

Department of Veterans Affairs Office of Inspector General

Office of Healthcare Inspections

Report No. 15-01283-220

Healthcare Inspection

Alleged Employee Intimidation Related to Research Study Results VA North Texas Health Care System Dallas, Texas

March 28, 2016

Washington, DC 20420

In addition to general privacy laws that govern release of medical information, disclosure of certain veteran health or other private information may be prohibited by various Federal statutes including, but not limited to, 38 U.S.C. §§ 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, OIG adheres to privacy and confidentiality laws and regulations protecting veteran health or other private information in this report.

To Report Suspected Wrongdoing in VA Programs and Operations: Telephone: 1-800-488-8244 E-Mail: vaoighotline@va.gov

Web site: <u>www.va.gov/oig</u>

Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections reviewed an allegation by a third party that an employee conducting research was intimidated by managers after notifying them of preliminary research study data that, per the complainant, reflected negatively on the VA North Texas Health Care System (VANTHCS), Dallas, TX.

We could not substantiate that VANTHCS managers threatened the employee with job reassignment after she presented the preliminary findings of her research study. We found that the current Associate Director for Patient Care Services (ADPCS) was performing appropriate stewardship of resources when he began reassigning staff in unapproved positions back to either their former positions or equivalent vacant positions within the Nursing Service. The current ADPCS made good faith efforts to meet the employee's needs and requests while ensuring adequate staffing.

We also could not substantiate that the employee's professional reputation was threatened. Managers did not prohibit the employee from continuing to work on the study and offered to provide data analysis support—actions that were inconsistent with a finding that the employee's job and reputation were threatened *because* of the preliminary study results. As of April 2015, the employee was analyzing the data and summarizing the results.

The timing of the current ADPCS' position management actions and the employee's notification to managers of her preliminary research findings appeared coincidental. We made no recommendations.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with our report. (See Appendixes A and B, pages 7–8 for the Directors' comments.)

John V. Daigh. M.

JOHN D. DAIGH, JR., M.D. Assistant Inspector General for Healthcare Inspections

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections reviewed an allegation by a third party that an employee conducting research was intimidated by managers after notifying them of preliminary research study data that, per the complainant, reflected negatively on the VA North Texas Health Care System (VANTHCS), Dallas, TX. The purpose of the review was to determine whether the allegations had merit.

Background

VANTHCS is part of Veterans Integrated Service Network 17 and provides a broad range of inpatient and outpatient health care services to nearly 117,000 veterans in 40 counties in northern Texas and southern Oklahoma. VANTHCS has 853 hospital beds and Community Living Center beds and also has an active Research and Development Department with more than 90 principal investigators and 400 research staff. VANTHCS has approximately 5,000 employees.

An Institutional Review Board (IRB) is a board, committee, or other group formally designated by an institution to review, approve, require modification in, disapprove, and conduct continuing oversight of human research in accordance with applicable VA and Federal requirements.¹

Allegations

In November 2014, a third-party complainant notified the Office of Research Oversight (ORO) of concerns that an employee at the VANTHCS was told she would be reassigned and that her professional reputation would be discredited if she published, or otherwise made public, findings related to workplace bullying² at the VANTHCS. The complaint fell outside of ORO's jurisdiction³ and was forwarded to OIG for review.

Scope and Methodology

The review period for this inspection was from December 1, 2014, to May 7, 2015.

We interviewed the subject employee, the Chief of Research and Development, the current Chief of Nursing Research (CNR), the current Associate Director for Patient

¹ VHA Handbook 1200.05, *Requirements for the Protection of Human Subjects in Research*, November 12, 2014.

² In a June 11, 2014, memorandum, the acting Secretary of VA outlined the Department's support of Equal Employment Opportunity, Diversity and Inclusion, No FEAR, and Whistleblower Protection. The memorandum defined "bullying conduct" as fighting, threats, and intention to inflict harm or abusive, offensive, unprofessional, intimidating, slanderous, malicious, derogatory, or otherwise inappropriate or unacceptable language intended to degrade or humiliate a particular person or group of people.

³ ORO serves as the primary VHA office in advising the Under Secretary for Health on all matters of compliance and assurance regarding human subject protections, animal welfare, research safety and security, research information protection, and research misconduct.

Care Services (ADPCS),⁴ the Chief of Human Resources (HR), and additional staff knowledgeable about these issues. We reviewed documents including the study protocol, IRB meeting minutes, HR-related letters, and emails.

We **substantiated** allegations when the facts and findings supported that the alleged events or actions took place. We **did not substantiate** allegations when the facts showed the allegations were unfounded. We **could not substantiate** allegations when there was no conclusive evidence to either sustain or refute the allegation.

We conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

⁴ The ADPCS is the Chief Nurse Executive and is responsible for Nursing Service and other clinical departments.

Inspection Results

We could not substantiate that a VANTHCS manager attempted to reassign an employee after the employee notified supervisors of preliminary study data on workplace bullying, nor could we substantiate that the employee was told she would be professionally discredited if she published or otherwise made public her findings.

Sequence of Events

From 1989 to 2006, the employee worked as an operating room (OR) surgical technician at VANTHCS. Due to medical and other concerns, the employee requested, and received, a change to her work arrangement. In 2006, the former ADPCS (ADPCS-1) assigned the employee to provide pre-operative patient education and assist with "special projects" such as environment of care rounds and reusable medical equipment inspections. The employee's work hours were from 5:00 am to 1:30 pm, and she was supervised by the administrative officer for Nursing Service. Reportedly, ADPCS-1 made similar arrangements for other staff.

A new ADPCS (ADPCS-2) functioned in an acting role from February to June 2012 and accepted the position on a permanent basis in December 2012. During this time, ADPCS-2 began moving employees assigned to special projects by ADPCS-1 back to their previous, or similar, approved positions. The employee approached ADPCS-2 to discuss a research proposal focusing on workplace bullying. ADPCS-2 reviewed the proposal and forwarded it to the former CNR (CNR-1) to review. CNR-1 reportedly endorsed the proposal in June 2013.

In July 2013, VANTHCS' IRB reviewed the initial protocol submission for the employee's research study. The IRB disapproved the study protocol documenting, "There does not appear to be sound scientific methodologies for this project and the reviewers questioned the [project lead's] qualifications for conducting this kind of study." The employee made revisions and resubmitted the proposal in October; however, the discussion was tabled. In November 2013, the IRB approved the protocol for 12 months. The employee was granted some duty time to work on the research study. This was in addition to her normal duties; she was still assigned to pre-operative education when not conducting her research.

Per the protocol, the study would consist of a 30-minute (Phase I) questionnaire with 250 individuals who self-identified during the recruitment process as targets of some form of workplace bullying or with knowledge of the phenomenon. In December 2013, the employee began recruiting for study participants through VANTHCS' daily bulletin. After completing an estimated 32 interviews, the employee reported identifying a "disturbing pattern that warranted attention" and notified the new CNR (CNR-2) of her concerns.⁵

⁵ CNR-2 was hired in January 2014 but was not assigned to supervise the employee until April.

In early March 2014, the employee presented to CNR-2 and ADPCS-2 preliminary study findings, which generally reflected that interviewees thought bullying was a problem at VANTHCS, and some interviewees reportedly made aggressive and violent statements about how they wanted to respond to acts of bullying. Further, interviewees reportedly said that current systems to address workplace discord, such as through HR, the Equal Employment Opportunity office, and the Union, were ineffective. ADPCS-2 asked the employee to follow up on several issues and report back.

In May 2014, a meeting was scheduled between the employee, CNR-2, and ADPCS-2 to discuss the status of the research study, and in June, the employee provided the VANTHCS Director with a copy of the preliminary findings. A meeting was held in mid-June involving upper-level VANTHCS managers, and CNR-2 was assigned to assist the employee with data analysis.

In early July 2014, the employee received an email stating that she would be *detailed* to the Non-VA Care Coordination program for 3–6 months to assist with consult closures. After the employee told her supervisors that the position required a nurse to fulfill the duties, the assignment was terminated. This assignment lasted 2 weeks. The employee continued to work on her study during this time period. The employee returned to her pre-operative education role and continued to conduct her research study.

In mid-August, the employee presented her study findings again to CNR-2 and ADPCS-2 and proposed that VANTHCS create a "multi-faceted anti-bullying program that addresses workplace bullying for employees separate from any other programs in the organization." The employee proposed that the program be supported by five staff members. According to ADPCS-2, this was the last time he discussed the research study with the employee. After the meeting, the employee continued to conduct her research study.

In the first quarter of fiscal year 2015, ADPCS-2 made additional efforts to reassign the employee from pre-operative education to other select positions, as follows:

- An October 2014 memo assigned the employee to Sterile Processing Service. The Union subsequently requested a 2-week delay in reassignment, which was granted. However, this assignment was later rescinded because of position grade level conflicts.
- A November 2014 memo *detailed* the employee to a program support position in the critical care unit for 90 days. The employee, citing her previously agreed-upon work hours of 5:00 am to 1:30 pm, declined to work the 7:30 am to 4:00 pm hours needed in the unit.⁶
- A December 2014 memo assigned the employee to clerical duties for 30 days in the 9th floor reception area. The same memo stated that in January, the employee

⁶ The employee reportedly had a second job in the afternoon.

would return to her previous position as an OR technician with duty hours from 9:00 am to 5:30 pm. This memo reminded the employee that staff could not engage in outside employment or any other outside activity that conflicts with his or her official duties.

In December 2014, the employee requested workplace adjustments to include a modified work schedule and other environment-related requests. Nursing Service did not have an appropriate position, and in February 2015, the employee reported to the Readjustment Counseling Service for an interim position. As of April 2015, the employee told us she had completed all of the study-related interviews and was analyzing the data.

Assessment/Findings

We could not substantiate that the employee was reassigned or was threatened with reassignment *because of* her preliminary study findings. VANTHCS managers' lack of actions—specifically, to discontinue or attempt to discontinue the research study, prohibit the employee from working on the study, or attempt to suppress the preliminary study results—did not appear to support the allegation. In April 2015, the employee told us that she was analyzing data and summarizing the results.⁷ Previously, ADPCS-2 also reported that with "additional guidance" [to assist the employee], results of the study could still be published.⁸

We found that VANTHCS managers had legitimate reasons for attempting to reassign the employee because, since 2006, the employee had not been in a position approved through formal management HR channels. We concluded that while the timing of some personnel management actions may have appeared suspicious to the employee and complainant, these actions were reasonable and appropriate to assure adequate staffing in key clinical areas.

We could not substantiate what the employee was allegedly *told* regarding her professional reputation. We received conflicting testimony as to the content of the various discussions between the employee and her supervisors, but as described above, we found that managers' actions in allowing the employee to continue the study and offering to provide data analysis support were inconsistent with a finding that the employee's reputation was threatened.

Conclusions

We could not substantiate that VANTHCS managers attempted to reassign the employee to a different job after she presented the preliminary findings of her study on workplace bullying. We found that ADPCS-2 was performing appropriate stewardship of resources when he began reassigning staff from unapproved positions back to either

⁷ The IRB granted a 12-month continuation of the study to allow for follow-up and data analysis.

⁸ We conducted the interview in January 2015.

their former positions or equivalent vacant positions within the Nursing Service. ADPCS-2 made good faith efforts to meet the employee's needs and requests while ensuring adequate staffing.

We could not substantiate what the employee was allegedly told regarding her professional reputation. However, managers did not prohibit the employee from continuing to work on the study and offered to provide data analysis support; these actions would be inconsistent with a finding that the employee's job and reputation were threatened *because of* the preliminary study results. As of April 2015, the employee was analyzing the data and summarizing the results.

The timing of ADPCS-2's position management actions and the employee's notification to managers of her preliminary research findings appeared coincidental.

We made no recommendations.

Appendix A

VISN Director Comments

Memorandum **Department of Veterans Affairs** January 19, 2016 Date: From: Director, VA Heart of Texas Health Care Network (10N17) Subj: **Draft Report**—Healthcare Inspection – Alleged Employee Intimidation Related to Research Study Results, VA North Texas Health Care System, Dallas, TX Director, Atlanta Office of Healthcare Inspections (54AT) To: Director, Management Review Service (VHA 10AR MRS OIG Hotline) 1. I have reviewed the draft report and concur with the report's findings. Attached is the facility's response to the report. 2. If you have any questions or need additional information, please contact Denise Elliott, Quality Management Manager, VISN 17, at (817) 385-3734. etwork Directo

Appendix B

Facility Director Comments

Memorandum **Department of** Veterans Affairs January 5, 2016 Date: From: Director, North Texas VA Health Care System (549/00) Subj: Draft Report—Healthcare Inspection – Alleged Employee Intimidation Related to Research Study Results, VA North Texas Health Care System, Dallas, TX To: Director, VA Heart of Texas Health Care Network (10N17) 1. Thank you for the opportunity to view the draft report related to Alleged Employee Intimidation at VA North Texas Health Care System (VANTHCS). We appreciate the thorough review and concur with the report as written. 2. If you have any questions or need additional information, please contact Deanna Boyer, Chief, Quality, Safety & Value, at (214) 857-0200. For And In The Absence Of Jeffery L. Milligan (original signed by:) Peter Dancy Associate Director

Appendix C

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Victoria Coates, LICSW, MBA Sheyla Desir, RN, MSN Alan Mallinger, MD Joanne Wasko, MSW, LCSW

Appendix D

Report Distribution

VA Distribution

Office of the Secretary Veterans Health Administration Assistant Secretaries General Counsel Director, VA Heart of Texas Health Care Network (10N17) Director, North Texas VA Health Care System (549/00)

Non-VA Distribution

House Committee on Veterans' Affairs House Appropriations Subcommittee on Military Construction, Veterans Affairs, and **Related Agencies** House Committee on Oversight and Government Reform Senate Committee on Veterans' Affairs Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and **Related Agencies** Senate Committee on Homeland Security and Governmental Affairs National Veterans Service Organizations **Government Accountability Office** Office of Management and Budget U.S. Senate: John Cornyn, Ted Cruz U.S. House of Representatives: Joe Barton, Michael Burgess, K. Michael Conaway, Bill Flores, Louie Gohmert, Kay Granger, Jeb Hensarling, Eddie Bernice Johnson, Sam Johnson, Kenny Marchant, Randy Neugebauer, John Ratcliffe, Pete Sessions, Mac Thornberry, Marc Veasey, Roger Williams

This report is available on our web site at www.va.gov/oig.