performance measure, but instead was developed as a tool to offer group sessions to better serve Veterans reluctant or apprehensive to come in for Mental Health treatment.
- If a patient in CORE or any other area of the hospital is found to need immediate intervention and treatment, they receive treatment immediately.
- Prior to going public with the Whistleblower's allegations, CBS news was granted an interview with Dr. Roberts. When the story ran soon after, Mental Health was not mentioned, leading Dr. Roberts to believe his rebuttal to the Whistleblower's allegations had been successful. On June 11, 2014, or June 12, 2014, CBS reporter Wyatt Andrews contacted Dr. Roberts "off the record" and after explaining that he had excluded the allegations against Mental Health in his previous story, told Dr. Roberts he had more questions about Joan Ricard. It was felt that Andrews was implying some type of quid pro quo, and did not respond, but the request was forwarded to the Director's office.
- Many of the staff in Mental Health are very upset because the Whistleblower has suggested that the very programs implemented by Mental Health to increase access and improve treatment were in fact designed to hide access issues. The witness asserted this is not the case.

Witness 3, (VAMC Director)

- Believes the Whistleblower was referring to the Mental Health tracking tool as the "secret list," but maintained there are no secret lists at the Hines VAMC.

Witness 4, (VISN Director)

- Regarding the Whistleblower's allegation of "secret lists," he believes the Whistleblower was referring to Mental Health's tracking tool, which he was aware of.

Non-Mental Health

Although the Whistleblower's allegations focused primarily on the Mental Health unit, she stated that she thought similar practices were occurring throughout the VAMC. The VA OIG investigation also addressed whether there were "secret" waiting lists in other areas.

Witness 5 (MSA, non-Mental Health)

- In regards to "secret lists," the witness believes there is no such thing. He believes computerized listings of pending consult appointments, which often become backlogged, could be misconstrued as such. He believes there is no ill intent in doing this; rather, system scheduling limitations gives them no other alternative.

Witness 6 (MSA Supervisor, non-Mental Health)

- The witness has never heard of any kind of secret list, and surmised that the Whistleblower may be referring to either the Electronic Wait List, recall reminder list, the pending consults list, or the Mental Health section's "Calendar List," none of which are secret.

Witness 7 (MSA Supervisor, non-Mental Health)

- When asked about "secret lists," the witness advised she was not aware of any such lists. Approximately three or four weeks ago, PAS did find out there was a lengthy New Enrollee Appointment Request (NEAR) list in eligibility, which has now been "cleared up."

Witness 8 (MSA, non-Mental Health)

- The witness does not know anything about secret lists or what that may be referring to.

Witness 9 (MSA Supervisor, non-Mental Health)

- The witness has never heard of any secret wait lists or backlog lists.
- Just before this investigation began, Joan McKenzie-Hobbs and PAS supervisors knew of a list containing 500 to 600 new enrollees, and Saturday overtime was offered to volunteers to come in and try and get Veterans on this list scheduled. Assistant Director Kenny Sraon was very involved in this process

Witness 10 (PAS Supervisor)

- It's possible some may perceive the Pending Consults listing to be the "secret" wait list; however, it is a legitimate, tracked computerized list.

Witness 11 (Physician, Primary Care)

- The witness has no knowledge of "secret" wait lists, but stated pending consults are not typically scheduled in a timely manner.

Witness 12 (Nursing, Outpatient)

- The witness believes Surgical Prep used some sort of patient tracking list, but otherwise does not know of any "secret lists" or anything inappropriate.
- In the past the witness has seen a backlogged procedures list in GI Lab, i.e. patients waiting for colonoscopy procedures, but she doesn't feel this is a secret list or otherwise inappropriate.

Witness 13 (Clinical Administration, non-Mental Health)

- In 2013, nurses on the Surgical Floor used patient scheduling logs. The witness did not agree with the use of these logs and was vocal about her opposition.
- The scheduling logs contained PII (patients' last names and the last four digits of their social security numbers) which she felt was a security concern. The log also included a calendar date for when a procedure was to be performed. She believed it to be a wait list or schedule log that was kept for patients waiting for pain treatment until an appointment was available. When an appointment was available they had an MSA schedule the appointment.
- She believes this method caused excess delay in pain treatments because the log was not visible and was locked in a drawer instead of being placed in an approved computer system.
- The logbook was maintained by two nurses. (Witnesses 14 below.)
- In approximately March 2014, when waiting time investigations became known, the logbook was taken out of use and "shredded." The information began to be

put in an Excel spreadsheet in SharePoint, which she helped implement in approximately April 2012.

Witnesses 14 and 15 (Nursing, non-Mental Health)

- Witness 14 created the log described by Witness 13, which she referred to as a "Patient Tracking List" or "Scheduling List," in approximately 2011. The witnesses stated that it is not a waiting list, and it is not secret. [Witness 15 is Witness 14's supervisor.]
- Pain treatment schedules vary weekly, depending on provider availability and providers' specialties in administering injections, etc. MSAs do not have the working knowledge to efficiently schedule patients for the multitude of treatments they require. Therefore, when nurses work a patient needing treatment into an appointment slot based on the provider availability, they then immediately have an MSA schedule the treatment in VistA.
- This is the only practical way to get patients in for pain treatment that really needs it at the time they need it.
- When Witness 13 objected to the log, it was transferred to the computerized log in the SharePoint system. Witness 12 stated it was known that logbooks were not to be used; however, this book was viewed as necessary for the efficiency of treating the Veterans.
- Witness 14 stated that Witness 11 did not grasp what this log was, in addition to its practicality.
- The log was never utilized for the purpose or intention of hiding wait times, and once it became known that this could be considered a forbidden "logbook," it was taken out of use.

Witnesses in the non-Mental Health areas talked about a spreadsheet informally referred to as the "Priscilla Report." We found that the report, which was generated at the VAMC, identified all scheduled appointments that fell outside the established acceptable 14-day wait time. It was not a "secret report."

Bonuses

The Whistleblower asserted that wait times were artificially lowered so that upper management would receive large bonuses. She believed low wait times is one of three critical elements in their yearly performance evaluations, and that some have received "five-figure" bonuses. The OIG received a similar complaint from Senator Mark Kirk regarding bonuses including an allegation that $16.6 million was paid in bonuses since 2011. We did not substantiate that anyone received a "five-figure" bonus or that bonuses were specifically tied to waiting times. We also did not substantiate that $16.6 million was paid in bonuses since 2011. The VISN Director told the investigators:

- The bonus system does not provide much financial incentive to hide data and Hines is not different from other VISN 12 facilities in bonus amounts, etc.
- His bonus and Director Ricard's are determined via a point system by the Corporate Senior Executive Office in Washington D.C., and he does not believe high access numbers in a large facility like Hines would be a significant factor.
- The bonus amounts released to the press and Senator Kirk reflect all retention incentives, etc., not just performance awards. He stated of the $16 million alleged, $9.5 million was in salary incentives and retention bonuses (which are widely known and necessary), not performance awards. Overall ratings drive performance awards, and access is such a small fraction it does not influence overall awards.

Intentional and/or malicious falsification of wait times

Although the Whistleblower did not provide any specific complaint or evidence regarding falsification of wait times, the VA OIG investigation addressed the issue. On June 30, 2014, approximately 245,000 VA official emails were obtained by the OIG Forensic Laboratory for the following VA officials:

Karandeep (Kenny) Sraon
Joan Ricard
Christopher Wirtjes
Joan McKenzie-Hobbs
Donna Fagan
Daniel Zomchek
Priscilla Hartel
Brian Hertz
Jeffrey Murawsky
Jack Bulmash

There were no emails found that were indicative of intentional and/or malicious falsification of wait time data within the Hines VAMC. To the contrary, multiple emails from 2010 to the present by Hines and VISN 12 leadership clearly show the acknowledgement of and intolerance to gaming strategies and intentional falsification of wait time data. They also show ongoing dialogue between Hines providers and management stressing that wait times cannot be hidden, supporting their belief that MSA input errors and desired date reliability was in question, frustrations with the limitations of software systems, and that more resources were needed to truly address access issues.

During interviews, various MSA and PAS staff referenced a report referred to as the "Priscilla Report."

Testimony regarding the "Priscilla Report" included:

- The MSA Leads then distributes the lists [Priscilla Report] as applicable to the MSA's with instructions to "fix errors" in the scheduling. "Fix errors" means that MSAs are to go back into the VistA system, cancel the appointment in question,

then immediately re-make the appointment with a desired date showing the same as that of the appointment date, which decreases the wait time to zero. After the MSAs make the requested changes, she reports the changes back to her supervisor. If the changes are refused, she does not get further involved. She explained that the column on the far right of the spreadsheet was the difference in number of days between the Veteran's desired date of appointment and the date the appointment was created, i.e. entered into the computer system. She stated any "zero" in this column was an error by the MSA who entered the appointment, and she was tasked with having the MSAs go back to "fix" the errors as stated above. (Witness 16)

- The new Chief, PAS directed the weekly (or so) review of the Priscilla Report, and the "correction" of "errors" by changing the desired dates to the actual appointment dates. In one such meeting, he told MSA staff that the Hines numbers were "in the red"; that Hines was the only medical center in the VISN getting "dinged," and that other facilities were entering appointments using a desired date that matched the appointment date, as long as the Veteran agreed to the appointment. This was referred to as the "back out method." The witness did note that those appointments whose "create date" is the same as the desired date are indeed frequently occurring errors resulting from MSAs going through the system too fast. (Witness 7)
- She attended the meeting which occurred in July or August 2013, during which the Chief, PAS told MSA supervisors that they were to start using the 'back out method." Most MSA supervisors were unhappy with this, and the Chief, PAS instructed them to "make the numbers look good" by trying to get the Veteran to agree to the next available appointment. Another PAS supervisor told her verbally on different occasions to have MSAs on the "Priscilla Report" remake appointments in VistA so that the desired dates match the appointment dates. The PAS supervisor pushed MSA supervisors to utilize a Letter of Inquiry for MSAs who were frequently on the Priscilla Report. However, the witness never utilized a Letter of Inquiry. (Witness 9)
- The "Priscilla Report" is officially known as an IRM Data Run, automatically generated in the VistA system, which she imports into an Excel spreadsheet and emails to a group comprising managers overseeing MSA leads and other various supervisors. The purpose of the report is to identify patient wait times that are in excess of 14 days. Wait time is calculated as the time between the patient's desired appointment date (or a doctor's consult date) and the date of the actual appointment scheduled. The witness noted that these are unrealistic standards that VAMC cannot meet. (Witness 17)
- The "Priscilla Report" is a list generated to identify all scheduled appointments that fall outside the established acceptable 14-day wait time. This report is used

to identify "clerical" errors made by MSAs. Contrary to the Chief, PAS, the witness stated the MSAs are then asked to contact the Veteran to clarify the desired date and change it in the system. (Witness 18)

- The witness' current duties include support and oversight to PAS Section Chiefs, who oversee MSA supervisors and MSAs. The witness feels that the changing of desired dates by MSAs as a result of the "Priscilla Report" and other data pointed out to her by two providers was an attempt to correct errors made by MSAs wherein desired dates were the same as create dates. If this was the case, MSAs were supposed to make comments in the system to reflect why this was the case. The witness was not aware of any intentional manipulation of data to decrease wait times. If the witness had felt that were the case, she would not have condoned it. The witness recently initiated an audit of the wait time numbers, where approximately 1200 patients' wait times were reviewed for accuracy. Her data showed that from February 2013 to May 2014, 27% of patient wait times exceeding 14 days were due to MSA scheduling errors, 59% were due to legitimate access issues, and 14% were due to MSAs not inputting required comments in the VistA system to account for the desired date matching the create date. (Witness 19)

Witnesses testified that after the issues at the Phoenix VA broke, the Chief, PAS held a meeting with all MSAs and told them that their supervisors had taught them the wrong way to schedule appointments. He also had a meeting with the MSA supervisors in which he told them that they had misunderstood his orders.

The Chief, PAS disputed statements by others regarding his instructions:

- He has utilized the "Priscilla Report," which is generated to identify the number of appointments exceeding the 14-day established acceptable wait time period between desired appointment date and actual appointment date. The intent of this list is not to manipulate numbers in order to shrink the percentage of appointment wait times exceeding 14 days, but rather to identify "clerical errors" made by MSAs when scheduling appointments.
- As PAS Chief, he re-implemented old methods of scheduling wherein an MSA could select "next available" appointment, then view the grid of available appointments. They could then "back out" of the appointments, which would allow them to input the desired date after viewing the grid of available appointments and getting the patient to agree to an available date. Often, due to a system default, the MSAs mistakenly end up entering the create date as that of the desired date, which would only be accurate for a walk-in same day appointment. If this is the case, the MSA is required to enter a notation in the comment field, stating this is the case and is not a mistake.

- When he became PAS Chief, the MSA supervisors under him "misunderstood" his intent and directions in these methods of scheduling practices, and the purpose and use of the "Priscilla Report." He has since learned that they thought he directed them to correct these "errors" by going back into VistA and make the desired date and appointment dates match. He never told anyone to go back and change dates. He did not realize they were doing so, and his intent with the "Priscilla Report" was only to educate MSAs.
- He stated he thought the scheduling practices under the prior Chief, PAS, i.e. not letting MSAs back out of the grid, was too restrictive. In approximately September 2013, he met with the MSA supervisors and instructed them to view appointments as part of the discussion with the Veteran, and if the Veteran didn't care and agreed to another available date, that becomes the desired date (transcript p. 77-78). He later realized this was too liberal and was in the process of updating these directions just prior to this investigation.
- Allowing MSAs to back out of the grid and get the patients to agree to another date was a mistake and "not in line with our directive." He agreed that wait time data, i.e. desired dates, were being changed which resulted in better "wait time" numbers at the Hines VAMC, but blamed the MSAs' and MSA supervisors' misunderstandings of the situation.
- Although he found out weeks prior to the investigation that MSAs were changing desired dates subsequent to the "Priscilla Reports," he did nothing to stop this. He denied receiving results of "Priscilla Report" "fixes," as well as reporting "fixes" up his chain of command.
- He steadfastly denied instructing MSA supervisors or anyone down the chain of command to purposely alter dates in the VistA system in response to the Priscilla Report.

In regards to scheduling processes by MSAs throughout the Hines VAMC, it has been shown that MSAs were changing data within the VistA system under the direction of MSA supervisors, who asserted these orders originated from the Chief, PAS. Although the existence of MSA clerical errors due to antiquated confusing scheduling software appears valid, the Chief, PAS denied giving orders for MSAs to go back into VistA and change data subsequent to wait time IRM Data Reports being issued (Priscilla Reports). The results of these changes, whether by design or by unintentional and indirect effect, resulted in decreased wait time data sets. The interpretation of scheduling processes, in specific regard to desired date interpretation and negotiation of desired date with Veterans, appears to vary across the MSAs interviewed. The Chief, PAS admitted to implementing scheduling methods in which the MSAs could encourage agreement from Veterans for alternate desired dates closer to the scheduled appointment dates. While arguably practical, this violates VHA Scheduling Directive 2010-027. There is no

evidence to suggest management above the Chief, PAS had knowledge of these practices.

Alleged Deaths Due to Waiting Times

Although the Whistleblower told the investigators that she was contacted by 20 to 25 people who claim to have knowledge of additional scheduling manipulations, and/or deaths occurring at Hines, she refused to provide the names of the individuals who contacted her and did not provide any other information regarding this issue. None of the witnesses interviewed by the VA OIG investigators had any knowledge of patient deaths or harm. The one witness stated he was aware of two patients who had chosen to go to outside providers. One chose to go to an outside provider due to a delay in surgical availability for kidney cancer and the other due to a delay in coordination of a care plan at Hines VAMC; however, he stated they were not directly attributable to scheduling manipulation or processes, but rather provider/surgical availability. These cases were referred by the VA OIG investigators to the VA OIG Office of Healthcare Inspections for review.

3. **A summary of the evidence obtained during the investigation**.

The evidence is summarized above in Section 2.

4. **A listing of any violation or apparent violation of any law, rule, or regulation.**

The VA OIG determined that there was arguably a violation of VHA Directive 2010-027, VHA Outpatient Scheduling Process and Procedures.

5. **A description of any action taken or planned as a result of the investigation.**

The Chief, PAS has received a proposed 14-day suspension for implementing inappropriate scheduling practices, failing to take timely action to end such improper practices, and failing to provide clear instruction to subordinates regarding scheduling procedures. That action is pending a decision by the Deciding Official.

On May 8, 2014, the VAMC Director issued a memorandum to all employees notifying them that taking steps to make waiting times look good without actually improving the timeliness of appointments was inappropriate. The Director asked employees to follow the rules and to report unethical scheduling practices to the VAMC Compliance Officer. Also, during the weekend of May 3, 2014, VAMC management approved overtime for MSAs to work overtime to clear backlogs and pending consults. Witnesses told the OIG investigators that shortly after the matter was reported to the media, the Chief, PAS

advised the staff that he had been misunderstood and that he did not mean that they should go back to "questioned" scheduling methods. (Witnesses 6, 7, 10, and 20)

DEPARTMENT OF VETERANS AFFAIRS
Washington DC 20420

U.S. OFFICE OF
SPECIAL COUNSEL
WASHINGTON, D.C.

2015 JUL 30 PM 3:01

July 28, 2015

The Honorable Carolyn N. Lerner
Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW, Suite 300
Washington, DC 20036

RE: OSC File No. DI-14-2762

Dear Ms. Lerner:

I am responding to your letter regarding allegations made by a whistleblower at the Edward Hines, Jr. VA Medical Center (VAMC) in Chicago, IL. The whistleblower alleged that "Hines management has failed to adhere to VA patient scheduling policies" and "has directed staff to use improper scheduling procedures in an effort to conceal excessive wait times for patient appointments". The VA Office of Inspector General (OIG) conducted an investigation into the whistleblower's allegations and provided a report, dated January 21, 2015, to the Office of Accountability Review (OAR) on January 26, 2015. The Secretary delegated to me the authority to sign the enclosed report and take any actions deemed necessary under 5 U.S.C. § 1213(d)(5).

The Secretary directed the Office of Accountability Review (OAR) to conduct an investigation concerning the whistleblower's allegations. OAR, in turn, reviewed the OIG report and related evidence and determined that the OIG report thoroughly addressed the issues the whistleblower raised in her letter to OSC. Therefore, no additional investigation was required by OAR. OAR substantiated that Medical Support Assistants (MSAs) throughout the VAMC were changing data within the VistA system under the direction of MSA supervisors who asserted these orders originated from the Patient Administrative Services (PAS) Chief. Although OAR determined that no additional investigation was necessary, appropriate administrative action is being taken by the facility and Veterans Integrated Service Network against the Hines' Chief of PAS for violations of Veterans Health Administration (VHA) Directive 2010-027, VHA Outpatient Scheduling Processes and Procedures. This action is based on the OIG report and OAR's subsequent review of the evidence.

Findings from the OIG investigation and OAR review are contained in the enclosed report, which I am submitting for your review. I have reviewed these findings and agree with the recommendations listed in the report. We may also send your office a follow-up response describing actions which have been and will be taken in response to this report.

Thank you for the opportunity to respond.

Sincerely,

Robert L. Nabors II
Chief of Staff

Enclosure

DEPARTMENT OF VETERANS AFFAIRS

Washington, DC

Report to the

Office of Special Counsel

OSC File Number DI-14-2762

Department of Veterans Affairs
Edward Hines, Jr. VA Medical Center
Chicago, IL

Report Date: July 28, 2015

Any information in this report that is the subject of the Privacy Act of 1974 and/or the Health Insurance Portability and Accountability Act of 1996 may only be disclosed as authorized by those statutes. Any unauthorized disclosure of confidential information is subject to the criminal penalty provisions of those statutes.

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Executive Summary

Pursuant to its authority in Title 5, U.S. Code (U.S.C.) subsection 1213(c), the Office of Special Counsel (OSC), by letter dated June 5, 2014, to the former Acting Secretary of Veterans Affairs (VA or the Department), referred for investigation specific allegations made by VA employee, Ms. Germaine Clarno (hereafter, the Whistleblower), that "Hines management has failed to adhere to VA patient scheduling policies" and "has directed staff to use improper scheduling procedures in an effort to conceal excessive wait times[1] for patient appointments". Ms. Clarno is a Social Worker and the local American Federation of Government Employees (AFGE) Union President. The VA Office of Inspector General (OIG) conducted an investigation into the allegations and provided a report, dated January 21, 2015, to the Office of Accountability Review (OAR) on January 26, 2015. OAR, in turn, reviewed the report and evidence, and determined that the OIG report thoroughly addressed the issues which Ms. Clarno raised in her letter to OSC. Therefore, no additional investigation was conducted by OAR.

Specific Allegations of the Whistleblower:

1. Mental Health Service Line staff was 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;

2. Scheduling staff in certain units were improperly directed to "zero out"[2] patient wait times in violation of agency policy;

3. Management's failure to adhere to scheduling protocols and the use of improper scheduling practices have created a false appearance of acceptable wait times, while making significant delays in veteran's access to care.

OAR reviewed the OIG report and determined that conducting an administrative investigation was not necessary. Based on the OIG report and its evidence, OAR **substantiated** allegations when the facts and findings supported that the alleged events or actions took place, and **did not substantiate** allegations when the facts and findings showed the allegations were unfounded. The OAR team was **not able to**

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[1] Wait time is calculated as the time between the patient's desired appointment date (or a doctor's consult date) and the date of the actual scheduled appointment.

[2] To "zero out' involves entering the next available "appointment date" as the "desired date" to give the appearance of zero wait times. VHA Directive 2010-027: "The desired date is defined by the patient without regard to schedule capacity. Once the desired date has been established, it must not be altered to reflect an appointment date the patient acquiesces to accept for lack of appointment availability on the desired date."

substantiate allegations when the available evidence was not sufficient to support conclusions with reasonable certainty whether the alleged event or action took place.

Summary Statement

This constitutes the Department's response, as required by 5 U.S.C. § 1213(d).

This report was developed after a thorough review of the OIG Comprehensive Report of Investigation entitled "Hines VAH Wait Times", File No. 2014-02890-IC-0072, to address OSC's concerns that the Medical Center may have engaged in actions that constitute a violation of law, rule or regulation, gross mismanagement, an abuse of authority, or a substantial and specific danger to public health. In particular, OAR has examined the issues from a Human Resources perspective to establish accountability for improper personnel practices when necessary. OAR found actions that constituted a violation of agency policy, however, the actions did not constitute a violation of law, rule or regulation, gross mismanagement, abuse of authority, or a substantial and specific danger to public health.

After careful review of findings, VA makes the following conclusions and recommendations.

Conclusion for Allegation #1:

Not substantiated. – There is no evidence to suggest the tracking tools utilized by the Mental Health Service Line were in conflict with VHA Directive 2010-027, VHA Outpatient Scheduling Process and Procedures or used with intent to hide delays in treatment. It appears the Trauma Services database, and its related spreadsheet located on a shared drive, were used to assist in the tracking of modern mental health treatment in a way in which antiquated VA scheduling software was deficient. The database is used in addition to the Veterans Health Information Systems and Technology Architecture (VistA), VA Computerized Patient Record System (CPRS), and other VA programs. It is not used in their place, or used to circumvent the process. The National Center for Post-Traumatic Stress Disorder has been aware of the database's existence.

Recommendation: None

Conclusion for Allegation #2:

Substantiated - Medical Support Assistants (MSAs) throughout the Edward Hines, Jr. VA Medical Center were changing data within the VistA system under the direction of

MSA supervisors, who asserted these orders originated from the Patient Administrative Services (PAS) Chief.

Recommendation: Administrative action should be taken for violations of VHA Directive 2010-027, VHA Outpatient Scheduling Processes and Procedures.

Conclusion for Allegation #3:

Not able to substantiate - There is no evidence to suggest management had knowledge of improper scheduling practices. In addition, the Patient Advocate Office provided copies of approximately 1,100 patient complaints for review by the OIG investigators. The complaints were neither supportive of allegations made during the investigation, nor were they indicative of problems which can be associated with intentional schemes to hide wait time data at the Hines VA Medical Center.

Recommendation: None

Report to the Office of Special Counsel

I. Introduction

The former Acting Secretary of Veterans Affairs authorized OAR to investigate a complaint lodged with the OSC by a whistleblower employed by the Department at the Edward Hines, Jr. Medical Center, Chicago, IL. The Whistleblower, Ms. Germaine Clarno, alleged that Hines management has failed to adhere to VA patient scheduling policies" and "has directed staff to use improper scheduling procedures in an effort to conceal excessive wait times for patient appointments".

II. Facility Profile

Edward Hines, Jr. VA Hospital (Hines VAH), located 12 miles west of downtown Chicago on a 147-acre campus, offers primary, extended and specialty care and serves as a tertiary care referral center for VISN 12. Specialized clinical programs include Blind Rehabilitation, Spinal Cord Injury, Neurosurgery, Radiation Therapy and Cardiovascular Surgery. The hospital also serves as the VISN 12 southern tier hub for pathology, radiology, radiation therapy, human resource management and fiscal services.

Hines VAH currently operates 471 beds and six community based outpatient clinics in Elgin, Kankakee, Oak Lawn, Aurora, LaSalle, and Joliet. Over 600,000 patient visits occurred in fiscal year 2010 providing care to over 54,000 Veterans, primarily from Cook, DuPage and Will counties. In FY 2010 the budget for Hines was over $510 million.

III. Allegations

A letter, dated June 5, 2015, sent from the OSC to the former Acting Secretary of Veterans Affairs alleged the following:

- 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 have created a false appearance of acceptable wait times, while making significant delays in veteran's access to care.

IV. Conduct of Investigation

Between May 15, 2014 and August 14, 2014, interviews of Medical Support Assistants (MSAs), MSA supervisors (in both outpatient and specialty clinics), clinical staff; and members of facility and VISN senior management were conducted jointly by members of the VA OIG Investigations and Audit Division. The OIG team consisted of Special Agents (SAs) J. Cossairt and S. Humeniak, as well as Auditors O. Young and C. Nielson. The Whistleblower was interviewed on May 27, 2014 in the presence of her AFGE Attorney, J. Ward Morrow.

During the site visit, the OIG team interviewed the individuals listed below, who were all provided their Garrity rights[3]. Several employees had representation from the union, a coworker, or a private attorney.

Germaine Clarno, Social Worker, Whistleblower
Joyce Boyd, Health Care Technician
Amin Sahtout, MSA
Parrish Brown, MSA
Richard Gibbs, MSA
Sharel Aldridge, Lead MSA
Curtis Cunningham, MSA Supervisor
Lovette Parks, Inpatient MSA Supervisor
Carla Logan, MSA Supervisor
Eric Shank, MSA Supervior
Mary Muth, MSA Supervisor
Rashad Kighten, MSA
Loretta Haley, Medicine Subspecialty MSA
Sarah Berry, Medicine Subspecialty MSA
Jessica Garcia, MSA
Stella Caro, MSA Supervisor
Priscilla Hartel, Automatic Data Processing Coordinator
Christopher Wirtjes, Chief of Patient Administrative Services
Donna Fagan, former Chief of Patient Administrative Services
Ryan Landi, Section Chief of Ambulatory Care
Joan McKenzie-Hobbs, Assistant Chief, Patient Administrative Services
Dr. Kelly Phipps Maieritsch, Psychologist and Program Manager, Trauma Services Division, Mental Health Service

[3] The ***Garrity* warning** is an advisement of rights usually administered by state or local investigators to their employees who may be the subject of an internal investigation. The *Garrity* warning advises subjects of their potential criminal and administrative liability for any statements they may make, but also advises subjects of their right to remain silent on any issues that tend to implicate them in a crime.

Dr. Brian Hertz, Associate Chief of Staff
Dr. Christine Erickson, Physician, General Medicine
Dr. Bruce Roberts, Chief of Mental Health
Dr. Jonathan Sachs, Physician, Primary Care
Cecilia Beauprie, Chief Nurse of Outpatient Care
Marivic Gregorio, Quality Improvement and Systems Specialist; former Clinical Nurse Manager
Deborah Dear, Clinical Information System/Anesthesia Record Keeper Coordinator; former Staff Nurse in Surgical Clinic
Jodi Azzolin, Clinical Nurse Manager
Catalina Burke, RN, Pain Clinic
Hattie Frierson-Johnson, Acting Supervisor of Admissions and Administrator on Duty
Karandeep (Kenny) Sraon, Assistant Director
Dr. Jack Bulmash, Chief of Staff
Joan Ricard, former Medical Center Director
Dr. Jeffrey Murasky, Network Director, VISN 12
Tom Grego, Patient Advocate Office

Those interviewed were asked to submit emails and other documents related to the matters-at-hand. Some individuals were also asked to produce reports. All of the documentation is included in the "Documents Reviewed" section at the conclusion of this report.

V. Findings, Conclusions, and Recommendations

Allegation #1: ***That 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 was NOT substantiated.***

Regulations: N/A

Policy: VHA Directive 2010-027, VHA Outpatient Scheduling Process and Procedures, effective June 9, 2010 and expiring June 30, 2015, provides policy for implementing processes and procedures for the scheduling of outpatient clinical appointments and for ensuring the competency of staff directly or indirectly involved in any or all components of the scheduling process.

In April 2010, the Deputy Undersecretary for Health for Operations and Management issued a memorandum to all VISN Directors regarding "Inappropriate Scheduling Practices." This memorandum called for immediate facility reviews of

current scheduling practices to identify and eliminate all inappropriate practices, and included a list of known "gaming strategies" for decreasing the appearance of excessive patient wait times.

In October 2013, the Hines VAH issued Policy Memorandum # 578-13-001P-002, entitled "Paper Logbook Policy," to establish policy guiding the limited use of paper logbooks containing Individually-Identifiable Information and Individually-Identifiable Health Information throughout the Hines VAH and community-based outpatient clinics. This policy prohibits the use of paper logbooks, which are defined as follows:

> ***Paper Logbooks***: Any written record of activity or events comprised of data which may uniquely identify an individual or contain sensitive personal information and maintained over a period of time for the purpose of tracking information or creating a historic record. Examples include laboratory or morgue disposition logs, autopsy logs, wound care logs, facility access logs, logs of cases cleared, and logbooks of hearing attendance.

This policy does, however, provide exceptions for rare instances when a paper log may be required by directive or compelling business requirement. If so, a memorandum must be submitted to the Hospital Director outlining why this is necessary. If approved, they are allowed and must be in a locked cabinet or room.

Findings:

Dr. Kelly Phipps Maieritsch, a psychologist and Program Manager of the Trauma Services division of the Mental Health Service line, created a database to aid in tracking veterans' treatments. The Whistleblower stated that the database was created in response to the mandate from VA Central Office that patients receive care within 14 days, however, Dr. Maieritsch started utilizing the database in approximately 2008, long before the 2011, 14-day mandate.

The database consists of three separate databases; one for referrals, one for the Core Program, and one for treatment. The database is used in addition to VistA, CPRS, and other VA programs. It is not used in their place or to circumvent its use.

The Core Program is a two-day orientation program used as a clinical tool to begin the process of treatment for Post-Traumatic Stress Disorder (PTSD). Dr. Maieritsch created the program while at a different VA facility and with no consideration for VA Central Office-mandated wait time goals. Dr. Bruce Roberts, Chief of Mental Health, confirmed that the Core Program was not created in response to a performance measure but instead was developed as a tool to offer group sessions to better

serve veterans reluctant or apprehensive to come in for mental health treatment.

The database is used to comprehensively track veterans' care in a way currently not possible with VistA, CPRS, and other VA programs. The database is held on a shared protected drive, to which all clinicians in her section have access. Dr. Roberts is aware of its existence, as is the National Center for PTSD, and Dr. Jeffrey Murawsky, VISN 12 Director.

Dr. Maieritsch stated veterans are immediately scheduled for appointments in VistA, as available. No Trauma Services' clinicians have scheduling access. Clinicians complete scheduling sheets for each veteran and submit them to MSAs assigned to Mental Health for entry into VistA.

Dr. Maieritsch asserted that the allegation her database was intended as a means in which to artificially lower wait times is "ridiculous." She went on to explain that the VistA system is not reflective of the nature of on-going mental health treatment and the concept of desired date is not really applicable in the context. She maintained veterans are being seen in a timely manner, within facility goals, and when they want to be seen.

Conclusion: There is no evidence to suggest the tracking tools utilized by Mental Health are in conflict with VHA Directive 2010-027 or used with intent to hide delays in treatment. It appears the Trauma Services database with related spreadsheets, which are located on a shared drive, is used to assist in the tracking of modern mental health treatment in a way that antiquated VA scheduling software was deficient.

Recommendation: None

Allegation #2: ***That scheduling staff in certain units were improperly directed to "zero out" patient wait times in violation of agency policy WAS substantiated.***

Regulations: N/A

Policy: VHA Directive 2010-027, VHA Outpatient Scheduling Process and Procedures, effective June 9, 2010 and expiring June 30, 2015, provides policy for implementing processes and procedures for the scheduling of outpatient clinical appointments and for ensuring the competency of staff directly or indirectly involved in any or all components of the scheduling process.

In April 2010, the Deputy Undersecretary for Health for Operations and Management issued a memorandum to all VISN Directors regarding "Inappropriate Scheduling Practices." This memorandum called for immediate facility reviews of

current scheduling practices to identify and eliminate all inappropriate practices, and included a list of known "gaming strategies" for decreasing the appearance of excessive patient wait times.

Findings: There were a total of 15 MSAs and MSA supervisors interviewed by the OIG investigators. There was clear consistency in witness statements regarding instructions they were provided by former PAS Chief, Donna Fagan versus current PAS Chief, Christopher Wirtjes.

Ms. Fagan, who was the PAS Chief immediately prior to Mr. Wirtjes, was hired in approximately January 2011. Before Ms. Fagan assumed her supervisory role as Chief, if patient appointment wait times were greater than 30 days, MSAs were given lists of such appointments and told to change the dates in the VistA system to show a smaller wait time. Under Ms. Fagan's supervision, the above practice was stopped.

After the departure of Ms. Fagan and under the supervision of the current PAS Chief, Mr. Wirtjes, MSAs were once again given lists of appointment wait times exceeding 14 days, told to enter the VistA system and told to change desired dates in order to decrease the wait times to the 14-day window.

Mr. Wirtjes revised a Power Point presentation, previously created by Ms. Fagan, to reflect his scheduling methods and asked MSA supervisors to re-train the MSAs. MSAs were re-trained in September 2013. Mr. Wirtjes told the MSA supervisors to instruct their MSAs to find open appointments in VistA and then "back out" of the system. MSAs were then told to schedule an appointment by setting the desired date as the same date as the actual appointment, making the wait time appear to be zero days.

A report called the "Priscilla Report" has been generated for many years by employee Priscilla Hartel. This report is an Excel spreadsheet officially known as an Information Resource Management (IRM) Data Run and shows appointments where the wait times exceed 14 days. This report is distributed to Lead MSAs who, in turn, sort the lists by MSA names and distribute the lists to those MSAs. Under Ms. Fagan, this list was used to "fix" clerical errors only. Under Ms. Wirtjes, "fixing errors" meant that MSAs were to go back into the VistA system, cancel the appointment in question, then immediately re-make the appointment with a desired date showing the same as that of the appointment date, which decreased the wait time to zero.

There was a meeting held sometime between July and October 2013 during which Mr. Wirtjes told staff that the Hines wait times numbers were the worst in VISN 12. He also instructed staff to start using the "back out method" and "make the numbers look good."

Mr. Wirtjes further stated that his only intent with using the Priscilla Report was to educate MSAs. He denied receiving results of Priscilla Report "fixes". He also denied instructing MSA supervisors or anyone in their chain of command to purposely alter dates in the VistA system in response to the Priscilla Report.

After the Phoenix VA Medical Center investigation was conducted, revealing manipulation of wait times, Mr. Wirtjes told MSAs that the MSA supervisors "misunderstood" his orders and that he never gave instructions to alter appointment desired dates. Although he agreed that wait time data was being changed, resulting in better wait times numbers, Mr. Wirtjes blamed the MSAs and MSA supervisors for their misunderstandings of the situation.

Mr. Wirtjes stated that he met with the MSA supervisors in approximately September 2013 and instructed them to view appointments as part of the discussion with the veteran, and if the veteran didn't care and agreed to another available appointment date, to treat the new date as the desired date. He later realized this was too liberal and was in the process of updating these directions immediately prior to the OIG investigation.

Conclusion: It has been clearly shown that MSAs were changing data within the VistA system under the direction of MSA supervisors. Both MSAs and MSA supervisors asserted these orders originated from PAS Chief, Mr. Wirtjes. The interpretation of scheduling processes, in specific regard to desired date interpretation and negotiation of desired date with veterans, varied across the MSAs interviewed. Mr. Wirtjes admitted to implementing scheduling methods in which the MSAs could encourage agreement from veterans for alternate desired dates closer to the scheduled appointment dates. While arguably practical, this violates Veterans Health Administration (VHA) Scheduling Directive 2010-027.

Recommendation: Administrative action should be taken against the PAS Chief for violation of the VHA Scheduling Directive 2010-027. As of the writing of this report, Hines' VA Medical Center senior management and Human Resource Service have received the complete evidence file in order to determine what kind of appropriate administrative action should be taken against the PAS Chief. This is being handled at the local level.

Allegation #3: ***That Management's failure to adhere to scheduling protocols and the use of improper scheduling practices have created a false appearance of acceptable wait times, while making significant delays in veteran's access to care was NOT ABLE TO BE substantiated.***

Regulation: N/A

Policy: VHA Directive 2010-027, VHA Outpatient Scheduling Process and Procedures, effective June 9, 2010 and expiring June 30, 2015, provides policy for implementing processes and procedures for the scheduling of outpatient clinical appointments and for ensuring the competency of staff directly or indirectly involved in any or all components of the scheduling process.

In April 2010, the Deputy Undersecretary for Health for Operations and Management issued a memorandum to all VISN Directors regarding "Inappropriate Scheduling Practices." This memorandum called for immediate facility reviews of current scheduling practices to identify and eliminate all inappropriate practices, and included a list of known "gaming strategies" for decreasing the appearance of excessive patient wait times.

Findings: Ms. Fagan, previous PAS Chief, stated that she believed former Medical Center Directors, Sharon Helman and Joan Ricard, had no idea manipulation of data was occurring. She further stated that she believes Assistant Director, Kenny Sraon's re-implementation of the questioned scheduling practices was done out of ignorance and a lack of understanding of the MSA scheduling process as opposed to an intent to "scam" anyone or anything.

When he began at Hines as Assistant Director on November 4, 2012, Mr. Kenny Sraon, had a dialogue with Dr. Brian Hertz, Associate Chief of Staff, and other senior staff regarding scheduling wait time issues. Dr. Hertz asserted MSAs were making "scheduling errors," which made wait times appear longer. Mr. Sraon was not ingrained in the details nor did he fully understand them. He received the "Priscilla Report" as did other senior leaders. He asked Mr. Wirtjes to explain the Priscilla Reports to him and Mr. Wirtjes explained that errors were identified in the difference between the "create date"[4] and actual appointment dates, which resulted in numbers ranging from negative figures to positive figures. His understanding from Mr. Wirtjes was that numbers in the zero and one range were deemed likely "clerical errors," which were then re-addressed. When shown a "Priscilla Report" by the OIG, it was pointed out that the difference in desired date and appointment date was what actually populated the list. Mr. Sraon stated he was unaware of this distinction.

Mr. Sraon stated that he had observed most MSA scheduling training had been handled "verbally" by Donna Fagan. He urged the training to be changed to include giving employees access to VHA handbooks and directives so that they could be

[4] Although this term is not referenced in VHA Directive 2010-027, it is interpreted to mean the date the appointment is put into the VistA system.

trained correctly. He did not comprehend in detail the issues/problems involving scheduling at that time.

Mr. Sraon selected Chris Wirtjes to be the new PAS section chief after the departure of Ms. Fagan. He relied on Mr. Wirtjes and Joan McKenzie-Hobbs, Assistant Chief, PSA, to properly train MSA supervisors and MSAs on how to schedule patient appointments according to VHA policy.

Since Mr. Sraon arrived at Hines and prior to the recent issues, he was unaware anyone was manipulating desired dates in VistA. Mr. Sraon did acknowledge seeing the memorandum regarding "Inappropriate Scheduling Practices", dated April 26, 2010. Prior to this investigation and recent media coverage, he was not aware any of these practices were occurring at Hines. He does not believe any pressure to "fix" wait time numbers comes from the directorship at Hines.

Mr. Sraon provided various e-mails in which he addressed possible scheduling errors by MSAs and the need for training to include proper ways to interpret and enter desired dates. The e-mails show dialogue among Mr. Sraon, Mr. Wirtjes and senior management in 2013, wherein management appears to be imploring proper training and adherence to the scheduling directive and proper use of the Electronic Wait List.

Dr. Hertz testified that he never instructed Mr. Wirtjes to manipulate desired dates and he never received orders from anyone above him to have the numbers manipulated.

Marivic Gregorio, Quality Improvement and Systems Specialist, testified that nobody senior to her ever asked her to have MSAs change desired dates or any appointment information.

Dr. Jack Bulmash, Chief of Staff, testified neither he, nor anyone in the directorship at Hines, has ever ordered or condoned the deliberate falsifying of access to care data. He believes if any intentional changing of data directed by mid-level management occurred, it was only intended to improve accuracy and decrease input errors by MSAs. He had no knowledge or understanding of why Mr. Wirtjes would train or instruct MSAs to change desired dates other than for legitimate data accuracy.

Ms. Joan Ricard, former Hines Medical Center Director, testified that she was familiar with the memorandum regarding "Inappropriate Scheduling Practices", dated April 26, 2010. When she came to Hines, she was made aware of MSA clerical errors and issues regarding desired date interpretation. Ms. Ricard stated that she never ordered any data manipulations or otherwise instructed anyone to engage in such

practices. She was unaware that data was being changed, other than the aforementioned MSA input / clerical errors, over which she had various conversations with Chris Wirtjes.

The OIG showed Ms. Ricard an e-mail, dated April 9, 2014, wherein the VISN 12 Director, Dr. Murawsky, referenced a hearing where the VA "took a beating" on access and advised Ms. Ricard that Hines had access issues. She replied to Dr. Murawsky that sustained improvement takes time and that: "If you want me to put a band aid on it and do what the majority of other facilities do and do work-arounds, I am unwilling to do so. I am willing to defend the approach we are taking and if this is not quick enough for Congress then they will need to find another Director." After reviewing this email Ms. Ricard stated she was aware that other facilities in the past have used "band aid solutions", i.e. numbers gaming work-arounds, but she has never and will not utilize such scheduling tactics to improve access numbers. She was not aware MSAs were changing desired dates at the behest of their supervisors until recently when audits and investigations were being done. She believed MSA supervisors and MSAs misinterpreted correction of clerical errors to be simply changing desired dates. She recently learned from speaking with MSAs that they were being told to change desired dates by their supervisors and that they feared retaliation if they did not. She was not previously aware of this. She doesn't know why Mr. Wirtjes would say he felt pressure from anyone in the Director's Suite to change desired dates.

All facility senior leaders were aware of challenges with scheduling, especially in measuring access and wait times. Dr. Murawsky echoed this sentiment. In addition, he stated that, as a provider, he knows there are long wait times for care. As an administrator, he knows that desired date-based data is very inaccurate, with a lot of room for human error by MSAs in interpretation of desired date.

Dr. Murawsky was not aware Mr. Wirtjes had re-implemented "block scheduling". He has never ordered or otherwise instructed any staff to intentionally alter data to hide wait times.

There was no testimony from MSAs, MSA supervisors, or either Ms. Fagan or Mr. Wirtjes that facility senior leadership instructed them to alter the desired date or manipulate wait times.

Conclusions: There is no evidence to suggest management above Mr. Wirtjes had knowledge of improper scheduling practices. In addition, the Patient Advocate Office provided copies of approximately 1,100 patient complaints for review by the OIG investigators. The complaints were neither supportive of allegations made during the

investigation, nor were they indicative of problems which can be associated with intentional schemes to hide wait time data at the Hines VA Medical Center.

Documents Reviewed

1. VHA Directive 2010-027, VHA Outpatient Scheduling Process and Procedures, dated 06/09/10 and expiring 06/30/15
2. Memorandum Re: "Inappropriate Scheduling Practices", dated 04/26/10.
3. Hines Policy Memorandum 578-13-001P-002, Paper Logbook Policy dated 10/21/13.
4. Letter from Senator Mark Kirk to Richard Griffin, dated 05/21/14.
5. Memorandum from Ms. Joan Ricard to Hines' employees, Re: Accuracy in Scheduling Practices, dated 05/08/14.
6. Letter from Senator Mark Kirk to Sloan Gibson, dated 07/03/14.
7. E-mail from Dr. Bruce Roberts, dated 05/06/14 and e-mail from Joan Ricard, dated 5/8/2014.
8. Transcript of interview of Ms. Germaine Clarno, dated 05/27/14.
9. VA Central Office Site Visit Close-Out Report, dated 05/14/14.
10. Fax cover page and e-mail from Deborah Dear, dated 05/14/14.
11. First eight pages of an IRM Data Report, known as a "Priscilla Report," dated 05/13/14.
12. "Scheduling Business Rules" PowerPoint presentation, dated 05/10/13.
13. "Scheduling Business Rules" PowerPoint presentation, dated 09/12/13.
14. Two letters of inquiry issued by Ms. Carla Logan, dated 12/03/14 and 12/04/14.
15. Complaint letter of Mr. Rashard Knighten.
16. Transcript of interview of Mr. Christopher Wirtjes, dated 05/19/14.
17. Blank sample pages of the databased referenced by Dr. Kelly Phipps Maieritsch during her interview
18. Memorandum for Record, dated 07/17/14.
19. E-mails of Ms. Deborah Dear dated 11/14/13, 3/12/14 and sample Minor Local Procedure log
20. E-mails provided by Mr. Karandeep (Kenny) Sraon from July through November 2013.
21. E-mail of Dr. Jack Bulmash, dated 04/24/14.
22. E-mail between Dr. Jeffrey Murawsky and Ms. Joan Ricard, dated 4/9/14.
23. E-mails between Hines VA Medical Center and VISN 12 management between 2010 and 2014.
24. E-mail of SA Greg Porter to Ms. Germaine Clarno and attorney, dated 07/28/14.
25. Office of Inspector General Report, File No. 2014-02891-IC-0072