



U.S. Office of Special Counsel
1730 M Street, N.W., Suite 218
Washington, D.C. 20036-4505

OSC Cites Deficiencies in VA Health Care Reports

FOR IMMEDIATE RELEASE **CONTACT: Nick Schwellenbach, (202) 254-3631; nschwellenbach@osc.gov**

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Today, the U.S. Office of Special Counsel (OSC) reported that the Department of Veterans Affairs (VA) often admits to serious deficiencies in patient care, while implausibly denying any impact on veterans' health. According to [a letter](#) sent by Special Counsel Carolyn Lerner to the White House and Congress, her office reached this conclusion after reviewing reports from cases at VA facilities throughout the country.

According to the Special Counsel's letter, "The VA, and particularly the VA's Office of the Medical Inspector (OMI), has consistently used a 'harmless error' defense, where the Department acknowledges problems but claims patient care is unaffected." This approach hides the severity of systemic and longstanding problems. OSC raised similar concerns previously, and today's letter is OSC's most thorough accounting.

OSC's letter details ten cases where the VA's conclusions appear to contradict its own investigative findings. In one case, the VA's OMI said it could not find "a danger to public health and safety," although its investigators confirmed that nearly 3,000 veterans at a VA facility in Fort Collins, Colorado, were unable to reschedule canceled appointments, including veterans whose "routine primary care needs were not addressed" as a result.

In a second case, a VA psychiatrist disclosed serious concerns about patient neglect in a long-term VA mental health care facility in Brockton, Massachusetts. Specifically, the OMI report substantiated allegations that a veteran with a 100 percent service-connected psychiatric condition was a resident from 2005-2013 but had only one note written in his medical chart. That note, from 2012, addressed treatment recommendations for the first time. Another veteran with significant and chronic mental health issues did not receive his first comprehensive psychiatric evaluation until 2011, more than eight years after he was admitted.

Despite these findings, OMI denied that the confirmed neglect of residents at the facility had any impact on patient care. Given the lack of accountability, OSC requested a follow-up report. The second report continued the VA's "harmless error" approach, concluding: "OMI feels that in some areas [the veterans'] care could have been better but OMI does not feel that their patient's rights were violated."

In a third case, OMI confirmed allegations that, instead of recording current readings from patients, a pulmonologist at a VA facility in Montgomery, Alabama copied prior provider notes in over 1,200 patient records, likely resulting in inaccurate health information being recorded. OMI stated that it could not substantiate whether this activity endangered patient health.

Today's letter also finds unreasonable the VA's response to the following issues at the facility in Jackson, Mississippi:

- Chronic understaffing in the Primary Care Unit resulted in physicians being unable to address critical medical alerts about patients for up to three weeks;
- Improper physician supervision and licensing of nurse practitioners, which the whistleblower alleges has led to misdiagnoses of patients;
- The use of "ghost clinics" – scheduling veterans for appointments without an assigned provider – that resulted in excessive wait times and veterans leaving without treatment;
- Nurse practitioners improperly prescribing narcotics to veterans in violation of federal law; and
- A radiologist's failure to review patients' CT and X-ray images.

OSC has over 50 additional pending disclosure cases alleging threats to patient health or safety at the VA; 29 have been referred to the VA for investigation and the rest are under OSC review for possible referral. These cases represent more than a quarter of all matters referred by OSC for investigation government-wide. And, while today's letter addresses whistleblower disclosures of wrongdoing, OSC is also currently reviewing approximately 60 cases of alleged retaliation against whistleblowers who reported concerns about scheduling, understaffing, and other patient care issues in VA facilities.

The Special Counsel noted her support for recent statements from Acting VA Secretary Sloan Gibson, who recognized the significant contributions whistleblowers make to improving quality of care for veterans. "Moving forward, I recommend that the VA designate a high-level official to assess the conclusions and the proposed corrective actions in OSC reports, including disciplinary actions, and determine if the substantiated concerns indicate broader or systemic problems requiring attention," Special Counsel Lerner stated in the letter.

The URL to the letter can be found at: <https://osc.gov/PublicFiles/FY2014/14-15%20DI-12-3816%20and%20DI-13-1713/14-15%20DI-12-3816%20and%20DI-13-1713%20-%20Letter%20to%20the%20President.pdf>

An in-depth analysis of the Jackson VAMC matters can be found at: <https://osc.gov/PublicFiles/FY2014/14-15%20DI-12-3816%20and%20DI-13-1713/14-15%20DI-12-3816%20and%20DI-13-1713%20-%20Analysis.pdf>

The U.S. Office of Special Counsel (OSC) is an independent federal investigative and prosecutorial agency. Our basic authorities come from four federal statutes: the Civil Service Reform Act, the Whistleblower Protection Act, the Hatch Act, and the Uniformed Services Employment & Reemployment Rights Act (USERRA). OSC's primary mission is to safeguard the merit system by protecting federal employees and applicants from prohibited personnel practices, especially reprisal for whistleblowing, and to serve as a safe channel for allegations of wrongdoing. For more information, please visit our website at www.osc.gov.