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

The Special Counsel

February 9, 2017

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

Re: OSC File No. DI-14-3310

Dear Mr. President:

Pursuant to my duties as Special Counsel, I have enclosed the Department of Veterans Affairs' (VA) reports based on disclosures of wrongdoing at the Memphis VA Medical Center (Memphis VAMC), Memphis, Tennessee, made to the Office of Special Counsel (OSC). Maurice Skillern, a physician assistant, alleged that from 2012 to 2014 Memphis VAMC management failed to send patients needing full-joint replacements to private providers on a fee-basis, resulting in a year-long wait time for joint replacement procedures. Mr. Skillern further alleged that patients waiting for joint replacements were placed on prescription drugs for pain management, which had a negative effect on their health. I have reviewed the VA's report and, in accordance with 5 U.S.C. § 1213(e), provide the following summary of the agency investigation and whistleblower comments as well as my findings.[1]

I referred Mr. Skillern's allegations to former Acting Secretary Sloan D. Gibson for investigation pursuant to 5 U.S.C. § 1213(c) and (d). Mr. Gibson forwarded the allegations to former Interim Under Secretary for Health Carolyn M. Clancy, M.D., who, in turn, directed the Office of the Medical Inspector to conduct the investigation. Mr. Gibson delegated responsibility to submit the agency's report to former Chief of Staff Jose D. Riojas, who submitted the report to OSC on March 6, 2015. Dr. Clancy submitted the agency's

[1]The Office of Special Counsel (OSC) is authorized by law to receive disclosure of information from federal employees alleging violation of law, rule, or regulation, gross mismanagement, a gross waste of funds, an abuse of authority, or a substantial and specific danger to public health and safety. 5 U.S.C. § 1213(a) and (b). OSC does not have the authority to investigate a whistleblower's disclosure; rather, if the Special Counsel determines that there is a substantial likelihood that one the aforementioned conditions exists, she is required to advise the appropriate agency head of her determination, and the agency head is required to conduct an investigation of the allegations and submit a written report. 5 U.S.C. § 1213(c) and (g). Upon receipt, the Special Counsel reviews the agency report to determine whether it contains all of the information required by statute and that the findings of the head of the agency appear to be reasonable. 5 U.S.C. § 1213(e)(2). The Special Counsel will determine that the agency's investigative findings and conclusions appear reasonable if they are credible, consistent, and complete based upon the facts in the disclosure, the agency report, and the comments offered by the whistleblower under 5 U.S.C. § 1213(e)(1).

supplemental report on May 6, 2015. Mr. Skillern provided comments to the reports pursuant to 5 U.S.C. § 1213(e)(1).

The VA substantiated Mr. Skillern's allegation that there was a year-long wait for joint replacements in the past, but found that the current wait time for these procedures is six to eight weeks. The agency, however, did not substantiate that the prior extended wait times resulted from the facility's failure to send patients to private providers on a fee-basis. Rather, the investigation found that several years ago, a small number of patients who were referred for treatment to a non-VA hospital experienced negative outcomes and had to return to the Memphis VAMC for additional treatment. The Chief of Orthopedic Surgery indicated that, as a result, he was reluctant to refer patients to facilities outside of either the VA or the University of Tennessee's Campbell Clinic, which is an affiliate of the Memphis VAMC, because he believed they would receive the best care in the VA system. Nevertheless, the Memphis VAMC did not, as a matter of policy, decline non-VA care, and funding was always available for such care. Also, beginning in 2012, the Memphis VAMC again began to increase the use of non-VA care to reduce extended patient wait times. Further, the VA did not substantiate that the wait times experienced by orthopedic patients had a negative effect on their overall health. The investigators analyzed the records of 16 patients who lodged complaints with the facility's patient advocate regarding their care, and determined that their care was appropriately managed.

The report also addressed the facility's previous practice of placing patients into VistA, the agency's electronic scheduling system. When a patient is placed in VistA, they then appear on the VistA Electronic Wait List (EWL), allowing the facility to track patient wait times. The agency confirmed that patients should be placed into VistA as soon as their required evaluations and clearances for surgery are completed and operation dates scheduled. At the Memphis VAMC, however, patients were entered into the VistA system only when they were scheduled for their preoperative appointments 30 days before their surgeries. During that time, the orthopedic nurse liaison placed patients awaiting their clearances on a written pending list.

The VA substantiated Mr. Skillern's allegation that patients waiting for total joint replacements do receive prescriptions for pain management. The report noted that patients are also referred to their primary care manager for additional pain treatment, including refills of narcotics prescriptions. The investigation found that this is a standard medical practice that results in better overall pain management and control for patients.

As a result of these findings, the VA made the following recommendations to the Memphis VAMC to improve wait list oversight, reduce overall patient wait times, and prevent negative health consequences:

1) Retrain and reeducate staff on the use of EWL to ensure accurate data on wait times;
2) Improve management oversight of EWL to ensure the continued reduction of wait times for total joint replacements;

3) If wait times are in excess of 30 days, ensure that patients are informed of their options for total joint replacements, including from non-VA medical care contract providers;
4) Continue to monitor patient wait times for total joint replacements and manage their care appropriately;
5) Hire appropriate staff to support the expansion of operating rooms and to assist in the scheduling of operating rooms to ensure that the maximum weekly number of total joint procedures can be performed;
6) Collaborate with Human Resources to ensure a sufficient number of orthopedic surgeons, nurses, and support staff to meet the needs of the expanded operating rooms;
7) Ensure that opioid contracts are in place for veterans who receive narcotics while waiting for total joint replacements in accordance with VHA Directive 1005; and
8) Continue participation in "Pain Management Boot Camp" educational seminars or equivalent training for primary care providers.

The agency confirmed that all of its recommendations have been implemented or are near completion. For example, all appropriate staff have received training on proper use of the EWL and more than 10 new employees have been hired or are in the hiring process. Additionally, as of January 2017, there is no wait list for joint replacement surgery under the Choice program at the Memphis VAMC.

In his comments to the agency's report, Mr. Skillern stated his belief that the investigation was flawed. Mr. Skillern asserted that the facility and witnesses received notification of the investigation ahead of the arrival of investigators, allowing them to cover up wrongdoing within the facility.

On March 31, 2015, OSC requested a supplemental report concerning three additional questions that the initial report did not thoroughly address. In its May 6, 2015 supplemental report, the agency explained that in 2012 there was only one non-VA facility in the area that was available to take joint replacement patients. The supplemental report also stated that the agency was unable to provide more specific details pertaining to the percentage increase in the number of patients referred to non-VA providers for joint replacements from 2012 to 2013 because the coding system in use prior to 2013 was not specific to the service or the specialty of the referral. However, the agency noted that there was a seventy-nine percent increase in orthopedic consults between fiscal years 2013 and 2014. Finally, the supplemental report clarified that the 16 patients interviewed by investigators represented the totality of veterans who filed complaints about wait times for non-VA orthopedic care.

In his comments to the agency's supplemental report, Mr. Skillern reiterated his belief that the investigation was not conducted in a proper manner in an effort to cover up wrongdoing. Mr. Skillern also emphasized his assertion that the Memphis VAMC had

maintained an improper, off-the-books wait list for orthopedic surgeries. Mr. Skillern stated his understanding that the agency report denied the existence of the wait list. However, I note that the agency did address the orthopedic nurse liaison's handwritten pending list and make recommendations to correct the method of tracking patient wait times with proper use of the EWL.

I have reviewed the original disclosures, the agency reports, and the whistleblower's comments. Based upon my review, I have determined that the VA's reports contain all of the information required by statute and the findings appear reasonable. I thank Mr. Skillern for bringing these concerns forward; improvements to reduce patient wait times resulted from his disclosures.

As required by 5 U.S.C. §1213(e)(3), I am now transmitting the agency reports and Mr. Skillen's comments to you and to the Chairmen and Ranking Members of the Senate and House Committees on Veterans' Affairs. I have also filed copies of the redacted agency reports and the whistleblower's comments in OSC's public file, which is available online at www.osc.gov. This matter is now closed.

Respectfully,

Carolyn N. Lerner

Enclosures