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The Special Counsel

March 5, 2019

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

Re: OSC File No. DI-16-2511

Dear Mr. President:

I am forwarding a report from the Department of Veterans Affairs (VA) based on disclosures of wrongdoing at the Memphis VA Medical Center (Memphis VAMC). The allegations were provided by [redacted], a staff nurse in the Care Coordination Unit, who alleged that the Memphis VAMC Neurology Clinic improperly cancelled approximately 150 electromyography (EMG) tests at the direction of management and that these patients had waited on average more than 6 months for care. [redacted] asserted that the EMG tests were improperly cancelled to circumvent VA performance management measurements.[1]

The investigation partially substantiated [redacted] allegations, finding that Memphis VAMC staff did not follow appropriate procedures when they discontinued a backlog of 143 EMG clinic consults for 140 veterans. The agency did not conclude that the cancellations were ordered to disguise patient wait times. Instead, the cancellations were a method to enroll patients in VA's Choice program where they faced shorter wait times.

In response to the investigation's findings, the agency carried out several corrective actions. These included ensuring that Neurology Clinic staff schedule patients in accordance with VA procedures, hiring additional staff to work in the Neurology Clinic and the Memphis VAMC Business Office, and training an employee who displayed particular difficulty in following proper procedures.

[redacted] comments disputed the conclusion that the EMG tests were not cancelled to disguise wait times. He called attention to the timing of the cancellations, noting that they occurred shortly after a business meeting where long wait times were discussed by managers. In addition, [redacted] highlighted the excessive wait times

[1] [redacted] allegations were referred to former Secretary of Veterans Affairs Robert McDonald for investigation pursuant to 5 U.S.C. § 1213(c) and (d). VA's Office of Inspector General conducted the investigation. Former Chief of Staff Vivieca Wright Simpson reviewed and signed the report.

patients were subject to, on average 169 days for care, with the longest waits stretching beyond 250 days.

I have reviewed the original disclosure, the agency report, and [redacted] comments. Based on the investigation, it appears that [redacted] identified serious problems in the scheduling and patient access to care. However, in response to this referral, the facility is now taking these problems seriously and carrying out more fulsome measures to ensure patients are receiving appropriate and timely access to care.

For these reasons, I have determined that the report meets the statutory requirements and the findings appear reasonable. As required by 5 U.S.C. § 1213(e)(3), I have sent a copy of this letter, the agency report, and the whistleblower's comments 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 referral letter in our public file which is available at www.osc.gov. This matter is now closed.

Respectfully,

Henry J. Kerner
Special Counsel

Enclosures