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The Special Counsel

November 15, 2013

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

Re: OSC File No. DI-11-3558

Dear Mr. President:

Pursuant to 5 U.S.C. § 1213(e)(3), enclosed please find agency reports based on disclosures made by an employee at the Department of Veterans Affairs, Texas Valley Coastal Bend Health Care System, Harlingen, Texas. The whistleblower, Richard Krugman, MD, who consented to the release of his name, alleged that VA employees engaged in conduct that constituted a violation of law, rule, or regulation, gross mismanagement, a gross waste of funds, an abuse of authority, and a substantial and specific danger to public health in the management and operation of the Health Care Center (HCC) at Harlingen.

The VA partially substantiated many of Dr. Krugman's allegations. The report specifically noted that the Health Care Center staff did not comply with VA Handbook 1100.19, which concerned the credentialing and privileging of surgeons. It also found that the facility was not paying fee-basis physicians in a timely manner, resulting in some physicians refusing to care for VA patients. In response to the findings, the investigative team made six recommendations for improving management and processes in areas identified as weak. Those recommendations were adopted and continue to be monitored by the Veterans Health Administration, which oversees the Health Care Center. The report, however, found no violation of law or evidence of gross mismanagement, a gross waste of funds, an abuse of authority, or a substantial and specific danger to public health and safety.

The VA did not substantiate failures within its administrative or patient care functions, but did identify instances in which some of these functions were "not 100% reliable." The VA implemented policy and process changes designed to improve hospital administration as well as patient care based on these findings.

While the report meets all statutory requirements and these findings appear reasonable, I am unable to assess whether the corrective actions were adequate to fully resolve the identified deficiencies, particularly where the scope of the problem was not defined in a meaningful way.

Dr. Krugman's allegations were referred to the Honorable Eric K. Shinseki, Secretary of Veterans Affairs, to conduct an investigation pursuant to 5 U.S.C. § 1213(c) and (d). The investigation of the matter was delegated to the Deputy Under Secretary for Health for Operations and Management. Secretary Shinseki transmitted the agency's initial report to the Office of Special Counsel (OSC) on June 24, 2011. On August 8, 2013, the VA submitted a status report on the six recommendations made in the June 24, 2011 report. Dr. Krugman provided comments on the agency report. As required by law, 5 U.S.C. § 1213(e)(3), I am now transmitting the report to you.[1]

Dr. Krugman's Disclosures

Dr. Krugman disclosed that from the time he was hired in September 2010, the HCC, intended as an Ambulatory Surgical Center, had been without adequate medical staff or equipment and had insufficient specialty services available to operate as intended. He alleged that the facilities at the HCC were inadequate to support surgical equipment, including flaws in the Heating, Ventilation, and Air Conditioning (HVAC) System and back-up generators, or to perform sterilization of equipment. He alleged that the distance between the operating rooms and recovery room bays was too great, and that the walled structure of the bays required more staff than was allocated to this unit.

Dr. Krugman alleged that highly paid specialists were hired significantly in advance of the HCC's opening and underutilized during the readying of the facility, yet paid during this period. Dr. Krugman asserted that, since the facility could not support surgical procedures and the surgeons were not performing surgery, any payments made for surgical expertise were inappropriate. Further, Dr. Krugman questioned the length of time that passed during which these specialists performed no surgeries, including one surgeon who had performed no surgical procedures for two years. Finally, Dr. Krugman also alleged that several specialists were hired under titles not tied to their specialties or work functions to avoid licensing or certification problems, and paid on a scale according to their educational or experiential titles, not the work they were hired to perform at the VAMC.

Dr. Krugman alleged that patient care was impacted by the VA's requirements to cut costs. He disclosed that physicians were directed to reduce by ten percent the number of specialty referrals made to private providers on a fee-basis, depriving patients of needed care that was not available within the Texas Valley Coastal Bend Health Care System. Dr. Krugman alleged that the agency

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[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) and (g).

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).

began using the Fecal Occult Blood Test even though patients often struggled to comply with the Fecal Occult Blood Test kit protocols. The agency did so because the closest VA provider performing colonoscopies was four hours away by car and the agency did not want to pay for fee-based services closer to Harlingen.

When the agency did authorize fee-based services, Dr. Krugman alleged that more often than not the VA Primary Care providers were not notified about patient visits with fee-providers or of the outcomes of these visits. Dr. Krugman asserted this was due to the absence of an adequate VA care management system to coordinate care between providers. In addition, Dr. Krugman demonstrated that local private providers near the Texas Valley Coastal Bend Health Care System were owed millions of dollars, thus making these physicians reluctant to perform additional specialty services for veteran patients. Finally, Dr. Krugman asserted that immediately before a scheduled Joint Commission[2] visit to the facility patient records were lost and so the number of patients waiting for specialist visits was not apparent to the Joint Commission. Taken together, Dr. Krugman alleged that there was a failure to provide adequate and appropriate specialty services to VA patients.

The Agency Report

The Investigation

Secretary Shinseki tasked Under Secretary for Health Dr. Robert A. Petzel to review this matter, who directed the Deputy Under Secretary for Health for Operations and Management to investigate the allegations and report his findings. A fact-finding team conducted a site visit of the HCC. The team consisted of two Network Chief Medical Officers and a Chief of Staff (all physicians), the Director of VHA Healthcare Engineering and two Staff Engineers, an Associate Director and a Human Resources Consultant. According to the report, the site visit included interviews of Dr. Krugman and 28 other VA employees and/or experts, including the physicians noted in Dr. Krugman's allegations, and a review of policies, procedures, and reports related to these allegations.

The fact-finding team partially substantiated many but not most of the allegations. The team indicated that there was one instance of noncompliance with VA Handbook 1100.19, which concerned the credentialing and privileging of surgeons. As a result of the investigation, six recommendations were made to the Texas Valley Coastal Bend Health Care System. It found no violation of law or evidence of gross mismanagement, a gross waste of funds, an abuse of authority, or a substantial and specific danger to public health and safety.

The Adequacy of the Facility for Surgical Procedures

The investigation did not substantiate the allegation that the HCC's facilities were inadequate to provide surgical services. The investigation found that the HCC is serviced by a dedicated HVAC

[2] The Joint Commission is an independent, not-for-profit organization that accredits and certifies health care organizations and programs in the United States. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization's commitment to meeting certain performance standards. http://www.jointcommission.org/about_us/about_the_joint_commission_main.aspx

system designed to control humidity in the operating theatre, and that a 600-kilowatt diesel-fueled generator provides back-up electrical power. The investigation also found that the HCC has an adequate ventilation system and sterilization facility to support surgical procedures. Finally, regarding the proximity of the surgery and recovery areas, the team found there was no distance requirement to be met, and that these areas have a functional relationship and appropriate proximity with each other. The surgery and recovery areas at the HCC are directly adjacent to each other on the same floor, and the recovery bays are separated by multi-paneled sliding glass partitions that are analogous to traditional privacy curtains, thus not requiring any additional staffing than a traditional recovery area.

The Appropriateness and Timing of Hiring and Corresponding Salaries

Dr. Krugman's allegations were partially substantiated that the VAMC hired surgeons before there were proper facilities and, thus, these surgeons were unable to perform operations for a significant period of time. The investigation found that one surgeon named by Dr. Krugman did not perform a surgical procedure for 11 months while employed by the VAMC. The investigative team found that it was difficult to recruit surgeons in the south Texas region, so the hiring was reasonable even if the timing was not optimal. However the investigation also found that the facility did not follow VHA Handbook 1100.19, *Credentialing and Privileging*, Paragraph 6g, which requires surgeons lacking recent surgical experience to undergo a Focused Professional Practice Evaluation (FPPE) before returning to the operating room. Indeed, the report notes that the current Acting Chief of Surgery and Specialty Clinics performed only biopsies for an extended period. While the investigative team found no atrophy of her skills or resulting risk to patient safety, it recommended that she should participate in the FPPE to comply with regulations. The report also recommended observation for any newly hired surgeons who do not have recent surgical experience.

The investigation did not substantiate Dr. Krugman's allegation that the HCC assigned false titles to physicians to avoid conflicts with licensing or certification requirements, or that physicians were hired for certain duties but paid for other duties or expertise. To address his allegations, however, the report recommends, going forward, that the facility use pay tables consistent with the actual privileges requested by surgeons for their time at the facility, and not the expertise that they may or may not carry.

Patient Care Concerns

The investigation did not substantiate Dr. Krugman's allegations regarding patient care concerns. Instead, the report noted that the facility has made efforts to reduce blanket, open-ended authorizations for fee-based program costs. The facility spent $46,973,778 on fee-basis care during fiscal year (FY) 2011, totaling 93,305 authorizations. Instead of a mandate to cut medically based fee-basis referrals, the agency made a choice to try to provide more services within the facility. The report acknowledges that the facility has room to improve in some areas, but finds that there were not systemic patterns of violations or practices suggesting gross mismanagement, a gross waste of funds, an abuse of authority, or a substantial and specific danger to public health and safety.

Dr. Krugman's allegation that the facility was not providing appropriate colorectal cancer screenings due to the use of Fecal Occult Blood Test screening instead of colonoscopies was not

substantiated. The report indicated that there are multiple acceptable forms of colorectal cancer screening, and that veterans are given the choice between medically appropriate tests.

Administrative Issues Impacting Patient Care

Dr. Krugman's allegations that the Texas Valley Coastal Bend Health Care System administrative systems were insufficient to support patient care needs were partially substantiated. The report found that the system for communication between the VA and non-VA providers "is not 100% reliable, [but] there was evidence found in reviewed medical records that this process did occur." Thus, while the report acknowledged that the process was not fully reliable, it did not identify with greater detail how frequently errors occurred. As noted by Dr. Krugman in his comments, the evaluation of these administrative issues, which the agency denied affected patient care in any systemic way and found to be "sufficient," focused not on the failures identified, but on the corrective measures being developed at the time. As such, while there were concerns identified, the report does not quantify the concerns or assign responsibility for the failures of the system then in place.

In addition, the report identified weaknesses in the system for notification to VA patients. While VA patients received the majority of notification letters mailed to them, the investigative team found that in an unspecified number of cases, incorrect veteran addresses led to incorrect mailings of the patient notification letters. Thus, while the provider notification process appeared to be sufficient, there were likely a "few instances" where letters were not received by patients. The investigative team concluded that this was not a common occurrence or a systemic problem and the majority of patients were notified appropriately. As noted above, at the time of the report, the facility had begun developing a more comprehensive coordination of care process, and the investigative team recommended that this process be completed and implemented as soon as possible. According to the supplemental report, the Texas Valley Coastal Bend leadership team has implemented the Non-VA Care Coordination Center, which processes all consultations for non-VA care, including the following: 1) review and approval of the consultations from VA providers; 2) appointment management with pre and post calls to ensure compliance with the consultation; and 3) obtaining clinical documentation from the consultant for VA provider review.

The investigation partially substantiated Dr. Krugman's allegation that patient care is impacted by the Texas Valley Coastal Bend Health Care System's inability to pay fee-basis providers for services rendered in a timely manner, noting that there is a substantial debt owed to community providers. The facility is working toward decreasing the amount owed, and has complied with the requirements of the Prompt Payment Act, 31 US.C. § 39, when making late payments. The investigative team found that a few private sector providers, including an orthopedic surgeon, refuse to provide care for VA patients. This number is very small, however, and no VA provider stated that a patient had been unable to receive care due to these refusals; the patient chose another physician in the area. The investigation did not substantiate that patient care has been compromised by the debt, and noted that even where patients were forced to choose a second provider, there was no delay of necessary or urgent care.

Finally, the investigation did not substantiate that patient records were lost or discontinued in advance of a visit by the Joint Commission. Instead, the facility was required to re-create a record

system and did so in a reasonable manner oriented toward patient safety. During this process it became clear that approximately 1,800 consultations remained incompletely resolved after 90 days from the date of referral, often due to duplicate referrals, a failure to close referrals administratively, or a patient's failure to show for the appointment. Thus, the agency chose to clean up those outstanding files on a case-by-case basis, but only when the evidence within the file and the VA's primary care physician determined the consult was no longer required. There was no indication that these records were formally closed and/or amended in preparation for the Joint Commission inspection. Further, there is no indication that records were lost during this process.

The Report's Recommendations

In response to the investigative findings, the fact-finding team made six recommendations: 1) surgeons without recent surgical experience should undergo FPPE to ensure competence; 2) in the future, physician pay should be decided using the pay tables in a manner consistent with the privileges the physician requests; 3) the Texas Valley Coastal Bend Health Care System should complete and implement a more comprehensive coordination of care process for fee-basis appointments and provider notification, and this process should be coordinated with the national Veterans Health Administration's effort to improve fee-basis processing; 4) the Texas Valley Coastal Bend Health Care System should make renewed efforts to decrease the backlog of outstanding claims for fee-basis services; 5) communication with community providers and health care systems should be continued and/or increased, including face-to-face meetings, status reports, and the development of a dispute resolution process to address long-standing debts and other issues, and; 6) the VHA's Office of Compliance and Business Integrity should, in concert with the Integrated Ethics Program, conduct a Focused Review of the facility and, if necessary and appropriate, assist in implementing any identified corrective or improvement measures. The VA concurred with the findings, conclusions, and recommendations of the report.

In response to OSC's request for a status update on the recommendations, the VA provided a Fact Sheet on August 8, 2013, as a supplement to its report. The Fact Sheet outlined the process implemented to ensure that surgeons without recent surgical experience undergo focused professional practice evaluations to ensure competencies. It also reported on the physician pay setting practices used by Texas Valley Coastal Bend Health Care System, which are in accordance with VA Handbook 5007, Part IX, Paragraph 13.

With regard to fee-basis referrals, the Fact Sheet identifies the processes established by the Chief Business Office Non-VA Care Coordination initiative. Implementation of these processes was in phases, with completion on July 1, 2013. All consultations for non-VA care are processed by the Non-VA Care Coordination Center. This ensures compliance with the consultation and in obtaining clinical documentation from the consultant for VA provider review. In addition, Texas Valley Coastal Bend Health Care System and VISN 17 Fee offices have jointly developed new systems to decrease the backlog of outstanding claims for fee-basis services. The goal is to pay 80 percent of valid claims within 30 days of receipt. As of February 2012, Texas Valley Coastal Bend had a total of 44, 991 claims pending payment with 33,945 of those claims older than 30 days. As of July 5, 2013, the region had 5,327 claims pending payment with 1,080 claims older than 30 days. The Fee office continues to collaborate with vendors on a case-by-case basis to assist in resolving their claims payment issues. Texas Valley Coastal Bend also created a non-VA care provider handbook to

disseminate to physicians in the community which provides an explanation of the claims processing and payment processes.

Finally, the agency reported that as of August 2013, Texas Valley Coastal Bend Health Care System is in the process of scheduling a consultative visit by VHA's Office of Compliance and Business Integrity in conjunction with the National Center for Ethics in Healthcare. This visit will focus on the nine elements of the Compliance and Business Integrity Program, which includes non-VA care as well as a review of the ethics framework of the organization.

Dr. Krugman's Comments

Dr. Krugman provided extensive comments on the agency report, but declined to comment on the supplemental report. In his comments, Dr. Krugman asserted that the investigation ignored the substance of the allegations and, specifically, that fraud, waste, and abuse occurred. He provided background, explaining that the veterans of southern Texas had to rely on the VA hospital in San Antonio for major medical problems. San Antonio is approximately 260 miles away. As such, the VA agreed to establish an Ambulatory Care Center in Harlingen, Texas, to resolve minor surgical matters that required in-and-out "day" surgery. It was for the purpose of establishing and administering such a facility that Dr. Krugman was hired. He reiterated that he arrived to find a facility with design defects and management errors. He stated that the agency report finds that the design issues are corrected now, without acknowledging that errors were initially made, or addressing the costs to correct them. He provided a point-by-point assessment of the flaws and errors in the report, as well as matters that the investigative team overlooked or ignored.

Dr. Krugman further noted that although some of the allegations were not substantiated, the VA implemented policy changes to avoid addressing the problems he raised. With respect to the condition of the facility and its HVAC system, Dr. Krugman noted that the report's conclusion that the facility is now adequate ignored the fraud, waste and abuse inherent in the need for correction and/or re-modeling. With regard to the hiring and credentialing processes, Dr. Krugman maintained that the hiring of physicians outside their areas of specialty was a waste of money and reflects poor planning. He also believes that the agency's failure to utilize his skills to correct the problems he identified at the HCC was wasteful. Regarding the services provided to VA patients by non-VA providers, Dr. Krugman noted that failure to pay physicians impacts hospitals as well, and casts a negative shadow over the VA and the federal government in general.

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The Special Counsel's Findings and Conclusion

I have reviewed the original disclosure and the agency reports. The VA did not substantiate failures within its administrative or patient care functions, but did identify instances in which some of these functions were "not 100% reliable." The VA implemented policy and process changes designed to improve hospital administration as well as patient care based on these findings. While the report meets all statutory requirements and these findings appear reasonable, I am unable to assess whether the corrective actions were adequate to fully resolve the identified deficiencies, particularly where the scope of the problem was not defined in a meaningful way.

As required by 5 U.S.C. § 1213(e)(3), I have sent copies of the unredacted reports and Dr. Krugman's comments to the Chairmen and Ranking Members of the Senate and House Committees on Veteran's Affairs. I have also filed copies of the redacted reports and the whistleblower's comments in OSC's public file, which is now available online at www.osc.gov. The redacted report identifies VA employees, other than Dr. Krugman, and other individuals by title.[3] OSC has now closed this file.

Respectfully,

Carolyn N. Lerner

Enclosures

[3] The VA provided OSC with a report containing employee names (enclosed), and a redacted report in which employees' names were removed. The VA cited Exemption 6 of the Freedom of Information Act (FOIA) (5 U.S.C. § 552(b)(6)) as the basis for its redactions to the report produced in response to 5 U.S.C. § 1213, and requested that OSC post the redacted version of the report in our public file. OSC objects to the VA's use of FOIA to remove these names because under FOIA, such withholding of information is discretionary, not mandatory, and therefore does not fit within the exceptions to disclosure under 5 U.S.C. § 1219(b), but has agreed to post the redacted version as an accommodation.