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The Special Counsel

June 1, 2016

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

Re: OSC File Nos. DI-14-2839 and DI-14-2975

Dear Mr. President:

Pursuant to my duties as Special Counsel, I am forwarding a Department of Veterans Affairs' (VA) report based on disclosures of wrongdoing at the Carl T. Hayden Veterans Affairs Medical Center (the Hayden VAMC), Phoenix, Arizona. I have reviewed the report and in accordance with 5 U.S.C. §1213(e) provide the following summary of the agency report, whistleblower comments and my findings.[1] The whistleblowers, Paula L. Pedene, a VA public affairs officer, and Pauline DeWenter, a medical support assistant, who consented to the release of their names, alleged that managers at Hayden VAMC failed to address or resolve serious and life threatening deficiencies in patient care and access and have engaged in illegal patient scheduling practices.

I referred the whistleblowers' allegations to then-Acting Secretary Sloan D. Gibson on June 20, 2014, for investigation pursuant to 5 U.S.C. § 1213(c) and (d). On July 31, 2014, the VA Office of Inspector General (OIG) informed the Office of Special Counsel (OSC) that the allegations were the subject of a criminal investigation. Between July 2014 and November 2015, OIG informed OSC on five separate occasions that the matter remained under criminal investigation. In response, OSC postponed the due date for the VA's report several times. On November 16, 2015, representatives from the OIG informed OSC that the allegations in OSC's referral were addressed in an OIG report released on August 26, 2014, entitled Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System, and that this

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

report constituted the VA's response under 5 U.S.C. § 1213. Despite the regular communication about this matter, the VA did not notify OSC that this report was the agency's response to OSC's referral or that the report had been publicly released.

After reviewing this initial report, OSC determined it was not responsive to certain allegations originally referred for investigation, and as a result, on November 18, 2015, OSC requested a supplemental review of six specific issues. The Secretary requested the Office of the Medical Inspector (OMI) provide a response to these allegations. Under Secretary for Health David J. Shulkin, M.D.. was delegated the authority to review and sign the OMI supplemental report, which was submitted to OSC on February 26, 2016. The whistleblowers provided comments on March 30, 2016.

The initial report substantiated the whistleblowers' allegations, determining that barriers to care—such as limited clinic hours and failure to follow VA scheduling policy—adversely affected the quality of primary and specialty care at the Hayden VAMC. The investigation identified over 3,500 veterans—many of whom were placed on unofficial wait lists—who were at risk of never obtaining requested or necessary medical appointments. In addition, the initial report determined that Hayden VAMC schedulers were using inappropriate scheduling practices and that executives and senior-level staff were aware of these improprieties. The initial report identified 28 instances of clinically significant delays in care associated with improper scheduling. Six of the 28 patients died waiting for care. In response, the agency implemented a variety of corrective actions to improve access to care and eliminate improper scheduling practices.

The agency's supplemental report indicated that the Hayden VAMC also created procedures to prevent the use of "ghost panels," or rosters of patients who have not been reassigned to a primary care provider after their provider leaves the VA. The whistleblowers alleged this practice was pervasive at the Hayden VAMC, and was used to create the appearance that large numbers of patients were being treated in order to justify receiving additional agency funding. The supplemental report also addressed allegations concerning the availability of weekend medical care, noting that the Hayden VAMC has operated three Saturday clinics since June 2013 and is reassessing the need for clinics on holiday weekends to expand access to care. In response to allegations asserting that Hayden VAMC employees improperly returned deceased veterans to patient waiting lists to conceal that these individuals died waiting for care, the supplemental report explained that deceased veterans were automatically placed back on electronic waiting lists due to automated administrative routines in agency computer systems. The report found no evidence of improper conduct or employee involvement in these errors and noted that this computer issue has since been corrected. Finally, the supplemental report asserted that improper scheduling practices have ceased and new Hayden VAMC managers working to ensure appropriate and prompt access to care.

The whistleblowers disputed the findings in both reports. They asserted that available evidence supported the conclusion that ghost panels were used extensively to

allow the Hayden VAMC to receive agency funding for a large number of patients, even though patients were not assigned to providers and did not receive care. The whistleblowers also explained that while there are Saturday clinics, there are no clinics in place for new patient appointments on weekends. Ms. DeWenter specifically disputed the explanations for why deceased veterans were returned to waitlists. She explained that she provided evidence to the VA OIG regarding manual data manipulation and alleged that the OIG's conclusions are inaccurate and not supported by the available facts.

I have reviewed the original disclosures, the agency reports, and the whistleblowers' comments. The misconduct at issue in this matter is serious and hurt a vulnerable population of patients. In addition, the agency's response to OSC's referral was unnecessarily delayed. Over a 16-month period, OIG informed OSC five times that a criminal investigation into these allegations was ongoing. Therefore, OSC granted repeated extensions of time for a response. However, OIG subsequently notified OSC that it believed the allegations OSC referred were addressed in a report released only one month after OSC sent the VA its referral. While together the IG report and OMI's supplemental report meet all statutory requirements and the findings appear reasonable, it is important that interagency communication improves to ensure against unnecessary delays and government waste when OSC refers cases.

As required by 5 U.S.C. § 1213(e)(3), I have sent a copy of this letter, the agency reports, and the whistleblower comments to the Chairmen and Ranking Members of the Senate and House Committees on Veterans' Affairs. I have also filed copies of these documents in our public file which is available at www.osc.gov. This matter is now closed.

Respectfully,

Carolyn Lerner

Carolyn N. Lerner

Enclosures