



U.S. OFFICE OF SPECIAL COUNSEL
1730 M Street, N.W., Suite 300
Washington, D.C. 20036-4505

The Special Counsel

February 6, 2019

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

Re: OSC File Nos. DI-18-1683 and DI-18-1827

Dear Mr. President:

I am forwarding to you a report from the Department of Veterans Affairs (VA), Orlando VA Medical Center (Orlando VAMC), Orlando, Florida. The whistleblowers, who chose to remain anonymous, disclosed an improper backlog of endoscopy procedures at the Orlando VAMC. I have reviewed the agency report and, in accordance with 5 U.S.C. § 1213(e), provide the following summary of the report and my findings.¹

The whistleblowers alleged that approximately 453 veteran patients at the Orlando VAMC were awaiting endoscopy procedures at the facility, with wait times for the procedure exceeding 30 days from the clinically indicated date (CID). Additionally, the whistleblowers disclosed that the Acting Chief of Medicine instructed gastroenterology (GI) not to utilize community care, such as the Veterans Choice Program, to alleviate the backlog. Finally, the whistleblowers asserted that failure to offer veterans access to community care when wait times exceed 30 days was a violation of the Veterans Access, Choice, and Accountability Act of 2014 (Choice Act).

The VA substantiated all of the whistleblowers' allegations. The VA found that veteran wait times exceeded 30 days from the CID for endoscopy procedures. The VA's report determined that the rate of colonoscopy screenings for at-risk veterans within 180 days or less of identifying positive preliminary indicators was declining, which increased the risk of delays in diagnosis and treatment of colorectal cancer. The report further acknowledged that the wait times between preliminary evaluations and colonoscopies appeared to be increasing, and thus, raising the risk for other medical conditions to worsen and complicate the ability to complete the colonoscopy.

The report determined that the Acting Chief of Medicine instructed some GI personnel not to utilize Care In The Community (CITC). The investigation also determined that while 222 veterans awaiting endoscopies were offered CITC, the Orlando

¹The whistleblowers' 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 conducted the investigation. VA Secretary Robert Wilkie reviewed and signed the agency's report. The whistleblowers did not comment on the agency report.

The President
February 6, 2019
Page 2 of 2

VAMC failed to follow Veterans Health Administration policy and Choice Act rules to offer CITC to 285 other veterans. As a result of the investigation, the VA contacted 127 veterans and offered CITC for their endoscopy procedures. The VA also undertook efforts to contact the remaining 128 veterans and also offer CITC to them.

I have reviewed the original disclosures and agency report. While these allegations were very troubling, I commend the VA in their efforts to ensure that veterans at the Orlando VAMC receive proper medical services. I also want to acknowledge and praise the whistleblowers who brought this serious matter to our attention. Because of their intrepid allegiance to their agency's mission, these disclosures ensured that Orlando VAMC patients received the care that our nation's veterans deserve. In light of 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