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The Special Counsel

April 7, 2016

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

Re: OSC File No. DI-14-3389

Dear Mr. President:

On April 22, 2015, I forwarded you a report prepared by the Department of Veterans Affairs (VA) based on a whistleblower disclosure regarding the improper restriction of mental health medications by pharmacists at the Beckley VA Medical Center (Beckley VAMC), Beckley, West Virginia. The 2015 report substantiated the whistleblower's concerns, concluding that Beckley VAMC encouraged providers to switch patients to older, less expensive medications to meet a pharmacy cost-savings goal. The decision to restrict the use of certain medications violated VA policy, because the decision was driven by budgetary rather than clinical concerns. The VA's Office of the Medical Inspector (OMI) concluded that this violation of VA policy created a substantial and specific threat to the health and safety of mental health patients.

Shortly before OSC transmitted this report, the whistleblower, who requested confidentiality, contacted OSC with additional allegations concerning ongoing wrongdoing at this facility. On June 11, 2015, we received a supplemental report addressing this second set of allegations.

In addition, due to the serious nature of the original substantiated allegations, OSC requested a second supplemental report concerning the status of potential disciplinary actions for responsible managers, including the Beckley VAMC director, the chief of staff, and the chief of Pharmacy.

The VA's supplemental report on disciplinary action acknowledged that the Beckley VAMC chief of Pharmacy failed to properly document mental health provider objections to the medication restriction policy and did not apprise senior Beckley VAMC managers of these concerns, in violation of agency policy. The report notes that the chief of Pharmacy resigned in September 2015. In addition, the report determined that senior Beckley VAMC managers "did not understand...VHA policy," and did not seek guidance from the regional Pharmacy Executive before approving a policy that violated agency rules. However, the report found that these violations were not "knowing and willful" and, therefore, no disciplinary action was recommended.

I am concerned with the VA's findings on disciplinary action, particularly with regard to the chief of staff, who had direct oversight responsibility for the pharmacy program at Beckley. Requiring a "knowing and willful" violation to support a disciplinary action may

excuse negligent actions, such as failure to exercise appropriate oversight, or other forms of poor performance that create risks to patient safety. In other cases, including in formal litigation, the VA has sought disciplinary action against senior officials who failed to exercise appropriate oversight. We believe that this is a more appropriate standard, and should have been considered in response to OMI's findings at Beckley.

Additionally, the VA's Office of Accountability Review (OAR) stated "there was no evidence that any clinician ever brought any concern that patients may be harmed or denied access to the most effective medication to either the [Chief of Staff] or the [Medical Center] Director." However, OAR fails to note that the chief of staff was a member of Pharmacy and Therapeutics (P&T) Committee. Meeting minutes indicated that the chief of staff was present at the P&T Committee meeting when a mental health provider or providers raised concerns about the policy change's impact on the health and safety of patients. As noted, the OAR report states that these concerns were improperly withheld from the formal meeting minutes, and therefore not presented to the chief of staff or Beckley VAMC director at the time they approved the policy change to restrict the medication. However, it appears that the chief of staff heard the concerns directly and nevertheless chose to move forward with the policy.

Moving forward, we encourage OAR to use a consistent standard for pursuing discipline and to adopt an approach that best promotes accountability within the VA.

I. Background

In the original disclosure, the whistleblower alleged that Beckley VAMC pharmacists frequently rejected providers' prescription orders based exclusively on cost. The initial agency report substantiated this allegation and found that the Beckley VAMC P&T Committee enacted a policy that switched mental health patients from certain antipsychotic medications to cheaper drugs based on a cost savings goal for FY2013. The report noted that this decision violated Veterans Health Administration policy and posed a substantial and specific danger to public health and safety.

The report recommended an immediate cessation of this practice and a clinical review of any patients whose medication was switched. In addition, it recommended structural changes to the P&T Committee, which was improperly chaired by a pharmacist, not a physician. Finally, the report stated that, if appropriate, "action should be taken against Medical Center leadership and the P&T Committee for approving actions that were not consistent with VHA policy...and may constitute a substantial and specific risk to public health."

II. The Whistleblower's Additional Allegations

The whistleblower's additional allegations asserted that the Beckley VAMC Pharmacy Service improperly maintained a list of medications designated as "Special Drugs," which required additional written provider prescription justifications, and that many of these drugs were restricted based solely on cost, in violation of VA policy. The

whistleblower asserted that the Pharmacy Service maintained a spreadsheet demonstrating these restrictions, and the chief of the Pharmacy improperly directed employees to alter this list to remove evidence of drug constraints based on cost. The agency did not substantiate the whistleblower's additional allegations. The agency explained that it could not find evidence suggesting that a "Special Drug" list or spreadsheet indicating restrictions existed. In addition, investigators could find no evidence indicating that the chief of the Pharmacy ordered employees to delete these documents.

Investigators interviewed all mental health providers and pharmacists regarding these allegations. The agency explained that employees were not aware of a list of mental health medications requiring a restricted drug request before the medication could be dispensed. The report explained that this allegation may have stemmed from the fact that the Pharmacy Service maintains a list of locally restricted drugs and a list of drugs associated with a streamlined approval process for patients transferring to Beckley VAMC from another VA facility. The report noted that drugs can be restricted on the local level for non-cost related reasons, such as the prevention of antibiotic resistance.

The whistleblower commented that the investigation was flawed, observing that conclusions reached in the supplemental report were incorrect in light of the available facts. The whistleblower asserted that the investigation was carried out in a manner intended to protect VA management.

III. Proposed Disciplinary Actions

In July 2015, OSC requested a second supplemental report addressing disciplinary action proposed in the original report. OSC asked whether the agency determined if any disciplinary action was warranted and, if so, the nature of any proposals. On February 24, 2016, OAR provided a report addressing these questions. .

This report explained that OAR convened an Administrative Inquiry Board (AIB) to review senior leadership accountability concerns associated with pharmacy operations at Beckley. This review examined the roles of Karin L. McGraw, Beckley VAMC director; Brian Nimmo, the associate director; Dr. John Berryman, the chief of staff, and Debra Lynn Legg, the associate director for Patient Care Services. The AIB concluded that the chief of staff and director approved a policy that violated VHA policy, and had not consulted with Veteran's Integrated Service Network level pharmacy experts prior to approving this measure. The report further explained that during the P&T Committee meeting where this measure was approved, representatives of the Mental Health service line voiced concerns about this development, but the chief of Pharmacy did not include these objections in her policy recommendation to the chief of staff and director.

The report explained that the chief of staff and director did not understand relevant VHA policies. For these reasons, OAR did not attribute any culpability to their actions, noting that their approval of the improper pharmacy policy was not "knowing and willful." The report stated that chief of Pharmacy's failure to document the Mental Health service line

representatives' objections also violated policy. The chief of Pharmacy resigned in September 2015.

As stated above, I am concerned by the "knowing and willful" standard adopted by OAR in this case, and believe this is inconsistent with other disciplinary actions pursued by the VA. In addition, OAR failed to note that the chief of staff was present at the P&T Committee meeting at which concerns were raised. Evidence showing that the chief of staff attended the meeting was included as an attachment to the original OMI report. While the chief of Pharmacy did not include these concerns in the formal meeting minutes, the chief of Staff was present at the meeting at which they were raised and nevertheless decided to approve the improper policy.

III. The Special Counsel's Findings

I have reviewed the whistleblower's additional disclosure, the agency supplemental reports, and the whistleblower supplemental comments. Given the quality of the original OMI investigation, I have determined that the reports contain all the information required by statute, and the findings appear reasonable. However, I encourage the VA to adopt and implement a consistent standard in disciplinary action reviews.

As required by 5 U.S.C. §1213(e)(3), I have sent copies of the unredacted agency supplemental reports and the whistleblower's supplemental comments to the Chairmen and Ranking Members of the Senate and House Committees on Veterans Affairs. I have also filed a redacted version agency supplemental report and whistleblower comments in our public file, which is available at www.osc.gov.[1] This matter is now closed.

Respectfully,

Carolyn N. Lerner

Enclosures

[1] 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.