DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON DC 20420

March 3, 2015

The Honorable Carolyn N. Lerner
Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW, Suite 300
Washington, DC 20036

RE: OSC File No. DI-13-3174

Dear Ms. Lerner:

I am responding to the Office of Special Counsel's (OSC) request for supplemental information related to our report of December 6, 2013, which addressed allegations made by a whistleblower at the Department of Veterans Affairs (VA) Pittsburgh Healthcare System, Pittsburgh, Pennsylvania (hereafter the Medical Center). The whistleblower alleged that management at the University Drive Campus failed to maintain infrastructure, or properly execute, remediate, or inspect construction projects. While VA did not substantiate any of the report's five allegations, it did make eight recommendations to the Medical Center for process improvement, construction, and remediation. The Secretary has delegated to me the authority to sign the enclosed report and take any actions deemed necessary as referenced in 5 United States Code § 1213(d)(5).

At OSC's request, this report addresses the status of each of the eight recommendations in our earlier report, as well as answers to two additional questions: the status of the underground water storage project; and the most recent results of testing for Legionella in the VA medical center's water system. The Medical Center has now completed work on five of the eight recommendations, has initiated work on the three remaining recommendations, and has thoroughly addressed the status of the two additional questions in your request. Details are in the document, which I am submitting for your review.

Thank you for the opportunity to respond.

Sincerely,

Jose D. Riojas
Chief of Staff

Enclosure

Office of the Medical Inspector
Supplemental Report
to the
Office of Special Counsel
Veterans Affairs Pittsburgh Healthcare System, Pittsburgh, Pennsylvania
OSC File No. DI-13-3174
November 14, 2014

TRIM 2014-D-1446

The Under Secretary for Health (USH) requested that the Office of the Medical Inspector (OMI) assemble and lead a team to investigate allegations lodged with the Office of Special Counsel (OSC) concerning the Department of Veterans Affairs (VA) Pittsburgh Healthcare System (hereafter, the Medical Center) by John Lesjak (hereafter, the whistleblower). The whistleblower, a heating, ventilation, and air conditioning (HVAC) mechanic/inspector at the Medical Center alleged that Medical Center management had neglected the maintenance of critical infrastructure, failed to properly address unsafe conditions that pose health and safety hazards to patients and staff, and failed to adequately manage construction projects performed by contractors, allowing construction to interfere with patient care, thereby engaging in conduct that may constitute violations of laws, rules or regulations, and gross mismanagement, which may lead to a substantial and specific danger to public health. The VA team conducted a site visit to the University Drive (UD) campus on August 19–22, 2013, and VA transmitted its report to OSC on December 6, 2013.

Based on its findings, VA made eight recommendations for the Medical Center, all endorsed by the Secretary of Veterans Affairs and the USH. The VA team and the Veterans Health Administration's (VHA) Office of the Deputy Under Secretary for Health for Operations and Management reviewed and concurred with the Medical Center's action plan in response to report recommendations. Five of these actions have been completed and three are ongoing as described below:

Recommendation 1: Include the Safety Manager on the Incident Command System Team for any event where employees may have concerns about safety, personal risk, and the need for personal protective equipment.

Resolution: The Safety Manager is now a member of the Incident Command System Team, although the team has not been activated since the VA review.
Action Completed

Recommendation 2: Continue to implement the design, contracting, and engineering plans associated with the Medical Center's analysis and action plan for the operating room (OR) power outage.

Resolution: VA Central Office (VACO) Chief Electrical Engineer requested that a reliability study be performed on the design of the OR Electrical Redundancy Project.

This study has been awarded and will evaluate the critical points and sequencing of the system in terms of risk vs. reliability. The contractor will present study results to Medical Center leadership, safety, surgery leadership, quality, the VACO electrical engineer, and the Capital Asset Manager. Once they have reviewed results of the study, VACO and the Capital Asset Manager will determine funding levels.
Action Ongoing

Recommendation 3: Re-examine project #646-12-105, UD, for the relocation of the storm and sanitary drain pit to determine whether it can be prioritized for earlier completion.

Resolution: Project will commence once current projects are completed in 4th quarter of fiscal year 2017. This estimated date is based on current contractor schedules.
Action Ongoing

Recommendation 4: Address and fix the occasional odor emanating from the storm and sanitary drain pit.

Resolution: Facilities Management Service (FMS) installed a new water and air prohibitive hatch at the clean out pit. FMS also epoxied the walls and floors in the alcove where the pit is located to create an impervious surface that will improve the ability to keep this area clean.
Action Completed

Recommendation 5: Follow-up and report on the work order (W/O P130809-005) for location 2A131-1-UD to determine the status of completion.

Resolution: FMS repaired the section of pipe. The work order was completed on September 14, 2013.
Action Completed

Recommendation 6: Develop a plan to make timely use of the Contractor Performance Assessment Reporting System for contractor performance.

Resolution: As of February 24, 2015, 100 percent of the training has been completed.
Action Completed

Recommendation 7: Continue to follow Veterans Health Administration Directive 2010-036, Asbestos Management Program.

Resolution: On July 2, 2014, the policy changes were made and routed for concurrence. Comments for additional revisions and formatting changes were received. Medical Center leadership incorporated the changes and routed the policy a second time, finalizing the policy on July 12, 2014. MCM EC-066 Asbestos Management was completed and posted on SharePoint for availability to all staff on August 21, 2014.
Action Completed

Recommendation 8: Continue asbestos medical surveillance on those individuals identified as working in the UD crawl space.

Resolution: Employee's Supervisors forwarded to Occupational Health an employee list of those due for annual exam.
Action Completed

Additional information from the report was requested:

1. *What is the status of the underground water storage project?*

   Construction has been completed. In addition, FMS has awarded a contract to modify the design of the underground storage tanks to comply with the new VHA Legionella Directive. Design commenced in December 2014. Once a design has been completed, a contract will be solicited to incorporate the design changes.

2. *What are the most recent results of testing for Legionella in the Pittsburgh VAMC water system?*

   The following data was provided by the Medical Center as evidence of its vigilance in monitoring the remediation process. Since the outbreak in 2013, the Medical Center has collected nearly 6,000 water samples for testing. Of those, approximately 2 percent have been positive for various species of Legionella. Only 0.75 percent has been positive for Legionella sero group 1, the species most likely to cause pneumonia. Each time any positive sample has been identified, Infection Prevention ordered an appropriate remediation, collected adjacent samples, and following remediation, recultured the fixture to ensure that the remediation was effective.