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The Special Counsel

March 28, 2019

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

Re: OSC File No. DI-18-0857

Dear Mr. President:

I am forwarding to you a report from the U.S. Department of Veterans Affairs (VA), that responded to a disclosure of wrongdoing within the Eastern Kansas Health Care System (Eastern Kansas HCS). The whistleblower, [redacted] gastroenterologist (GI) who consented to the release of his name, disclosed that the Dwight D. Eisenhower and the Colmery-O'Neil VA Medical Centers (Eisenhower and O'Neil VAMCs, respectively) had an improper backlog of patients who did not receive timely follow-up endoscopy procedures.[1]

The whistleblower alleged that the Eisenhower and O'Neil VAMCs had a combined backlog of approximately 7,000 patients who had not received timely follow-up endoscopies. The agency substantiated that between the two VAMCs, 1,107 patients had not received timely follow-up endoscopies. As it currently stands, all needed appointments for the affected patients have been scheduled, and 99% of them have been seen. The VA also found that as of February 2018, the whistleblower was the only full-time GI working in the Eastern Kansas HCS, with one other GI performing procedures at the Eisenhower VAMC on Tuesday afternoons only, and one GI performing procedures on Mondays at the O'Neil VAMC. To remedy this obvious deficiency, Eastern Kansas HCS has been working with human resources to recruit and hire GI providers for O'Neil.

The VA further discovered that while the Eisenhower VAMC has availability for new clinic appointments, the O'Neil VAMC does not. Therefore, the O'Neil VAMC referred GI endoscopy requests to Community Care, which a few patients declined. However, some schedulers failed to properly document this in the patients' records. The report noted that endoscopy productivity at the VAMCs declined since 2009, falling below the 25th percentile in 2016. Further, the GI clinics did not notify patients of their endoscopy results within 14 days of receiving them as required by Health System Policy Memorandum 111-02. The clinics also failed to consistently remind patients to schedule

[1]The whistleblower's allegations were referred to former VA Secretary David J. Shulkin for investigation pursuant to 5 U.S.C. §1213(c) and (d). The VA Office of the Medical Inspector (OMI) investigated, and VA Secretary Robert Wilkie reviewed and signed the agency's report. The whistleblower did not comment on the agency report.

follow-up appointments and neglected to monitor the quality of colonoscopies as mandated in Veterans Health Administration (VHA) Directive-1-O-15. The report emphasized that access to quality colonoscopies is important and the VAMCs must ensure that the care provided meets quality benchmarks.

Given its findings, the VA's report made nine recommendations regarding the Eisenhower and O'Neil VAMC GI clinics including the following:

- The National GI Program Office conduct a consultative site visit;
- Continue to refer new consults to Community Care while decreasing the backlog and wait times;
- Audit all GI schedulers' training files, and retrain schedulers as needed;
- Monitor colonoscopy quality per VA policy;
- Update and reissue relevant local policies where needed; and
- Reeducate staff on the updated and reissued policies, and appropriately staff the GI clinics.

The report also recommended that the VAMCs use an electronic tracking system to document endoscopy reports, monitor procedure quality, and facilitate patient appointments.

The National GI Program Office also conducted an onsite review of the Eastern Kansas GI program and is completing a final report. The Office provided preliminary feedback on the review, finding that in the last 12 months GI consult wait times have decreased from 128 days to 55 days, and all GI schedulers have completed needed training. Colonoscopy cases are now reviewed daily and quarterly for quality metrics, and thus far, the metrics have been met at 100 percent. The relevant local policies were revised and renewed, and leadership expects all GI staff training on the revised policies to be completed by May 3, 2019.

The preliminary findings also show that Eastern Kansas HCS has hired a 0.5 full time equivalent for each Eisenhower and O'Neil VAMC GI clinic, and recruitment continues for another position at O'Neil. Further, training of GI staff on the newly implemented electronic tracking system is ongoing. Finally, primary care providers are also being trained on a GI clinical reminder system, and leadership designated an RN Care Coordinator in the GI program who will ensure all levels of the program work together.

I have reviewed the original disclosures and agency report. Though the allegation was very troubling, I commend the VA on the corrective actions taken to ensure that veterans at the Eisenhower and O'Neil VAMCs receive appropriate GI care. I also want to acknowledge the whistleblower who brought this serious matter to our attention. Because of his unwavering dedication to our nation's veterans and the VA's mission, this disclosure will ensure that patients within the VA Eastern Kansas HCS receive the medical care they deserve. Given the VA's response, I have determined that the report appears reasonable and meets all statutory requirements.

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

Respectfully,

Henry J. Kerner
Special Counsel

Enclosure