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

The Special Counsel

November 19, 2025

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

Re: OSC File No. DI-24-000312

Dear Mr. President:

I am forwarding to you reports transmitted to the Office of Special Counsel (OSC) by the U.S. Department of Veterans Affairs (VA) in response to the Special Counsel's referral of a disclosure of wrongdoing at the Veterans Health Administration (VHA), Lt. Colonel Charles Kettles VA Medical Center (Ann Arbor VAMC), Ann Arbor, Michigan.[1] OSC has reviewed the disclosure, agency reports, and whistleblower comments, and, in accordance with 5 U.S.C. § 1213(e), I have determined that the reports contain the information required by statute and the findings appear reasonable. As summarized below, the agency partially substantiated the allegations.

The whistleblower, [redacted], a physician and former Chief of [redacted], who consented to the release of his name, reported allegations of patient safety concerns and violations of VHA regulations, Joint Commission standards, and statutory requirements, including: (i) violations of VHA Directive 1220 requirements that the facility have a designation of Inpatient Complex for inpatient invasive procedures, including that the facility lacked infrastructure requirements, failed to provide qualified supervisory staffing, and failed to maintain a formal surgical call schedule; (ii) unauthorized access to VA computer systems by physician residents who lacked credentials approved by the VA; (iii) violations of Joint Commission standards regarding documentation of complex or high-risk surgical procedures; and (iv) violations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) resulting from discussions of protected health information (PHI) in the public waiting room of the facility.

[1] The whistleblower's allegations were referred to then VA Secretary Denis McDonough for investigation pursuant to 5 U.S.C. § 1213(c) and (d). Then Secretary McDonough signed the report. The VA Office of Inspector General conducted the investigation.

The investigation, conducted by VA OIG, substantiated that the Ann Arbor VAMC lacked infrastructure requirements for certain inpatient invasive procedures, including vascular and non-vascular interventional radiology, cardiac catheterization, and interventional neuroradiology, which are required for the Inpatient Complex designation under VHA Directive 1220(1). After OIG announced its investigation into the deficiencies, the facility initiated waivers for these requirements. The investigation did not substantiate that the facility lacked surgery service coverage or qualified inpatient coverage as required for an Inpatient Complex facility because the relevant records reviewed in connection with this allegation contained the required documentation by an in-house supervising practitioner necessary to maintain the Inpatient Complex designation.

To maintain an Inpatient Complex designation, VHA Directive 1220 also requires the facility to have a formal surgical call schedule, including a communication escalation procedure for on-call providers. The investigation found that the Ann Arbor VAMC is utilizing a formal call schedule based on guidelines set forth in VHA Directive 1220(1) for required surgical services and has a mechanism to escalate challenges with reaching on-call surgical providers. Although OIG identified one incident in which an on-call attending surgeon was not available on-site within 60 minutes of the page, it found that the communication escalation process, implemented in spring 2023, has solved this issue and there is no systemic difficulty in reaching the covering surgeon. As a result of OSC's referral, the facility's surgical services escalation pathway was reviewed with staff and is now posted with the Ann Arbor VAMC call schedules on the facility's SharePoint site.

The agency substantiated that anesthesia residents without approved credentials accessed the VA computer system, finding that facility leadership failed to ensure adherence to information security practices. Although this finding implicated a violation of agency policy, the investigation did not identify a violation of federal law. The report confirmed that upon learning from investigators that unauthorized computer access was being provided to residents, the Ann Arbor VAMC's Associate Chief of Staff for Education met with facility and affiliate stakeholders to review computer access requirements, requested support from the facility privacy officer to review compliance, and plans to continue work to reduce lapses in computer access for residents.

With respect to the alleged violations of Joint Commission standards regarding documentation of complex or high-risk surgical procedures, the agency found that while surgeons were not consistently completing the required operative notes before patients were transferred to the next level of care, facility leaders became aware of the issue prior to the investigation and took action to monitor and improve compliance. Leadership's oversight increased the compliance rate from 62% in March 2023 to 99.5% as of January 2024. However, in its report, the agency stated that it is concerned that the current monitoring methodology may result in inaccurate compliance data, because the data relies

on nursing staff identifying cases of noncompliance without a retrospective audit to ensure that missing documentation is consistently captured. In response to OSC's follow-up inquiry about this concern, the agency confirmed that Ann Arbor VAMC leadership reviewed and updated the process for monitoring documentation of complex and high-risk surgical procedures in October 2024. Under the current process, the Associate Chief Nurse of Surgery and Perioperative Service now completes a retrospective review of 100% of surgical cases to assess compliance with post-operative documentation. These results are also reviewed and discussed monthly at the facility's Surgical Work Action Group and Surgical Section Chief meetings.

Finally, the investigation did not substantiate the alleged HIPAA violations resulting from PHI-related discussions in the public waiting room of the facility. To safeguard patient health information, VHA requires that employees "be conscious of when and where it is appropriate to discuss issues involving individually identifiable health information" and "[s]peak quietly when discussing a patient's condition with family members in a waiting room ... or in other public areas."[2] In this case, the agency found that private spaces for sensitive discussions are available at the Ann Arbor VAMC as needed, and that no privacy complaints related to the surgical waiting area have been reported to the agency's privacy officer.

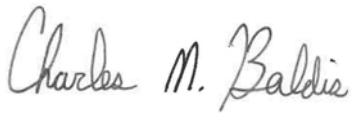
[redacted] disagreed with the agency's determination that two of his allegations were not substantiated and disapproved of the agency's attempt to comply with VHA Directive 1220 requirements. Regarding the failure to adhere to surgical documentation requirements, [redacted] contends that the agency's attempt to remedy the violations he reported, prior to the OSC referral in this matter, is not grounds for non-substantiation. Regarding the alleged HIPAA violations, [redacted] expressed dissatisfaction with the agency's investigatory methods, stating that if the investigators had visited the public waiting room or spoken with surgeons who have been raising concerns about this issue for years, they would have come to a different conclusion. [redacted] stated that the agency's findings with respect to the surgeon call schedule were not consistent with his experiences at the facility and that hospitalist staffing does not satisfy the qualified inpatient coverage requirement for an Inpatient Complex facility under VHA Directive 1220. Lastly, [redacted] expressed distrust in VA OIG's processes and their ability to meaningfully oversee the VA, stating that in his experience, VA OIG does not provide the oversight needed to mitigate risk for veterans.

I thank the whistleblower for bringing the allegations to OSC. As required by 5 U.S.C. § 1213(e)(3), I have sent a copy of this letter, the agency reports, and whistleblower

[2] VHA Directive 1605.0 I. Protected health information is "individually identifiable health information transmitted or maintained in any form or medium by a covered entity, such as VHA."

comments to the Chairmen and Ranking Members of the Senate and House Committees on Veterans' Affairs. OSC has also filed redacted copies of these documents and a redacted copy of the letter referring this matter in our public file, which is available at www.osc.gov. This matter is now closed.

Respectfully,



Charles N. Baldis
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Enclosures