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The Special Counsel

August 30, 2016

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

Re: OSC File No. DI-15-3017[1]

Dear Mr. President:

Pursuant to my duties as Special Counsel, I am transmitting Department of Veterans Affairs agency reports based on disclosures of wrongdoing at the Department of Veterans Affairs (VA), Greater Los Angeles Healthcare System (GLAHCS), Santa Maria Community Based Outpatient Clinic (CBOC), Santa Maria, California. I have reviewed both the agency report and the supplemental report and, in accordance with 5 U.S.C. §1213 (e), provide the following summary of the agency reports, whistleblower comments, and my findings.[2]

The whistleblower, Stephen Mayeri, who consented to the release of his name, is a psychiatrist at the Santa Maria CBOC. Dr. Mayeri disclosed that there were undue and harmful delays in filling prescriptions for mental health patients at the Santa Maria CBOC, which resulted in persistent delays in patients' receipt of their prescriptions. Dr. Mayeri further disclosed that the delay prevented patients with significant mental health disorders from receiving prescribed medications in a consistent and timely manner. Dr. Mayeri believes the backlog in prescriptions was the result of chronic understaffing. The agency substantiated Dr. Mayeri's allegations.

Dr. Mayeri's allegations were referred to Secretary of Veterans Affairs Robert A. McDonald on August 25, 2015 for investigation pursuant to 5 U.S.C. § 1213(g). Secretary McDonald tasked the VA's Office of the Medical Inspector (OMI) with the investigation.

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[1] When OSC initially transmitted this case to the Secretary of the VA, it contained an incorrect case number, DI-15-1216. Thus, both the agency and supplemental reports contain a reference to this incorrect case number. The correct OSC case number is DI-15-3017.

[2] The Office of Special Counsel (OSC) is authorized by law to receive disclosure of information from federal employees alleging a violation 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 the aforementioned conditions exists, she is required to advise the appropriate agency head of her determination, and the agency head is required to conduct an investigation of the allegations and submit a written report. 5 U.S.C. § 1213(c) and (g). Upon receipt, the Special Counsel reviews the agency report to determine whether it contains all of the information required by statute and that the findings of the head of the agency appear to be reasonable. 5 U.S.C. § 1213(e)(2). The Special Counsel will determine that the agency's investigative findings and conclusions appear reasonable if they are credible, consistent, and complete based upon the facts in the disclosure, the agency report, and the comments offered by the whistleblower under 5 U.S.C. § 1213(e)(1).

The VA, through then-Interim Chief of Staff Robert D. Snyder, submitted an agency report on February 3, 2016. OSC received a supplemental report on April 28, 2016. Dr. Mayeri provided comments regarding the initial agency report but declined to comment on the supplemental report.

OMI's investigation found that an unreasonable delay existed in the processing and delivery of prescriptions through the Santa Maria CBOC, as evidenced through chart reviews and patient cases provided by Dr. Mayeri. The report also confirmed that the delays had the potential to cause patient harm. Additionally, OMI determined that the delays and backlog also violated the Veterans Health Administration (VHA) handbook and local standard operating procedures. Finally, OMI confirmed that VA management charged with oversight of the CBOCs under the GLAHCS was largely unaware of the extent of the backlog in prescriptions processed through the Santa Maria CBOC, and did not properly log or report the backlog to the Veterans Integrated Support Network (VISN), as VA policy required.

In his comments, Dr. Mayeri indicated he was encouraged that his allegations were substantiated and that OMI discovered the underlying causes of the backlog. He remained concerned, however, that at the time OMI issued the report, the one staff pharmacist position at the Santa Maria CBOC was vacant, and Dr. Mayeri did not believe the VA had taken any steps to fill the position. Dr. Mayeri also commented that to his knowledge, the GLAHCS employed a uniform model for filling prescriptions through the CBOCs, and thus, the delay in filling prescriptions likely affected all patients receiving care through the facility, not just mental health patients.

In response to OMI's report and Dr. Mayeri's comments, OSC requested a supplemental report from the VA detailing first, what steps the VA had taken to appropriately staff the Santa Maria CBOC, and second, whether the VA had taken steps to ensure management accountability for the backlog and delays caused to patients. In response to this inquiry, OMI issued a supplemental report to OSC on June 13, 2016, which indicated that, as of April 11, 2016, the VA added an additional pharmacist to the Santa Maria CBOC staff. OMI further reported that on April 26, 2016, the VA offered a candidate a pharmacist position at both the Santa Maria CBOC and the nearby San Luis Obispo CBOC.[3] OMI also confirmed that the VA planned to hire one additional staff pharmacist who would "float" between the Santa Monica and Oxnard CBOCs, but who could be detailed to other GLAHCS CBOCs, such as Santa Maria, if necessary. Finally, in response to OSC's inquiry regarding management accountability, OMI reported that in September 2016, the VA's Deputy Under Secretary for Clinical Operations would conduct a site review of the prescription process for all of the GLAHCS facilities to address issues of management accountability and to assess structural adequacy.

After seeking additional information concerning the pending site review, OSC learned that the VA conducted site reviews of both the GLAHCS and the Santa Maria

[3] OSC subsequently learned that the candidate declined the position for personal reasons. Currently, the position is posted on USA Jobs with a 15% bonus for relocation.

CBOCs between June 26-29, 2016, earlier than projected. During that review, the VA assessed the processing and delivery of patient prescriptions identified for mail delivery and management accountability. The VA also conducted a full workforce management review of all pharmacy services governed by GLAHCS. Though the review concluded that there were no current prescriptions older than seven days in the system, the review determined the VA was not in compliance with several prescription processing and staffing-related regulations. Regarding management accountability for the prescription backlog, the review concluded that the senior pharmacy staff members who failed to report the prescription backlog were no longer on staff.

Through an additional inquiry, OSC learned that the VA has posted vacancy announcements for several registered pharmacist positions at the Santa Maria CBOC and is currently reviewing the list of certified candidates. As to the staffing issues noted in the site review, the VA confirmed it is in the process of establishing pharmacy workload metrics related to prescription processing and is re-evaluating pharmacy staffing. The VA's Acting Chief, Pharmacy, will continue to provide quarterly updates to the VHA central office as the recommended action items are completed.

I have reviewed the original disclosures, the agency reports, and Dr. Mayeri's comments. In light of the recent steps the VA has taken to hire additional staff at the Santa Maria CBOC and other local CBOCs and its decision to review issues of management accountability and structural adequacy for the GLAHCS' prescription process, I have determined that the reports contain all of the information required by statute, and the findings appear reasonable. I have sent a copy of this letter, the unredacted agency reports, and the 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 reports in OSC's public file, which is available online at www.osc.gov.[4] This matter is now closed.

Respectfully,

Carolyn N. Lerner

Enclosures

[4] 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.