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The Special Counsel

April 3, 2020

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

Re: OSC File Nos. DI-19-0865

Dear Mr. President:

I am forwarding a report from the Department of Veterans Affairs (VA), based on disclosures of wrongdoing at the Central Alabama Veterans Health Care System (CAVHCS), Montgomery and Tuskegee, Alabama. The whistleblower, [redacted], a staff physician and [redacted], alleged that CAVHCS mismanaged the closure of a contract primary care clinic thereby compromising patient access to care.[1] I have reviewed the disclosure and the agency report, and in accordance with 5 U.S.C. §1213(e) provide the following summary of the agency investigation and my findings.

[redacted] alleged that in November 2018, VA's contract expired with a service provider at the Dothan Clinic. During the closure process, CAVHCS failed to provide guidance to the provider, CR Associates (CRA), on maintaining patient continuity of care. He explained that approximately 4,500 patients were transferred to another facility, the Wiregrass Clinic, and placed on panels with no assigned provider, a practice commonly referred to as "ghost panels," or with providers whose panels were already full. [redacted] also asserted that the Dothan Clinic closure, coupled with employee departures, resulted in several additional CAVHCS ghost panels at other clinics. He further noted that due to the influx of patients to new clinics, providers including the whistleblower were pressured to approve the refill of controlled substance medications without personally examining patients.

The agency substantiated all of the whistleblower's allegations. The investigation found that CAVHCS grossly mismanaged the closure of the Dothan Community Based Outpatient Clinic (Dothan Clinic), that patients were not properly notified that they were being transferred to other sites of care, and that requiring the whistleblower to prescribe controlled substances for patients he had not personally examined may have violated standards of care and posed a safety risk to patients. The agency also acknowledged that due to the Dothan Clinic closure, patients were placed on ghost panels. Finally, the agency confirmed that the absence of an adequate number of providers impeded patient access to care.

[1]The whistleblower's allegations were referred to Secretary Robert L. Wilkie for investigation pursuant to 5 U.S.C. §1213 (c) and (d). The Office of the Medical Inspector conducted the investigation, and Secretary Wilkie reviewed and signed the report. [redacted] did not provide comments to the report.

The report explained that during the term of CRA's contract, CAVHCS encountered many concerns and conflicts with services provided by non-VA clinicians. Due to the continued conflicts, the contract was not renewed. As the contract closure date approached, CAVHCS was not prepared to transfer 4,500 patients to VA clinics. The investigation found that VA's planning for the clinic closure was fragmented, inconsistent, and ineffective. The report noted that there was no written strategic or operational plan outlining steps in the closure or transition of patients to new providers.

Human resources officials were not included in this transfer process until shortly before the contract expired. Approximately a month before the clinic closed, CAVHCS determined that 38 additional employees were needed to ensure continuity of care for affected patients. No staff were hired before the clinic closed, and CAVHCS continues to have challenges recruiting, hiring, and retaining providers.

CAVHCS eventually hired two nurse practitioners (NPs), who did not have Drug Enforcement Agency licenses, prohibiting them from writing prescriptions for controlled substances such as narcotics. [redacted], who at the time was [redacted], was assigned to write these prescription orders until the NPs obtained their licenses. The report noted "the process of physicians writing controlled substance prescription orders for patients without seeing them or actively examining them is a potential patient safety risk and a potential licensure issue for the covering physicians."

The report also confirmed that a ghost panel existed at the Wiregrass Clinic and found an additional panel of former Dothan Clinic patients assigned to a provider who did not work at the Wiregrass Clinic. Evidence also demonstrated that this panel did not follow appropriate scheduling practices, disrupting the continuity of care for these patients. At the Tuskegee Clinic, investigators found evidence of insufficient provider coverage over several shifts that "may negatively impact patient access to care, continuity of care, and patient safety."

Due to these deficiencies, the report found evidence of delayed wait times and over-paneled providers. Specifically, the report explained that patient assignments for providers at the Dothan and Wiregrass Clinics "are significantly above the recommended panel sizes." There was also limited evidence of written contingency plans for provider shortages. In sum, the agency confirmed that the absence of an adequate number of providers impeded patient access to care.

In response, CAVHCS is presently engaged in recruitment actions to fully and appropriately staff clinics and is now ensuring that prescriptions are issued in full compliance with applicable law. Similarly, efforts are underway to review clinic profiles and ensure appropriate coverage, patient scheduling, and panel sizes. Clinic wait times and panel sizes are now under review by CAVHCS management on a monthly basis to improve wait times and access to care.

I commend [redacted] for bringing forward such serious allegations. The health and wellbeing of our nation's veterans should never be jeopardized due to mismanagement of a facility closure. When access to care was suddenly limited, doctors were pressured to write prescription orders for controlled substances for patients they have not seen. This shortsighted planning and limited healthcare access put the health and safety of thousands of veterans at risk. While I am concerned by the organizational culture that resulted in such significant mismanagement of the Dothan Clinic closure, I am encouraged by the positive steps the VA is taking as result of [redacted] efforts. For these reasons, I have found that the report meets all the statutory requirements and the findings appear reasonable.

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

Respectfully,

Henry J. Kerner
Special Counsel

Enclosure