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Phoenix VA Whistleblower Exposes Significant Patient Wait Times

Delays May Have Contributed to A Veteran's Death and May Have Led to Other Adverse Health Impacts

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The Department of Veterans Affairs (VA) hospital in Phoenix, Arizona continues to struggle with significant patient wait times, according to confirmed whistleblower disclosures. The whistleblower is Kuauhtemoc Rodriguez, chief of specialty care clinics at the Phoenix VA. The U.S. Office of Special Counsel (OSC) sent the investigative findings to the White House and Congress today. The VA documented serious delays and their impact on care:

- In one case, the VA found that a veteran who died of cardiovascular disease did not receive a cardiology exam his VA physician ordered. The VA determined that had he received the exam in a timely fashion, further testing and interventions could have prevented his death.
- During a week in October 2015, nearly 3,900 appointments were cancelled. Of those, 59 should have been rescheduled and were not. Of those 59 patients, 12 may have experienced harm that could have been prevented without the delay in care.
- On an average day, the Phoenix VA has 1,100 patients waiting longer than 30 days for appointments.
- There are especially significant wait times for psychotherapy appointments, with patients waiting an average of 75 days.
- Out of a sample of 215 veterans with 295 consults who died while waiting for care, 62 of their consults (21 percent) were delayed. However, according to VA Office of Inspector General, the delayed consults did not relate to their cause of death.
- In another case, a veteran "waited in excess of 300 days for vascular care."
- Out of a sample of 30 inappropriately canceled chiropractic consults, 28 veterans did not receive requested chiropractic care.

OSC reviewed Mr. Rodriquez' disclosures and referred them to the VA for investigation. The VA's Office of Inspector General and Office of the Medical Inspector conducted the investigations for the VA. Mr. Rodriguez also provided comments on the reports.

"In case after case since 2014, Phoenix VA whistleblowers have exposed and helped to correct serious problems with veterans' care," said Special Counsel Carolyn Lerner. "I thank Kuauhtemoc Rodriguez for his courage, and urge the VA to act quickly in implementing all recommendations to improve timely access to care for veterans in Phoenix."

Over the last three years, VA cases have made up the largest portion of OSC's caseload. During that time, OSC press releases on VA whistleblower disclosures were published on December 6, 2016; October 13, 2016; August 31, 2016; June 9, 2016; April 27, 2016; April 8, 2016; February 25, 2016; December 11, 2015; September 17, 2015; July 29, 2015; April 22, 2015; December 3, 2014; June 23, 2014. Other recent releases on VA whistleblowers settling retaliation claims were published on October 19, 2016; May 6, 2016; November 3, 2015; September 8, 2015; July 22, 2015; April 9, 2015; January 20, 2015; and September 29, 2014. Special Counsel Carolyn Lerner and other OSC officials have testified before Congress on the issue of VA whistleblowers on September 14, 2016; September 22, 2015; July 30, 2015; April 13, 2015; and July 8, 2014.

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The U.S. Office of Special Counsel (OSC) is an independent federal investigative and prosecutorial agency. Our basic authorities come from four federal statutes: The Civil Service Reform Act, the Whistleblower Protection Act, the Hatch Act, and the Uniformed Services Employment & Reemployment Rights Act (USERRA). OSC's primary mission is to safeguard the merit system by protecting federal employees and applicants from prohibited personnel practices, especially reprisal for whistleblowing, and to serve as a safe channel for allegations of wrongdoing. For more information, please visit our website at www.osc.gov.