U.S. OFFICE OF SPECIAL COUNSEL
1730 M Street, N.W., Suite 300
Washington, D.C. 20036-4505

The Special Counsel

February 22, 2016

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

Re: OSC File Nos. DI-14-3650 and DI-13-4570

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 James E. Van Zandt VA Medical Center (Medical Center), Physical Medicine and Rehabilitation Service (PM&RS), Altoona, Pennsylvania. I reviewed the VA's report and, in accordance with 5 U.S.C. § 1213(e), provide the following summary of the agency investigation and whistleblower comments as well as my findings.[1]

The whistleblowers, James DeNofrio, PM&RS administrative officer, and Timothy Skarada, supervisor, physical therapy and occupational therapy, who consented to the release of their names, alleged that the PM&RS chief appeared to be neurologically impaired yet continued to serve as the chief and to treat patients. They also alleged that Medical Center officials failed to respond to the continuing concerns regarding the possible impairment of the PM&RS chief.

The Office of the Medical Inspector (OMI) investigation did not substantiate that the PM&RS chief was neurologically impaired or unable to fulfill the duties of his position. In September 2013, the chief underwent an independent neurological and neuropsychological evaluation, and in March 2015 he underwent a general medical evaluation and an additional neurological evaluation. None of the evaluations revealed evidence of impairment or that the PM&RS chief was unable to fulfill the duties of his position. OMI concluded, however, that the September 2013 evaluation did not comply with VHA policy, which requires that the provider undergo a general medical

[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).

evaluation and be removed from patient care during the pendency of the evaluation. In this case, the September 2013 evaluation was based on a neurological evaluation, and the PM&RS chief was not removed from patient care.

The investigation also found instances of the PM&RS chief's noncompliance with VA directives and Medical Center guidelines, but concluded that these issues should be addressed as performance matters. The investigation determined that the PM&RS chief's failure to timely approve an electronic lift neither caused nor hastened a veteran's death; nor was there evidence that his treatment of another patient adversely affected the patient. Finally, the investigation did not substantiate that Medical Center officials failed to respond to concerns about the PM&RS chief and found that his re-privileging at the facility was appropriate. Nevertheless, the investigation did result in counseling of the PM&RS chief, who retired in November 2015, and improvements in patient care. I have determined the report meets all the statutory requirements and the findings appear reasonable.

The allegations were referred to Secretary Robert A. McDonald for investigation pursuant to 5 U.S.C. § 1213 (c) and (d). The investigation was referred to OMI and then-Chief of Staff Robert L. Nabors, II, was delegated the authority to review and sign the report. On July 8, 2015, Mr. Nabors submitted the agency's report to OSC. The whistleblowers submitted comments on July 23, 2015.

The Disclosures

Mr. DeNofrio and Mr. Skarada disclosed that in June 2013 they reported to the VA Office of Inspector General that the PM&RS chief had cognitively declined. In October 2013 the OIG reviewed this concern with Medical Center Director William Mills. Shortly thereafter, Mr. Mills notified Mr. Skarada and Mr. DeNofrio that the PM&RS chief successfully completed neurological testing and was found to be capable of performing his duties as a physician. The inquiry was then closed.

Mr. DeNofrio and Mr. Skarada continued to observe and report changes in the PM&RS chief's behavior that they believe demonstrated impairment and disclosed that other employees reported similar concerns. They alleged that the PM&RS chief was frequently absent during the day without explanation, was treating patients in the waiting room or hallway without a consult referral or a scheduled appointment, and that he repeatedly failed to communicate with primary care providers and treating therapists regarding his clinical treatment and recommendations, or changes he made to patient treatment care plans. The whistleblowers reported that the PM&RS chief's documentation of patient encounters was consistently poor and disclosed specific instances of questionable and inappropriate treatment of patients and deficiencies in medical documentation.

The whistleblowers also alleged that Mr. Mills and Chief of Staff Santha Kurian failed to respond in accordance with VA policy to the continuing concerns regarding the PM&RS chief. They reported that Mr. Mills approved the PM&RS chief's re-privileging in July 2014,

even though he failed to meet numerous goals established in the Ongoing Professional Practice Evaluation, which is used to evaluate practitioners' competence and identify trends that could adversely affect the patient care or safety.

Mr. DeNofrio reported that during FY 2014 the PM&RS chief's performance measure for ordering MRIs was below the target goal of 90 percent. He further alleged that Dr. Kurian changed the standard used to evaluate the PM&RS chief's performance in order to avoid triggering a Focused Professional Performance Evaluation (FPPE). The whistleblowers reported that in the last quarter of 2014, the PM&RS chief was also below the target goals established for inappropriate copying and pasting in patient records and for unsigned co-signatures greater than 72 hours. They maintained that these performance measures should have trigged an FPPE and that the failure to initiate an FPPE was a violation of VHA Handbook 1100.19 Ch. 14. Thus, they contended that the PM&RS chief was re-privileged on the basis of an inaccurate record.

The Report of the Department of Veterans Affairs

OMI's investigation included two site visits, interviews with the whistleblowers and approximately 40 Medical Center staff, as well as review of electronic medical records and VA and Medical Center documents listed in the report. As explained in the report, a practitioner is considered impaired when a condition interferes with the practitioner's ability to engage safely in professional activities. VA Handbook 5019, *Occupational Health Services, Part III*, sets forth the process to be followed when assessing whether a Title 38 employee is impaired. The process includes a general medical evaluation followed by specialized diagnostic studies if warranted.

The report explained that the initial examination of the PM&RS chief in September 2013 included only neurological and neuropsychological evaluations and thus did not comply with VA Handbook 5019. Dr. Kurian referred the PM&RS chief for the neurological evaluations because the whistleblowers' allegations suggested a possible neurological condition. The evaluations determined that the PM&RS chief did not have dementia or significant intellectual compromise and further that he was capable of performing his duties as a physician. Medical Center leadership sought guidance from the Human Resources Department, the chief medical officer, and regional counsel who advised that in view of the findings of the evaluation, no additional action was necessary.

The witness interviews did not confirm that the PM&RS chief was absent without explanation, that he was increasingly confused or prone to angry outbursts or erratic behavior, or that he forgot the names of employees with whom he had worked for years. Health care providers who were interviewed reported that the PM&RS chief responds to consults in a timely manner and communicates his findings and recommendations either electronically or in face-to-face interactions. One documentation lapse, for which the PM&RS chief was counseled, was noted. However, the report also notes that some witnesses described occasions where the PM&RS chief was confused, forgetful or exhibited questionable judgment. Given these statements and noting that the signs of cognitive

impairment can be subtle, investigators believed that a general medical evaluation and repeat cognitive evaluation were warranted. On March 2, 2015, the PM&RS chief was removed from patient care activities and was evaluated by a general medicine physician and a neurologist. These providers concluded that he did not have any significant cognitive deficits or neurological disease. The neurologist opined further that there was no evidence of neurological disease that would compromise his duties as a physician.

The investigation did find that the PM&RS chief was not compliant with VHA Directive 2011-007 on hand hygiene requirements and that gloves were not readily available in all the patient care areas. Investigators reviewed patient care incidents identified by the whistleblowers and did not find that the PM&RS chief's treatment adversely affected patients. In addition, the investigation revealed some deficiencies in the PM&RS chief's communication and documentation of clinical findings discussed briefly below.

Investigators reviewed the performance measures for the PM&RS chief to assess whether Medical Center leadership was responsive to concerns regarding his performance and his re-privileging was appropriate. The initial Ongoing Professional Practice Evaluation (OPPE) of the PM&RS chief's MRI orders was conducted according to the McKesson Interqual criteria, which considers whether a service is clinically indicated and provided at the appropriate level of care. Under this standard, the PM&RS chief's performance rate was 73 percent, below the target goal of 90 percent. The report states that Dr. Kurian instructed the chief of Radiology to conduct a second review. The chief of Radiology used a specialty-specific criteria established by the American College of Radiology (ACR) to evaluate 599 orders from October 2013–June 2014 as well as the 13 MRI orders the PM&RS chief submitted from July–December 2014. The report explains that ACR identifies "best practices" and develops guidelines for the appropriate use of radiology. The chief of Radiology concluded that all the MRI orders submitted by the PM&RS chief met the ACR Appropriateness Criteria. OMI stated that the ACR Appropriateness Criteria is an appropriate standard for review.

With regard to the copying and pasting requirements, Mr. DeNofrio reported that the PM&RS chief did not meet the target performance measure of 90 percent. In the third quarter of 2014 Mr. DeNofrio reported this failure to Medical Center leadership who, in response, requested a FPPE. The report notes, however, that the FPPE does not appear to have been initiated. Following a second deficient score in October 2014, Mr. DeNofrio again reported the matter to Medical Center leadership, and an FPPE was requested and completed. The report notes that this review determined that the chief was compliant with copy-and-paste requirements. Mr. DeNofrio identified six patients whose medical charts he believed included examples of inappropriate cutting and pasting. OMI investigators reviewed the medical notes at issue and found no inappropriate copying and pasting.

Similarly, investigators reviewed the performance measures for the percentage of notes signed within 72 hours. The quality manager determined that the notes identified as unsigned within 72 hours were cases where the PM&RS chief was listed as a co-signer; therefore, his signature was not required within 72 hours. OMI reviewed these records and came to the

same conclusion. Mr. DeNofrio provided examples of eight charts that he believed reflected unsigned notes. OMI found that of those eight charts, two were assigned to the PM&RS chief and signed within the 72 hours, and the six remaining charts did not require his signature.

Additionally, Mr. Skarada reported that the PM&RS chief failed to adequately document assessments, appropriate recommendations, or follow-up information in medical notes, and failed to address appropriate diagnostic studies. The report notes that in July 2014, at the request of Dr. Kurian, the chief of Acute Medicine and Procedure Clinic Service reviewed several of the PM&RS chief's notes and found one case where the MRI results were not documented, and the patient was not notified of the results. No harm to the patient occurred as a result of this incomplete documentation. The reviewer recommended that primary care providers order MRIs instead of PM&RS providers because the primary care provider is more involved in patient care and follow-up.

The report states that on the issue of re-privileging, there were no documented instances of inappropriate patient care, no adverse incidents for licensure or malpractice reported for the PM&RS Chief. Further, his evaluation of September 2013 did not find any indication of impairment. For these reasons, the report states his re-privileging was appropriate.

In response to the investigative findings, the PM&RS chief was counseled for discussing private information in non-private areas. OMI recommended monitoring his compliance with documentation requirements and maintaining patient privacy, and addressing any continuing noncompliance with additional training or administrative or disciplinary action. OMI also recommended: providing training on hand hygiene practices and the process for evaluating a physician for impairment; ensuring that gloves are readily available in clinical areas of PM&RS; conducting a review of all remaining consultations of the chief's from October 2013–May 2015 to ensure that his clinical findings address the concerns of the referring provider and the proposed treatments were appropriate; and conducting a peer review for the care the chief provided to a patient identified as Veteran 2. OMI recommended that the Medical Center establish a process to ensure FPPEs are timely completed once a performance issue is identified. Finally, OMI recommended that the responsibility for the medical records review for OPPEs and FPPEs be reassigned from Mr. DeNofrio to a clinical staff member. The report explained that peers or supervisors of providers should be evaluating medical personnel, not administrative personnel.

On December 9, 2015, the VA provided an update on the implementation of these recommendations stating that the training had been provided, gloves are available, the FPPE process has been updated, and the OPPE and FPPE evaluations have been reassigned. The agency also reported that the peer review for the care of Veteran 2 had been completed and did not reveal any quality of care issues. A VISN physiatrist had completed review of 102 of the 406 medical records to be reviewed. On January 12, 2016, OMI advised OSC that the review of the remaining medical records was completed. The physiatrist confirmed that all patients received appropriate care and the care addressed the patients' primary clinical concerns. OMI also confirmed that the task of medical records reviews has been reassigned across all service lines, FPPE/OPPEs are ongoing in compliance with the new requirements

and that administrative staff are involved in the clinical review of clinicians. Finally, OMI reported that the PM&RS chief retired in November 2015 and noted that his retirement was at his request and was not in lieu of any pending administrative or disciplinary action.

The Whistleblower Comments

The whistleblowers provided detailed comments that are only briefly summarized here. They explain that they bring a combination of 20 years of experience in supervisory, administrative, and clinical experience at the VA as well as experience in healthcare in private and military facilities. They stated that in this case the VA improperly reworded and manipulated the allegations, and that the investigation did not accurately reflect their allegations. In support of this contention, they highlight the language in an OSC draft[2] of the referral letter that contains the factual summary of the disclosures. The whistleblowers write that although they do not speculate on the motive for the manipulation of the allegations, they assume that the wording of the allegations was altered because the investigative findings supported their allegations. They note that because of the improper rewording the VA's conclusions and recommendations were biased.

The whistleblowers also believe that the chief PM&RS is a "scapegoat" for the VA and Altoona VAMC leadership to deflect culpability from them. They reiterated that they had been reporting their concerns regarding the PM&RS chief to the Altoona VAMC leadership, the VA Office of Inspector General, and the VA Medical Inspector since April 2013. The comments chronicle the reports of the whistleblowers to officials regarding the PM&RS chief. They write that they were very disheartened by their leadership's persistent lack of response. The whistleblowers also state that VA officials have attempted to discredit them and have retaliated against them. The whistleblowers laud the VA providers and employees, describing them as some of the best in the world. They believe that VAMC Altoona provides excellent care despite what they describe as dysfunctional leadership at the facility.

The Special Counsel's Findings and Conclusions

I have reviewed the original disclosure, the agency report, and the whistleblower comments. Based on that review, I have determined that the report contains all of the information required by statute and that the findings appear reasonable.

In their comments, the whistleblowers suggest that the VA altered the language of the allegations to be investigated in order to sidestep the culpability of officials at the VA and the Altoona VAMC. I have determined, however, that the VA investigated and responded to the allegations referred to the Secretary. I also note that the VA has acted on the OMI's many recommendations for improving patient care. The VA has also confirmed that patients treated by the PM&RS Chief received appropriate care. I thank Mr. DeNofrio and Mr. Skarada for bringing these concerns to OSC's attention.

---

[2]OSC provided the factual summary section of the Special Counsel's referral letter to the whistleblowers for review prior to transmission of the referral to the Secretary of the VA.

As required by 5 U.S.C. § 1213(e)(3), I have sent copies of the unredacted agency report and whistleblower comments to the Chairmen and Ranking Members of the Senate and House Committees on Veterans' Affairs. I have also filed copies of the redacted agency report and whistleblower comments in OSC's public file, which is available at www.osc.gov.[3] This matter is now closed.

Respectfully,

Carolyn N. Lerner

Enclosures

[3]The VA provided OSC with reports containing employee names (enclosed), and redacted reports in which employees' names were removed. The VA has 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 reports produced in response to 5 U.S.C. § 1213, and requested that OSC post the redacted version of the reports 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 of the reports as an accommodation.