July 23, 2015

James DeNofrio & Timothy Skarada
Department of Veterans Affairs
James E Van Zandt VA Medical Center
Physical Medicine and Rehabilitation Svc.
2907 Pleasant Valley Boulevard
Altoona, PA 16601

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

Regarding: Combined Whistleblower response and comments of the Agency Report to the Office of Special Counsel of James DeNofrio and Timothy Skarada regarding OSC case numbers DI-14-3650 and DI-13-4570.

Introduction

In our combined response we would like to recognize and greatly thank the OSC Disclosure Unit and specifically Ms. Tracy Biggs, OSC attorney, for the hard work and diligence that they have demonstrated in processing our OSC disclosure cases DI-14-3650 and DI-13-4570. Ms. Biggs has demonstrated a level of excellence and professionalism that we believe to be unsurpassed and a credit to the Office of Special Counsel.

Summary of the Whistleblower Response

James DeNofrio and Timothy Skarada (hereafter the Whistleblowers) have completed their review of the Agency Report to the Office of Special Counsel regarding OSC file Numbers DI-14-3650 and DI-13-4570 and submit the following combined whistleblower response and comments for your consideration regarding this matter. It is our argument that the specific allegations of the Whistleblowers as stated in the Agency report and that were investigated by the Agency have been improperly reworded and manipulated by the Agency and do not accurately reflect the actual, specific allegations that the Whistleblowers presented in our disclosure to both the OSC and the VA Office of Medical Inspector as attached in the OSC draft factual summary of these disclosures.

We argue that the Agency's conclusions and recommendations in turn were biased by this action and do not accurately reflect or take in to account the specific allegations made in our disclosure to the OSC. Though we will not speculate on the motive for this action taken by the Agency, our

assumption is that the facts and findings discovered in this investigation by VA supported the actual allegations made in our disclosure. By changing and manipulating the wording of the allegations made by the Whistleblowers believe that the Agency was attempting to discredit the Whistleblowers and also protect VA and Altoona VAMC leadership from allegations made by the Whistleblowers regarding violations of VA and Altoona VAMC guidelines and directives and allegations of substantial and specific danger to the patients seeking treatment at the facility.

In review of the Agency report it is also our belief that Dr. Struthers is being held out as a scapegoat by VA and the Altoona VAMC leadership to deflect culpability from the VA and Altoona VAMC leadership, who had direct knowledge and responsibility regarding these matters. It is important to note in reading our response that we have been reporting the concerns found in the Agency report consistently to the Altoona VAMC leadership, the VA Office of Inspector General, and the VA Medical Inspector since April 2013. These reports were also provided to VA as evidence to support our allegations in the investigation of this disclosure.

In response the Whistleblowers will also respond to conclusions of fact made by VA that we believe to be false, conflicting, misleading, or excluded from the Agency report. Additionally, as a matter of relevance the Whistleblowers are uncertain why VA chose to reference and include the personal, protected Veteran status of whistleblower, James DeNofrio, and protected details as to where Mr. DeNofrio receives his own personal VA medical care in this Agency report. The Whistleblowers are also unclear why VA also included in the Agency report matters regarding Altoona VAMC employees accessing Mr. DeNofrio's personal medical records at the direction of the Altoona VAMC Chief of Staff following our disclosure to the OSC and investigation by VA. Though the Whistleblowers will point out that the VA is acknowledging as a conclusion of fact found through their own investigation that Altoona VAMC staff have been accessing Mr. DeNofrio's personal VA medical record, those matters are not related to the allegations made in our disclosure to the OSC and Mr. DeNofrio notes that those matters are currently pending final legal disposition in accordance with the Whistleblower Protection Act and Whistleblower Protection Enhancement Act. Even though the Whistleblowers are highly disappointed in the VA's decision to include Mr. DeNofrio's protected Veteran healthcare information, Mr. DeNofrio will respond to this matter since the Agency decided to include this information in their report.

Written Allegations As Stated in the Agency Report Do Not Accurately Reflect the Allegations Made by the Whistleblowers

The allegations as stated by the Whistleblowers are fundamentally different and have a separate meaning and implication than the allegations as stated by VA in the Agency report. It appears the allegations as stated by the Agency are inappropriately restated in a manner that attempts to shield the Agency from the implication of wrongdoing and shift culpability from the VA and the Altoona VAMC leadership to Dr. Struthers. In their report, the VA listed the Specific Allegations of the Whistleblowers to be as follows:

1. *Dr. Struthers, PM&RS chief, appears to be neurologically impaired and incompetent, yet continues to treat patients; and*

2. *Altoona VAMC officials have failed to respond to the continuing concerns regarding Dr. Struthers' impairment and incompetence.*

The specific allegations of the Whistleblowers are not accurately reflected in the Agency report. Mr. Skarada and Mr. DeNofrio specifically alleged the following in our disclosure to the Office of Special Counsel *(Please see page 3 of the OSC draft factual summary as attached to this document):*

1. *In spite of numerous complaints regarding Dr. Struthers' possible impairment and cognitive decline, he continues to see patients and serve as chief of PM&RS; and*

2. *The failure of Altoona VAMC to review Dr. Struthers' conduct and compliance with facility requirements is a violation of VA and Altoona VAMC guidelines and directives and constitutes a substantial and specific danger to the patients seeking treatment at the facility.*

Please note that it is the Whistleblowers' belief that VA manipulated and changed the wording of our allegations in the Agency report in order to protect Altoona VAMC and VA leadership officials who were negligent in properly addressing the Whistleblower's concerns and also negligent in stopping a substantial and specific danger to patients seeking treatment at the Altoona VAMC for two years after a disclosure was made. The Whistleblowers also believe that the Altoona VAMC and VA leadership violated policy and failed to provide Dr. Struthers with the assistance that he needed when the reports were made to the Agency. Please note as the Agency report states that Altoona VAMC was found to have violated VA and VHA policy in relation to these disclosures. The Whistleblowers believe that VA is now scapegoating Dr. Struthers. Prior to the issues and disclosures found in Agency report Dr. Struthers was one of the finest physicians and person that the Whistleblowers have ever known. The Whistleblowers made repeated request to Altoona VAMC leadership, VA, and the VA OIG in an attempt to get help and assistance for Dr. Struthers without success, so the Whistleblowers do not understand how those who had full knowledge of these matters for a period of two years, responded by retaliating against the Whistleblowers, and allowed and even perpetuated these issues to the detriment to patients are not being held to account.

Whistleblowers' Review and Response to Allegation Number 1 in the Agency Report

The first allegation as stated by VA is that Dr. Struthers appears to be impaired and incompetent yet continues to treat patients. In response to the allegation the agency concluded the allegation was unfounded based on evidence that Dr. Struthers underwent medical testing which indicated no evidence of impairment at that time. The focus on the allegation as written by the Agency appears to rest on a determination of Dr. Struthers' impairment and competence.

However, in contrast the actual first allegation as stated by the Whistleblowers actually is based on objective fact alleging that Dr. Struthers continues to see patients and serve as chief of PM&RS in spite of numerous complaints regarding possible impairment and cognitive decline. The allegation as stated by the Whistleblowers rests on the Agency's adherence (or non-adherence) to policy and the action taken by the VA to protect patients and employees when in receipt of complaints of possible impairment. The allegation made by the Whistleblowers is not dependent on the finding of impairment or competence. The conclusion of facts presented by the VA in the report support the Whistleblower's stated allegation that *in spite of numerous complaints regarding Dr. Struthers' possible impairment and cognitive decline, he continues to see patients and serve as chief of PM&RS* as follows:

- The VA concluded that beginning in April 2013 the Whistleblowers began reporting their allegations of Dr. Struthers' impairment to the Altoona VAMC Director, who shared the information with the Chief of Staff.

- The VA concluded that Altoona VAMC leadership did not initially send Dr. Struthers for evaluation of the reported concerns of impairment until September 2013 (5 months after the Whistleblowers initial reporting of concerns of impairment)

- Dr. Struthers continued to see patients without interruption and served as chief of PM&RS during the period of April 2013 through September 2013.

- The VA concluded that the Medical Center's first evaluation of Dr. Struthers for impairment did not comply with the procedures outlined in VA Handbook 5019, Occupational Health Services.

- Dr. Struthers continued to see patients without interruption and continued to serve as chief of PM&RS until March 2, 2015.

- The VA did not have Dr. Struthers evaluated in accordance with VA policy until March 2015. (2 years after the Whistleblowers initial reporting of concerns of impairment and repeated reporting of concerns of direct threats to patient care and safety)

Whistleblowers' Review and Response to Allegation Number 2 in the Agency Report

The second allegation as stated by VA is that *Altoona VAMC officials have failed to respond to the continuing concerns regarding Dr. Struthers' impairment and incompetence.* The VA's allegation appears to rest on an unspecified response or action being taken by the VA regarding continuing concerns of impairment and incompetence and the VA focused on Dr. Struthers competency and compliance with OPPE and attempted to incorporate Mr. DeNofrio's Veteran status and VA healthcare into their conclusions regarding this allegation, which we will address later in our response.

However, in contrast the second allegation as stated by the Whistleblowers actually is again based on a determination by the Whistleblowers that the failure of Altoona VAMC to review Dr.

Struthers' conduct and compliance with facility requirements is a violation of VA and Altoona VAMC guidelines and directives and constitutes a substantial and specific danger to the patients seeking treatment at the facility. The allegation as stated by the Whistleblowers again focuses on the actions of VA and Altoona VAMC leadership in response to disclosures and how the actions (and inaction of VA) to address the Whistleblowers' complaints adversely impacts Veterans. Again the allegation made by the Whistleblowers is not dependent on the finding of impairment or competence. In fact the allegation is not even based on impairment and competence, but rather based on conduct and compliance to VA policy, guidelines, and directives. The conclusion of facts presented by the VA in the report support the Whistleblower's stated allegation that *the failure of Altoona VAMC to review Dr. Struthers' conduct and compliance with facility requirements is a violation of VA and Altoona VAMC guidelines and directives and constitutes a substantial and specific danger to the patients seeking treatment at the facility* as follows:

- In their summary statement VA found violations of VA and VHA Policy.

- The VA concluded that the Medical Center's first evaluation of Dr. Struthers for impairment did not comply with the procedures outlined in VA Handbook 5019, Occupational Health Services.

- The VA did not have Dr. Struthers evaluated in accordance with VA policy until March 2015. (2 years after the Whistleblowers initial reporting of concerns of impairment) Dr. Struthers continued to provide direct patient care without interruption until March 2, 2015.

- During the period of April 2013 – March 2015 the VA concluded that some of the issues identified by VA would be considered noncompliance with accepted physician practices and adherence to Medical Center policies, and should be addressed as such.

- During the period of April 2013 – March 2015 the VA concluded Dr. Struthers failed to communicate his findings and recommendations for treatment to the referring provider in at least three instances while in other cases his documentation of consultation did not address the main reason for the consultation including some instances there is no evidence that Dr. Struthers examined the body part or region identified as the area of concern by the referring provider. Additionally, there were multiple cases identified that Dr. Struthers failed to notify patients of MRI findings.

- During the period of April 2013 – March 2015 the VA concluded that Dr. Struthers was not compliant with VHA Directive 2011-007, Required Hand Hygiene Requirements and repeatedly violated patient privacy.

- During the period of April 2013 – March 2015 the VA concluded that it is not clear whether Dr. Struthers' treatment of the patient on January 7, 2014 (*Veteran 2 in the Agency report*), negatively impacted the patient's condition.

- During the period of April 2013 – March 2015 the VA concluded that some (but not all) witnesses described Dr. Struthers as having occasional incidents of forgetfulness, slight confusion, or questionable judgement following his initial evaluation in 2013. However, he was allowed to continue to see patients without interruption until his re-evaluation and subsequent removal on March 2, 2015 when the Medical Center leadership removed him from direct patient care activities. Please note VA did not provide clarification to the exact representation of "some" when quantifying witness testimony.

- The VA concluded that since his evaluations revealed no impairment, some of the issues would be considered noncompliance with accepted physician practices and adherence to Medical Center policies, and should be addressed as such.

- Please note VA recommendations to the Altoona VAMC include a recommendation to review all remaining consultations performed by Dr. Struthers from October 1, 2013 to present. Evaluate whether Dr. Struthers findings address the concerns noted by the referring provider, and whether his proposed treatments are appropriate for the findings. If not, ensure patients receive an appropriate evaluation and treatment. *Please note that during the period of October 1, 2013 to March 2, 2015 Dr. Struthers is estimated to have completed 919 patient encounters and completed 673 patient visits.*

Additional Evidence Provided to VA to support Whistleblowers' Stated Allegations was Not Included in the Agency Report

Additionally, Mr. DeNofrio and Mr. Skarada made multiple direct and specific reports to Altoona VAMC leadership and the VA OIG that the failure of Altoona VAMC to review Dr. Struthers' conduct and compliance with facility requirements is a violation of VA and Altoona VAMC guidelines and directives and constitutes a substantial and specific danger to the patients seeking treatment at the facility. This evidence demonstrates that in spite of numerous complaints regarding Dr. Struthers' possible impairment and cognitive decline, he continued to see patients and serve as chief of PM&RS (Allegation 1) and the failure of Altoona VAMC to review Dr. Struthers' conduct and compliance with facility requirements is a violation of VA and Altoona VAMC guidelines and directives and constitutes a substantial and specific danger to the patients seeking treatment at the facility (Allegation 2). Examples of those reports that were submitted to the Altoona VAMC leadership, VA Inspector General, and VA Medical Inspector as evidence include but are not limited to the following:

1. July 8, 2013 – Mr. Skarada sent an email to the Altoona VAMC Director notifying him of concerns of possible impairment related to Dr. Struthers including unusual behavior, agitation, tardiness for scheduled patient appointments and meetings, difficulty recalling past conversations, festinating / tangential speech.

2. July 10, 2013 – Mr. Skarada was called to a meeting by the Chief of Staff and asked to monitor and assist Dr. Struthers. Mr. Skarada reported to the Chief of Staff that Dr. Struthers was not following department and VA policies and failing to complete his

documentation. Chief of Staff directed Mr. Skarada not to report the matter to the Director and only report concerns to her.

3. July 25, 2013 – Mr. DeNofrio sent an email to the Chief of Staff notifying her of his concerns that Dr. Struthers was exhibiting signs of an impaired provider.

4. July 26, 2013 – Mr. DeNofrio sent an email notifying the Altoona VAMC Director of concerns of physician impairment and that Chief of Staff had provided Mr. DeNofrio's report of impaired physician directly to Dr. Struthers.

5. August 7, 2013 – Mr. Skarada was contacted by the former Executive Assistant to the Director and asked to provide a summary of all of his recent concerns reported regarding Dr. Struthers. She stated the she was directed to conduct the review by the Director. She also stated that the Director had significant concerns.

6. August 12, 2013 – Mr. DeNofrio filed a complaint with the VA OIG (OIG Case No. 2013-04618-HL-1217) that alleged Altoona VAMC leadership had failed to take action regarding an impaired provider. Mr. DeNofrio reported in his complaint that that the effect of the wrongdoing was that there was a direct threat to patient care and safety due to a suspected impaired physician continuing to provide clinical care after reports were made.

7. August 21 and 22, 2013 – Mr. DeNofrio sent an email to the Altoona VAMC Director and Chief of Staff citing specific concerns and deficiencies related to Dr. Struthers care and practice and Mr. DeNofrio notified them of his concern for the safety of Dr. Struthers, VA patients, and PM&RS.

8. September 13, 2013 – Chief of Staff met with Mr. Skarada and directed him to reduce his duties because Dr. Struthers needed more help.

9. September 26, 2013 – Mr. Skarada sent an email to the HR Labor Specialist to notify of his direct reports about continued concerns of Dr. Struthers possible impairment. HR specialist advised Mr. Skarada to continue to make report to Chief of Staff and Director.

10. October 3, 2013 – Mr. DeNofrio sent an email notifying the Altoona VAMC Director and Chief of Staff that he had not noticed any improvement in Dr. Struthers actions and behavior.

11. October 18, 2013 – Mr. DeNofrio received an email from the Chief of Staff office notifying him that Dr. Struthers OPPE criteria were to be simplified.

12. October 29, 2013 – Mr. Skarada met with VAMC Altoona Director at the Director's request. Mr. Skarada was directed to no longer report concerns related to Dr. Struthers and impairment. Mr. Skarada notified the Director that Dr. Struthers had told a patient and a physical therapist (the patient was not under the care of Dr. Struthers) that Dr.

Struthers informed the patient that they were having pain because their spleen was regenerating. The patient had had a complete splenectomy.

13. November 5, 2013 – Mr. DeNofrio met with VAMC Altoona Director at the Director's request. Mr. DeNofrio was directed to no longer report concerns to the Director and Chief of Staff related to Dr. Struthers and concerns of impairment.

14. November 6, 2013 – Mr. DeNofrio emailed the Chief of Staff requesting direction regarding changes mandated to Dr. Struthers OPPE by the Chief of Staff and notified the Chief of Staff that Dr. Stuthers had failed OPPE. Email was deleted by the Chief of Staff without being read.

15. January 13, 2014 – Mr. DeNofrio sent an email to the Chief of Quality Management Service notifying her that Dr. Struthers did not have an approved OPPE for FY2014 and that the Chief of Staff had deleted Mr. DeNofrio's November 6, 2013 request for direction without response.

16. January 14, 2014 – Chief Quality Management Service directed Mr. DeNofrio back to Dr. Struthers for review of the deficiencies in Dr. Struthers OPPE reported to the Chief of Staff noting that VA OIG had fully reviewed this matter when they were at the Altoona VAMC.

17. April 4, 2014 – Chief of Staff met with Mr. Skarada regarding Veteran 1 named in the Agency report. Chief Staff question why Mr. Skarada notified the Director, and told Mr. Skarada that the Chief of Staff told Dr. Struthers that Mr. Skarada had made the disclosure against him. Following the meeting Dr. Stuthers repeatedly could not recall the name of Veteran 1 and did not document his patient contact or findings related to Veteran 1.

18. June 17, 2014 – Mr. Skarada sent an email to the Altoona VAMC Director requesting protection from escalating issues related to Dr. Struthers and the Chief of Staff following continued reports of possible impairment. Mr. Skarada sent an email report of chart review findings related to Dr. Struthers's documentation at the direction of the Director.

19. June 23, 2014 – Mr. DeNofrio sent an email to the Altoona VAMC Director citing specific concerns and deficiencies related to Dr. Struthers care and practice and notified the Director specifically that he continues to have serious concerns that patient safety is negatively impacted and patients are being placed at risk.

20. July 17, 2014 – Mr. DeNofrio sent an email to the Chief of Staff and Dr. Struthers requesting guidance and direction regarding direction from the Chief of Staff to simplify Dr. Struthers OPPE and remove and no longer report on indicators that Dr. Struthers had failed.

21. November 4, 2014 – Mr. DeNofrio sent an email to the Chief of Staff requesting direction regarding the completion of a FPPE for Dr. Struthers regarding OPPE indicators that did not meet for 3 months or more. No response received.

22. November 4, 2014 - Mr. DeNofrio sent an email to the Altoona VAMC Director and Chief of Staff citing specific concerns and deficiencies related to Dr. Struthers care and practice, that Dr. Struthers had failed one or more OPPE indicators every month in fiscal year 2014, and Mr. DeNofrio notified the Director and Chief of Staff specifically that he continues to have serious concerns that patient safety is negatively impacted and patients are being placed at risk.

23. December 2, 2014 - Mr. DeNofrio sent an email to the Chief of Staff requesting direction regarding the completion of a FPPE for Dr. Struthers regarding OPPE indicators that did not meet for 5 consecutive months. No response received.

24. December 12, 2014 – Mr. DeNofrio sent an email to the Altoona VAMC Director citing specific concerns and deficiencies related to Dr. Struthers and notified him of concerns of possible impairment.

25. December 29, 2014 – Mr. DeNofrio sent an email to Altoona VAMC Director and Chief of Staff citing specific concerns and deficiencies related to Dr. Struthers care and practice, concerns of possible impairment, and Mr. DeNofrio shared his concern that the ongoing incidents presented a serious and imminent threat to safety and patient care.

26. January 2, 2015 – Mr. DeNofrio sent an email to the Chief of Staff requesting direction and advice regarding the completion of a FPPE for Dr. Struthers regarding OPPE indicators that did not meet for 6 consecutive months as well as specific examples of documentation concerns. No response received.

27. January 7, 2015 - Mr. DeNofrio sent an another email to Altoona VAMC Director and Chief of Staff citing specific concerns and deficiencies related to Dr. Struthers care and practice, concerns of possible impairment, and Mr. DeNofrio shared his concern that the ongoing incidents presented a serious and imminent threat to safety and patient care.

28. January 23, 2015 - Mr. DeNofrio sent an email to the Altoona VAMC Director and Chief of Staff citing specific concerns and deficiencies related to Dr. Struthers' performance with the OPPE, and notified the Director and Chief of Staff that concerns have a direct impact on patient care and treatment.

29. January 30, 2015 – Mr. DeNofrio sent an email to the Chief of Staff requesting direction and advice regarding the completion of a FPPE for Dr. Struthers regarding OPPE indicators that did not meet for 7 consecutive months as well as specific examples of documentation concerns.

30. February 3, 2015 – Following an email from the Chief of Staff directing him to send Dr. Struthers OPPE deficiencies to the Altoona VAMC Risk Manager. Mr. DeNofrio

notified the Risk Manager and the Chief of Staff that he had been reporting similar findings on a regular basis to the Chief of Staff, the Director, and Quality Management Service since 2013.

Whistleblowers Review of the Agency's Conclusions and Recommendations

The Whistleblowers argue that the Agency's conclusions and recommendations do not accurately reflect or take in to account the specific allegations made in our disclosure to the OSC. Though we will again not speculate on the motive for this action taken by the Agency, our assumption is that the facts and findings discovered in the investigation supported the actual allegations made in our disclosure, and by changing the wording of the allegations the Agency was attempting to discredit the Whistleblowers and also protect VA and Altoona VAMC leadership from allegations made by the Whistleblowers of violation of VA and Altoona VAMC guidelines and directives and allegations of substantial and specific danger to the patients seeking treatment at the facility.

VA's Conclusions and Recommendations in the Agency report do not correlate to the allegations made by the Whistleblowers. Specifically, the failure of Altoona VAMC to review and promptly address Dr. Struthers' conduct and compliance in accordance with facility requirements is a violation of VA and Altoona VAMC guidelines and directives and constitutes a substantial and specific danger to the patients seeking treatment at the facility. The majority of the conclusions and recommendations apply directly to Dr. Struthers and a review of the concerns of impairment. The Agency report largely neglects to address the Altoona VAMC and VA leadership officials who ignored and attempted to discredit the reports of the Whistleblowers, allowed for violation of VA directives, policies, and accepted standards of medical practice by Dr. Struthers without intervention for a period of nearly two years, violated VA privacy policy and VA directives regarding Occupational Health and provider impairment as well as Ongoing Credentialing and Privileging process and allowed a known and ongoing direct threat to the patient care and safety to persist at the Altoona VAMC without intervention for a period of two years.

Please also note discrepancies between the findings of reviews conducted by VA and reviews conducted by the Altoona VAMC. For example, until Dr. Struthers failed multiple OPPE all practitioners were reviewed by the McKesson InterQual ® criteria. These reports were run by Quality Management Service and the objective reports were provided by the clinical service for physicians at the Altoona VAMC until Dr. Struthers repeatedly failed his OPPE MRI indicator. The Altoona VAMC Chief of Radiology found Dr. Struthers to be 100% compliant with new subjective criteria. However, MRI reviews conducted by VA and Altoona VAMC Quality Management found multiple deficiencies related to Dr. Struthers' ordering and follow-up of MRI including patients not being notified of MRI findings which is in contrast to the 100% compliance reported by the Altoona VAMC Chief of Radiology. Please note the Agency report failed to address the evidence given to them that Mr. DeNofrio was directed by the Chief of Staff and the Chief of Radiology to stop reviewing Dr. Struthers MRI criteria in July 2013 and the Chief of Radiology did not complete his review of Dr. Struthers MRI OPPE performance until June 2014 when Dr. Struthers was being re-credentialed for renewal of medical privileges at the Altoona VAMC. The VA also failed to note in the report that during the period of October 2013

Whistleblowers' Initials: _____ & _____

to June 2014 there was no review conducted of Dr. Struthers MRI OPPE performance even though Dr. Struthers had repeatedly failed the OPPE trigger. Additionally, VA also did not report that Mr. DeNofrio was initially directed by the Chief of Staff to complete a retroactive review of the MRI OPPE of Dr. Struthers in June 2014 prior to Dr. Struthers reprivileging review, but the review was given to the Chief of Radiology only after Mr. DeNofrio reported that Dr. Struthers continued to fail the MRI criteria. This evidence was also presented to VA in the course of this investigation, but excluded from the Agency report.

Additionally, VA reports states that other than the Whistleblowers, no staff members reported witnessing any angry outburst of erratic behavior by Dr. Struthers. However, during his interview with the VA Medical Inspector Mr. DeNofrio presented VA with direct evidence to this claim by presenting a Memo of Understanding between the Altoona VAMC and Mr. DeNofrio signed on August 6, 2014 by Dr. Struthers, the Altoona VAMC Director and Mr. DeNofrio. This memo states in part that Dr. Struthers will speak and interact with Mr. DeNofrio in a manner that is respectful; and that Dr. Struthers will respect Mr. DeNofrio's physical space boundaries and maintain a distance of at least one arm's length away as requested by Mr. DeNofrio following an alleged threat made by Dr. Struthers against Mr. DeNofrio and Mr. Skarada.

Additional, it appears to the Whistleblowers from review of the Agency report and discussions with the Whistleblower's witnesses that a substantial amount of information, statements, and evidence that directly supported the Whistleblower's allegations and reflected negatively on the Altoona VAMC leadership has been overtly excluded from the Agency report. Additionally, one witness notified the Whistleblowers that she was allegedly directed by Altoona VAMC leadership to provide false information and evidence to VA during the investigation in an attempt to discredit the Whistleblowers' allegations and protect Altoona VAMC leadership. The Whistleblowers cannot substantiate this claim and the information is not included from the Agency report.

The Whistleblowers also contend the Altoona VAMC leadership actively attempted to cover-up the allegations made by the Whistleblowers and discredit the Whistleblower's reports rather than address them. The Whistleblower's believe the Agency report is a whitewash of the serious and direct threats to patient care and safety during a period of two years. Additionally, VA is allowing the Altoona VAMC leadership to police themselves regarding the violation of VA and VHA policy and directives in this matter and are relying on information submitted by the Altoona VAMC to be true and accurate even though the members of the Altoona VAMC including members of leadership who are providing this information are the perpetrators of wrongdoing named in these disclosures. This is perceived by the Whistleblowers to be a striking conflict of interest and a mockery of due process which gives the wrongdoers at Altoona VAMC involved in this matter a free pass or "get-out-of-jail-free" card without so much as a slap on the wrist. This also sends signals to the Altoona VAMC leadership that they can resume their ongoing retaliation against the Whistleblowers unabated and without consequence which in turn silences future potential disclosures and intimidate other employees into silence. The Whistleblowers believe that the Agency reports selectively uses certain pieces of evidence to paint a different picture or put a different spin on what is actually happening at VA. The Whistleblower's also believe that a complete review of all evidence and witness statements

collected by VA during this investigation would paint a very much bleaker picture of the realty that exists at Altoona VAMC and VA.

Whistleblower Response to the Agency Inclusion of Unrelated Veteran Status and Veteran Healthcare Information of Whistleblower in the Agency Report

As a matter of relevance the Whistleblowers are uncertain why VA chose to reference and include personal, protected Veteran status of James DeNofrio and protected details as to where Mr. DeNofrio receives his own personal VA medical care in this Agency report and included in the Agency report matters regarding Altoona VAMC employees accessing Mr. DeNofrio's personal medical records at the direction of the Altoona VAMC Chief of Staff following our disclosure to the OSC and investigation by VA. Though the Whistleblowers will make note the VA is acknowledging as a conclusion of fact found through their investigation that Altoona VAMC staff have been accessing Mr. DeNofrio's personal VA medical record following his disclosure, those matters are not part of our disclosure to the OSC and Mr. DeNofrio notes that those matters are currently pending legal disposition in accordance with the Whistleblower Protection Act and Whistleblower Protection Enhancement Act. Although Mr. DeNofrio did not intend for his personal Veteran status to become a topic of this disclosure, he will address the matter directly in response to its inclusion by VA.

Additionally, VA's statement that a gerontologist accessed Mr. DeNofrio's medical record is misleading. As a matter of fact one of the individuals that accessed Mr. DeNofrio record was the Altoona VAMC Chief of Geriatric Service, and he accessed Mr. DeNofrio's medical record at the direction of the Chief of Staff, who is Mr. DeNofrio's second level supervisor. The VA also failed to note that evidence was provided to VA that the Altoona VAMC Occupational Health Physician advised the Chief of Staff and the Chief of Geriatric Service in writing that they should not access Mr. DeNofrio's medical records without signed consent from Mr. DeNofrio in accordance with guidance and direction from VA and the Chief of Staff and the Chief of Geriatric Service disregarded this advice. Additionally, the VA conclusion regarding the number of staff who accessed Mr. DeNofrio's medical record is also misleading. Evidence provided to VA demonstrates that at least eight VA employees were reviewed by the VA Privacy Office regarding access to Mr. DeNofrio's medical records between October 1, 2014 to present including a senior administrative staff member under the direct supervision of the Altoona VAMC Director and Chief of Staff, who was not a VA clinician. These employees are all listed as witnesses called by VA in the Agency Report for Altoona VAMC leadership. Additionally, the reason given by the VA as to why the Chief of Geriatric Service accessed Mr. DeNofrio's medical record is blatantly false. Evidence provided to VA clearly demonstrates that Altoona VAMC discontinued Mr. DeNofrio's consultation for medical care without notifying Mr. DeNofrio and then multiple staff members accessed Mr. DeNofrio's medical records after he made a complaint regarding the matter to the Chief of Staff.

Again even though the Whistleblowers are highly disappointed in the VA's decision to include Mr. DeNofrio's protected Veteran healthcare information, we will respond to this matter since the Agency decided to include this information in their report. The Whistleblowers believe that the release of Mr. DeNofrio's Veteran information that is not related to this OSC disclosure is

evidence a culture of fear and retaliation including ongoing harassment and a hostile working environment that the Whistleblowers believe they have been subjected to by Altoona VAMC leadership following the protected disclosures. It is the belief of the Whistleblowers that Altoona VAMC leadership and the VA will do anything to protect VA and Altoona VAMC leadership and that includes releasing Mr. DeNofrio's protected Veteran information in an effort to discredit the Whistleblowers. In discussion regarding subsequent retaliation and reprisal following these protected disclosures with the VA Medical Inspector during the course the investigation, Mr. DeNofrio mentioned that staff were accessing his VA medical records. The Medical Inspector stated that he would follow-up with the VA Privacy Office separate from the OSC case to ensure that the matter was addressed and stated that he was aware of similar complaints across VA. However, with the inclusion of this information in the Agency Report it appears that VA was misrepresenting their intentions and only serving VA self-preservation interests.

The Whistleblowers believe that VA will go to any length to silence and retaliate against Whistleblowers. Following protected disclosures the Whistleblowers believe that VA has demonstrated their desire to silence the Whistleblowers through persistent retaliatory actions that include but are not limited to VA significantly changing our duties and responsibilities, denial of promotions, creation of hostile work-environment, threatening to lower our performance ratings, accessed medical records, subjected us to multiple retaliatory investigations, denial of over-time and comp-time, changes to in our duties, responsibilities and working conditions, including not being allowed to use emails for review and approval of action items, being separated from other staff members on our team, having duties and responsibilities reassigned to other staff members, and being subjected to hostile and bullying behavior, and having corrective action taking against the Whistleblowers, the Whistleblower's witnesses listed in the Agency report, and against the entire PM&RS service. Please note that these issues are being addressed in accordance with the Whistleblower Protection Act as Whistleblower Protection Enhancement Act. However, Mr. DeNofrio believes that the only reason that he was not fired by VA prior to the acceptance of this case by OSC and actions taken by OSC to address these matter was because Mr. DeNofrio is a military service-connected disabled Veteran, who was retired honorably from the United States Army with a disability that is targeted for special protection under federal law. Had it not been for this special protected status, Mr. DeNofrio speculates that VA would have taken increased disciplinary action against him leading to termination from employment by VA. Additionally, the Whistleblowers note that by their own admission VA (at the direction of the Altoona VAMC Chief of Staff) accessed Mr. DeNofrio's VA medical record and had direct knowledge of the nature of his medical conditions and his VA healthcare needs. However, VA continued to retaliate against Mr. DeNofrio following his disclosures. Other Whistleblowers that did not have the same protections afforded to Mr. DeNofrio under federal law and have been subjected to disciplinary actions and termination across VA prior to intervention by the OSC.

Conclusion

The Whistleblowers bring a combination of 20 years of supervisory, administrative, and clinical experience at VA as well as 40 years of combined experience in the healthcare field in various settings including private practice, community hospitals, and military healthcare in addition to their experience at VA. While at the VA both Whistleblowers' performance was consistently

rated as Outstanding and both received multiple awards in recognition of the service and performance that they provided to VA. Prior to making disclosures, both Whistleblowers were actively involved in leadership assignments and responsibilities representing Physical Medicine and Rehabilitation Service and the Altoona VAMC. Regardless of these facts, when the Whistleblowers brought forward to Altoona VAMC leadership and to VA the very serious concerns described in the disclosure and Agency report, they were immediately vilified, removed from duties and responsibilities, slandered, subjected to hostile retaliation and threats simply for bringing to light matters that needed to be corrected at VA so that no harm came to Veterans or employees of the VA. Instead of correcting the deficiencies Altoona VAMC and VA aggressively attacked the Whistleblowers and ignored and attempted to cover-up the problems allowing them to intensify over a period of two years.

From personal experience the Whistleblowers believe that VA has some of the best clinical and front line employees in the entire world. We have seen this demonstrated on a daily basis by dedicated staff serving our nations Veterans and heard the thanks and praise from those that we serve. The level care that we are able to provide is often not possible outside of the VA as we often have much better resources and fewer constraints than our counterparts.

However, the Whistleblowers believe the excellent level of care and services that VA provides is not a reflection of the Altoona VAMC leadership or VA leadership, but happens in spite of VA leadership. The Whistleblowers believe that Altoona VAMC leadership and VA leadership is dysfunctional at all levels and is committed to the protection and advancement of their own self-interests, agendas, and motivations and not the best interests of the Veteran and the Mission of VA. Words cannot be found to describe how disheartening and troubling it was for us when our repeated complaints to leadership fall on deaf ears and that no actions were being taken to correct the problems or even to ensure patients care and safety.

From the Whistleblowers personal experience actions like those described in this disclosure are not acceptable in the military or the private sector without a tangible corrective response, meaning that responsible individuals are terminated or subject to court-martial, subject to disciplinary actions, lose their license to practice in a healthcare setting, reported to state licensing boards for disciplinary action, subject to lawsuits, etc… VA leaders do not have those types of fears and operate as if they are above the law and beyond reproach. Until actions are taken to fundamentally change the nature, character, and quality of VA leadership and hold VA leaders accountable for significant problems in VA, disclosures like those in this report will remain the norm instead of the exception.

Most of the good employees at the VA are afraid to step forward as Whistleblowers because of the retaliatory response they know that they will experience like we experienced and there seems to be a general consensus that that retaliation is acceptable in VA and those that do come forward do at their own peril and detriment to their careers. It is the opinion of the Whistleblowers that our disclosures and the Agency report only represents the very tip of the iceberg related to serious problems in VA. Until fundamental changes are made related to Altoona VAMC and VA leadership, we will continue to be addressing major problems years after the fact when they have snowballed to a size that can no longer be hidden, covered up, or ignored because good

employees are too afraid to step forward due to fears of the response from bad and failing VA leaders. Our Veterans deserve and have earned much better.

Thank you for your review of our comments. We believe that our conclusions above are reasonable.

Respectfully,

James M. DeNofrio, MA
Administrative Officer, PM&RS
Altoona VAMC

Timothy S. Skarada, MPT
Clinical Supervisor, PM&RS
Altoona VAMC

Attachment: Office of Special Counsel draft factual summary of disclosure DI-13-4570 and comments by whistleblower James DeNofrio dated December 18, 2014 (4 pages).

Denofrio, James

From: Denofrio, James
Sent: Thursday, December 18, 2014 8:00 AM
To: tbiggs@osc.gov
Subject: FW: review
Attachments: Scan.pdf

Follow Up Flag: Follow up
Flag Status: Completed

Ms. Biggs,

I completed the review. There were only a couple minor changes that I found (attached). Thank you very much, it is an excellent summary of the events reported.

Respectfully,

Jay DeNofrio
Administrative Officer
Physical Medicine & Rehab Service
James E. Van Zandt VAMC, Altoona, PA
(814) 943 - 8164 Ext. 8345

From: Biggs, Tracy [mailto:TBiggs@osc.gov]
Sent: Wednesday, December 17, 2014 3:47 PM
To: Denofrio, James
Subject: [EXTERNAL] review

Mr. Denofrio,

As discussed, please find attached a draft factual summary of your disclosure. It is provided for your review and feedback. If this matter is ultimately referred by the Special Counsel, the final version of the factual summary would be included as part of a correspondence from the Special Counsel to the agency head directing an investigation and report under 5 U.S.C. Section 1213. Please note that this draft is an OSC attorney work product. It may not be distributed or shared with anyone other than an attorney or representative assisting you in your OSC matter.

The scan has the pages out of order, but they are numbered so they are easy to arrange correctly. Also, I have the consent form so I am not resending it to you. Thank you.

Tracy Biggs
Attorney, Disclosure Unit
U.S. Office of Special Counsel
1730 M Street, N.W., Suite 218
Washington, D.C. 20036

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Mr. Denofrio and Mr. Skarada explained that from 2009 to 2014 PM&RS experienced significant growth resulting in an increase in patient visits from 7,000 to 30,000. They reported that they both worked with Dr. Struthers for several years and that he was an active manager and a leader in the growth and improvement of the facility. They described him as a personable and communicative physician who managed multiple clinics and clinical services without difficulty.

Mr. Denofrio and Mr. Skarada reported that since the spring of 2013 they have observed Dr. Struthers cognitively decline. In June 2013 ~~they~~ reported to the VA Office of Inspector General that Dr. Struthers was forgetting significant information, including the names of employees with whom he had worked for years, and administrative tasks, such as how to use the e-mail system. On October 29, 2013, they were notified by Altoona VAMC Director William Mills that Dr. Struthers had successfully completed neurological testing. On the basis of that testing, Mr. Mills stated that Dr. Struthers was competent to continue his duties and closed the inquiry in November 2013.

← Mr. DeNofrio reported to VA OIG

← Mr. Skarada was notified on 10/29/13

Mr. DeNofrio was notified on 11/6/2013.

Medical Center Memorandum (MCM) 11-14 provides that a practitioner is considered impaired when problems such as addiction, physical disabilities or neuropsychiatric difficulties interfere with the practitioner's ability to function with reasonable skill and safety. When there is an issue of practitioner impairment, a Physical Standards Board is convened to review the issues and make a recommendation regarding the individual's continued practice. The chief of staff's office is to be notified if there is evidence of impairment and that office may request that the director authorize a special physical examination as authorized in VA Handbook 5019, Occupational Health Services, Part II. Despite these requirements and their numerous reports to ~~the~~ Mr. Mills and to Chief of Staff Dr. Santha Kurian, Mr. Denofrio and Mr. Skarada alleged that these officials have failed to respond to the continuing concerns regarding Dr. Struthers' apparent impairment.

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Despite the favorable results of the neurological testing of October 2013, Mr. Denofrio and Mr. Skarada have continued to observe and report changes in Dr. Struthers' behavior that they believe demonstrate that he is an impaired practitioner. For example, they stated that Dr. Struthers is increasingly confused and agitated, and is prone to angry outbursts and erratic behavior. They disclosed that Dr. Struthers routinely becomes confused when faced with any administrative changes or instructions and appears to be uncertain about which employees he supervises. For instance, on one occasion he forgot that the audiology staff reports to him. Several staff members have also expressed concerns about his ability to perform his duties and treat patients and have reported to Mr. Denofrio and Mr. Skarada that Dr. Struthers is forgetful, cannot perform administrative duties and frequently requests assistance for tasks he was able to perform in the past, such as navigating the Human Resources request system. In a recent example from December 2014, Dr. Struthers reportedly asked Mr. Denofrio if he, Dr. Struthers, was a Senior Executive Service manager for the VA.

Mr. Denofrio and Mr. Skarada also reported that Dr. Struthers is frequently absent from their department during the day without explanation. When Dr. Struthers is present he has been observed treating patients he meets in the waiting room or hallway without a consult referral or a scheduled appointment. They noted that he has repeatedly failed to communicate with primary care providers and treating therapists regarding his clinical treatment and recommendations, or

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changes that he has made to the treatment care plans for patients. In addition, they disclosed that Dr. Struthers has engaged in questionable and inappropriate treatment of patients at the VA. For example, in April 2014, Dr. Struthers conducted a hernia examination on an individual who was not his patient, did not follow proper hygiene protocol, and later in the day did not recall examining the patient.

Mr. Denofrio and Mr. Skarada also alleged that Mr. Mills approved Dr. Struthers' re-credentialing for clinical privileges in July 2014 even though Dr. Struthers failed to meet numerous goals established in the Ongoing Professional Practice Evaluation (OPPE) criteria during Fiscal Years (FY) 2013 and 2014. Mr. Denofrio explained that OPPE, which includes administrative and clinical requirements, is an ongoing monitoring process used to evaluate practitioners' competence with respect to privileges at a facility and identify any trends that could adversely affect the quality of care or patient safety. OPPEs are used in the re-credentialing and re-privileging processes. According to the information provided, the Altoona VAMC Credentialing Committee has determined that the failure to meet OPPE performance measures for three consecutive months triggers a Focused Professional Practice Evaluation (FPPE). The FPPE is used to evaluate the privilege specific competence of a practitioner where the practitioner has not demonstrated competence in a specific area. Pursuant to VHA Handbook 1100.19, results of an FPPE are to be documented in the practitioners' file and reported to the Executive Committee of the medical staff for consideration on privilege recommendations.

Mr. Denofrio reported that during FY 2014 Dr. Struthers did not meet the target goal of 90% for ordering MRIs according to the appropriate standard. Dr. Struthers' performance was measured at 73%. Mr. Denofrio further alleged that Dr. Kurian changed the standard used to evaluate Dr. Struthers' use of MRIs in order to avoid triggering a review of his performance. Initially, Dr. Struthers' OPPE on the use of MRIs was to be evaluated on the Interqual standard, which measures whether a practitioner's orders MRIs appropriately. After Dr. Struthers failed to pass the Interqual standard, Dr. Kurian directed that he be evaluated according to the American College of Radiology (ACR) standard, which focuses on how to appropriately read an MRI. Mr. Denofrio explained that the change in evaluation standard instituted in February 2013 altered the MRI requirements applied to Dr. Struthers. He stated that the ACR standard is used to measure the performance of radiologists and is not the appropriate standard to assess Dr. Struthers' performance. Even under the altered standard, Mr. Denofrio maintained that Dr. Struthers' continued to fail this performance measure in FY 2014.

Additionally in the last quarter of 2014, Dr. Struthers achieved an 87% success rate on the measure for inappropriate copying and pasting in patient records where the target performance rate is 95%, and a success rate of 73% for the measure of unsigned co-signatures greater than 72 hours where the target rate is 95%. In October 2014, Dr. Struthers achieved only 40% in the area of inappropriate copying and pasting. Dr. Struthers's performance measures should have triggered a FPPE, however, Mr. Denofrio reported that no FPPE was initiated. According to the information provided by Mr. Denofrio, Vera Gehringer, Altoona VAMC credentialing coordinator, who is responsible for monitoring practitioners who are on FPPEs, informed him that no FPPE was initiated. Mr. Denofrio and Mr. Skarada stated that the VHA Handbook 1100.19 requires that the failure to meet the established performance indicators be documented. Mr. Skarada and Mr. Denofrio also contended that the failure to initiate FPPEs is a violation of

VHA Handbook 1100.19 Ch. 14 as well as local policies including MCM 11-26. For these reasons, they contended that Dr. Struthers was evaluated and re-credentialed on the basis of an inaccurate record.

As noted previously, several Altoona VAMC health care providers and employees have reported concerns regarding Dr. Struthers' behavior and treatment of patients to Mr. Denofrio and Mr. Skarada. Mr. Denofrio and Mr. Skarada can provide a list of approximately 16 individuals to VA investigators as well as additional examples of concerning behavior. Finally, Mr. Denofrio and Mr. Skarada have continued to repeatedly report their concerns regarding Dr. Struthers' conduct, interaction with patients and performance on the OPPE criteria to Dr. Kurian and Mr. Mills. Notwithstanding their reports, Dr. Kurian and Mr. Mills have failed to revisit the matter or taken any action.

In summary, Mr. Denofrio and Mr. Skarada alleged that in spite of numerous complaints regarding Dr. Struthers' possible impairment and cognitive decline, he continues to see patients and serve as chief of PM&RS. They allege the failure of Altoona VAMC to review Dr. Struthers' conduct and compliance with facility requirements is a violation of VA and Altoona VAMC guidelines and directives and constitutes a substantial and specific danger to the patients seeking treatment at the facility.