



**U.S. OFFICE OF SPECIAL COUNSEL**  
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**Washington, D.C. 20036-4505**

**The Special Counsel**

March 24, 2021

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

Re: OSC File Nos. DI-19-3969

Dear Mr. President:

I am forwarding a report transmitted to the Office of Special Counsel (OSC) by the Department of Veterans Affairs (VA), in response to disclosures of wrongdoing at the Central Alabama Veterans Health Care System (CAVHCS), Montgomery, Alabama. The whistleblower, [REDACTED], a former nephrologist at the facility, who consented to the release of her name, alleged that CAVHCS had a significant shortage of physicians in several specialties, which impeded patient access to care. Additionally, [REDACTED] asserted that due to this physician shortage, patients are often referred to non-VA providers in the community. Consequently, she explained that CAVHCS' Community Care Office is overwhelmed with the volume of referrals for non-VA care and patients often waited months for both routine and urgent specialty care referrals. I have reviewed the disclosure, the agency report, and [REDACTED] comments, and in accordance with 5 U.S.C. §1213(e) provide the following summary and my findings.<sup>1</sup>

The agency substantiated [REDACTED] allegations. The investigation first determined that CAVHCS had a physician vacancy rate over 50 percent, and that executive leadership positions, including the Medical Center Director, Associate Medical Center Director, and Chief of Staff were filled by individuals temporarily detailed in these roles. As a result of the physician vacancy rate, CAVHCS was unable to provide specialty services in Dermatology, Gastroenterology, Nephrology, Neurology, Oncology, Ophthalmology, and Rheumatology. The investigation also found that CAVHCS was not functioning at its designated complexity level, which raised "concern for clinical personnel's ability to adequately maintain the competencies required to care for a complex Veteran population."

The report also substantiated that a high percentage of consultations were referred to community care. The investigation determined that this resulted from the physician vacancy rate,

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[REDACTED] allegations were referred to former VA Secretary Robert L. Wilkie pursuant to 5 U.S.C. § 1213(c) and (d). The Office of the Medical Inspector investigated the matter. Former Secretary Wilkie reviewed and signed the report.

mentioned above, and an underutilized standard inpatient surgery program. The report stated that CAVHCS had a “long-standing culture and preference throughout the facility to perform ‘low volumes of low complexity procedures in low-risk patients’...and a significant ‘degree of risk aversion.’” These factors contributed to CAVHCS functioning beneath its operative complexity and infrastructure capabilities.

The report also substantiated that CAVHCS Community Care Office was “overwhelmed with the volume of referrals for non-VA care.” The report explained that some veterans waited more than two months for appointments but did not substantiate that veterans were waiting months for urgent non-VA care. The report explained that CAVHCS has made significant progress in managing community care consults, yet there are several remaining staffing vacancies which hinder the ability of the Community Care Office to manage the high volume of work.

██████████ provided comments to the report. Compellingly, she noted the human cost of CAVHCS’ deficiencies, recounting a situation where a patient with progressive kidney failure was unable to receive appropriate care at the facility as his kidney failure worsened. ██████████ observed that because the Community Care Office was unable to facilitate treatment by a private nephrologist, the patient ultimately had to seek care at an emergency room and required dialysis. ██████████ attributed many of these issues to policies created by the former Assistant Chief of Staff, and which functionally restricted the capacity of providers to refer patients to receive appropriate care. She also faulted CAVHCS for a workplace culture that made it difficult to recruit and retain skilled physicians.

I have reviewed the original referral, the agency report, and ██████████ comments. I note that the VA made a significant number of recommendations to both the facility and the Veterans Integrated Service Network (VISN) that supervises CAVHCS. These recommendations focus on sustaining positive progress that the Community Care Office has made in scheduling timely appointments and hiring additional physicians. The report noted that by the start of FY2020, the Community Care Office had implemented a variety of improvements and was scheduling all appointments expeditiously. Physician staffing presents an ongoing challenge. CAVHCS, the VISN, and the Veterans Health Administration are likewise engaged in an “intense recruitment and hiring strategy” to bring on executive leadership for the facility and are working with a physician-recruiting service to fill priority vacancies. The report also notes the establishment of a comprehensive orientation process and interviewing process, which appears to address the workplace culture concerns raised by ██████████.

Accordingly, I am encouraged by the positive steps the VA and CAVHCS have taken to remediate these problems. For these reasons, I have determined that the agency report meets all the statutory requirements, and the findings appear reasonable. Finally, I commend ██████████ for bringing these allegations forward to ensure CAVHCS patients are receiving timely and appropriate medical care.

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

Respectfully,

A handwritten signature in black ink, appearing to read "Henry J. Kerner". The signature is fluid and cursive, with a long horizontal stroke at the end.

Henry J. Kerner  
*Special Counsel*

Enclosures