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The Special Counsel

June 12, 2017

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

Re: OSC File No. DI-13-4519

Dear Mr. President:

Pursuant to my duties as Special Counsel, I am forwarding Department of Veterans Affairs' (VA) reports based on disclosures of wrongdoing at Veterans Health Administration (VHA) facilities in a variety of locations nationwide. I have reviewed the agency reports and, in accordance with 5 U.S.C. §1213(e), provide the following summary of the reports and my findings.[1] The whistleblower, whose identity is confidential, disclosed that VHA facilities do not maintain proper oversight over patients and providers. The VA substantiated the whistleblower's allegations.

The whistleblower's allegations were referred to former Secretary Robert McDonald for investigation pursuant to 5 U.S.C. §1213 (c) and (d). The Office of the Medical Inspector (OMI) investigated the allegations. Secretary McDonald delegated responsibility to review and sign the report to former Chief of Staff Robert L. Nabors, who submitted the report to OSC on July 9, 2015. Acting Under Secretary for Health Poonam L. Alaigh, M.D., submitted the agency's supplemental report to OSC on April 11, 2017. The whistleblower chose not to submit comments on the agency's reports.

The whistleblower disclosed that oversight of narcotics prescriptions is superficial or non-existent at many VHA locations across the nation.[2] The whistleblower alleged that

[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).

[2] The VA locations at issue are: Dover, DE; Durham, NC; Beaufort, SC; Jackson, MS; Conway, NH; Cape May, NJ; Northfield, NJ; St. George, UT; Lincoln, ME; Bangor, ME; Phoenix, AZ; Prescott, AZ, Cottonwood, AZ, Baltimore, MD; Santa Fe, NM; and Guam.

providers' assessments of pain-related complaints are extremely limited and that patient charts do not reflect a full examination of the patient or a review of the patient's history. The whistleblower also asserted that providers rarely reevaluate the patient at regular intervals. The whistleblower maintained that the failure to fully diagnose and reevaluate pain complaints could result in misdiagnoses and potentially lead to serious conditions such as malignancies. It could also lead to situations in which patients who have narcotics prescriptions get them refilled in perpetuity with no provider follow-up. The whistleblower offered an example of a provider at the Dover Community-Based Outpatient Clinic (CBOC) who renewed patients' narcotics prescriptions, month after month, with no follow-up. Providers were rarely conducting physical examinations and urine toxicology screens. According to the whistleblower, many patients had histories of substance abuse, polysubstance abuse, and alcoholism, but providers were not flagging these conditions.

The agency report substantiated that VA providers nationwide do not comply with VA guidelines for random drug testing of patients. The agency reviewed data from 16 VHA locations, noting that in 2013, the VA instituted an Opioid Safety Initiative (OSI) Dashboard to track system-wide trends in opioid usage through key metrics. The OMI compared OSI Dashboard opioid prescription data from the 16 locations and found that less than 55 percent of long-term, opioid-treated patients received routine, random urine drug tests, well short of VA guidelines for patients chronically medicated with opioids. The agency did not, however, find that overall follow-up with these patients was inadequate. Rather, the OMI determined that 95 percent of long-term opiate-treated patients nationally had regular follow-up contact with a provider. The OMI did find that two former providers at the Wilmington VA Medical Center (VAMC) had less follow-up contact than the national average and that they were not in full compliance with VA guidelines for random urine testing. However, both providers had left VA employment at the time of the investigation.

In response to these findings, the OMI recommended that the Wilmington VAMC continue to develop a comprehensive pain management program that includes opioid oversight using OSI Dashboard data. In its supplemental report, the agency confirmed that the facility took a number of steps to address the recommendations, including adding OSI Dashboard metrics and data to its Pain Management Committee scorecard for tracking and reporting purposes and restructuring its pain management program to have primary care providers manage patients' pain in consultation with other services.

The whistleblower also disclosed that VA providers regularly fail to make proper notes in patient charts by copying and pasting patient information. The whistleblower alleged that shoddy notetaking places patient health at risk and violates agency policy. The agency substantiated that, between fiscal years (FY) 2008 and 2014, only one of twelve VA medical centers reviewed by the OMI was in compliance with VHA

Handbook 1907.01, para. 25, which requires every VA facility to institute a policy on appropriate use of copy-and-paste functions and to monitor compliance through review of medical records. As of FY 2014, eight of the twelve facilities were not in compliance. As a result, the OMI recommended that the VHA ensure that all medical centers have a policy monitoring the use of the copy-and-paste function and take appropriate action when employees use it improperly. The agency's supplemental report stated that the Wilmington VAMC issued a revised policy on copying and pasting on December 23, 2014, and that education and monitoring are ongoing. The agency also indicated that, in a memorandum dated July 21, 2015, the Assistant Deputy Under Secretary for Health reminded facilities of the requirements of VHA Handbook 1907.01, specifically with regard to the copy-and-paste function.

The whistleblower further alleged that the Dover CBOC assigned a panel of 1200 patients to a temporary provider in May 2014, after the patients had been without a provider since July 31, 2013. Similarly, when a nurse practitioner departed the Dover CBOC on May 30, 2014, the facility failed to reassign her 1200-patient panel to a new provider. The whistleblower alleged that the failure to reassign patients placed patient health in jeopardy and violated VHA Handbooks 1101.10 and 1101.02, which require all patients to be assigned to a Patient Aligned Care Team (PACT).

The agency substantiated that Dover CBOC patients were not appropriately assigned to a provider, in violation of agency policy, and, as a result, patient care was delayed. The OMI recommended that the Wilmington VAMC take the following actions to address the situation:

- Review the care provided to every patient who was not reassigned to ensure each patient is receiving timely care and to identify any adverse events suffered as a result of delay. If patients are found to have been harmed by the delays, provide for clinical or institutional disclosure as appropriate.
- Review the events associated with the improper assignment of patients to PACTs, identify staff responsible for these practices, and take appropriate administrative, instructional, or disciplinary action.
- Develop, maintain, and enforce a contingency planning policy promoting early identification and replacement of primary care staff, maximizing involvement of the chain of command.

The agency confirmed in its supplemental report that medical record reviews were completed in 2015 and did not reveal any adverse events. Further, following a review of PACT assignments by facility leadership in 2014, the former chief of Primary Care stepped down. The supplemental report noted that the associate chief of staff of Primary Care and the Primary Care business manager now handle patient panel assignments.

Additionally, on September 2, 2016, the facility issued a memorandum regarding provider absentee coverage, which requires primary care provider staff to have 45-day advance approval for leave and places responsibility with section chiefs for supervision of the requirement.

I have reviewed the original disclosure and the agency reports. I have determined that the reports meet all statutory requirements and the findings appear reasonable. I thank the whistleblower for bringing these concerns to light. The reports confirm delays in patient care at the Dover CBOC and a nationwide failure to fully monitor patients with opioid prescriptions. In response, the VHA and the Wilmington VAMC have taken a number of significant steps to ensure that patients receive appropriate and timely care, to educate providers and staff, and to monitor their compliance with agency and local requirements. However, given the seriousness of the allegations and the finding that some failures are nationwide, I urge the VA to continue to vigilantly oversee and enforce its policies regarding opioid prescriptions and pain management.

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

Respectfully,

Carolyn N. Lerner

Enclosures