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

September 29, 2017

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

Re: OSC File No. DI-16-3638

Dear Mr. President:

Pursuant to 5 U.S.C. § 1213(e)(3), the Office of Special Counsel (OSC) is forwarding a report from the Department of Veterans Affairs (VA) based on disclosures of wrongdoing at the Louis A. Johnson VA Medical Center (Johnson VAMC), Clarksburg, West Virginia. OSC has reviewed the agency reports and provides the following summary of the report, whistleblower comments, and OSC's findings.[1] The whistleblower, who chose to remain anonymous, alleged that Johnson VAMC managers directed employees in the Emergency Department (ED) to intentionally manipulate patient data to artificially reduce reported wait times and the volume of patient visits.

The whistleblower's allegations were referred to former Secretary Robert McDonald for investigation pursuant to 5 U.S.C. §1213 (c) and (d). The Office of the Medical Inspector investigated the allegations, and Chief of Staff Vivieca Wright Simpson was delegated the authority to review and sign the OMI report. On April 7, 2017, Ms. Simpson submitted the report to OSC. On April 19, 2017, OSC requested a supplemental report, which the VA provided on May 24, 2017. The whistleblower provided comments on June 5, 2017.

The agency largely substantiated the whistleblower's allegations. The investigation revealed that over the last seven years, a Primary Care manager attempted to inappropriately influence ED nursing staff to place emergency patients in two unofficial clinics used to improperly reduce reported ED wait times and the number of ED patient encounters. Affected patients were also improperly coded for medical billing

[1] The Office of Special Counsel (OSC) is authorized by law to receive disclosures of information from federal employees alleging violations 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 of the aforementioned conditions exists, he is required to advise the appropriate agency head of his 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). 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).

purposes. The decision to create these unofficial clinics violated several VA Directives and prevented an accurate analysis of ED staff workload. It also gave the false impression that the Primary Care clinic had a greater workload and demand for services. In response, Johnson VAMC immediately discontinued the practice, developed a process for clinic approvals, and educated leadership and staff on the requirements contained in agency directives violated in this matter. In the report, the VA noted that the Primary Care manager claimed that she initiated the improper clinics in an effort to reduce costs billed to veterans.

Based on this information, OSC requested that the VA address whether any effort to review improper medical copayment billing was conducted and provide an update on any administrative action recommended for the Primary Care manager. The VA informed OSC that 602 veterans were charged an incorrect copayment, resulting in a total lost revenue of $21,070 for the clinic. The agency is currently determining how to recoup lost payments. In addition, the Primary Care manager responsible for the creation of these improper clinics received a written counseling for her inappropriate conduct.

In comments to the report, the whistleblower praised ED staff who resisted these instructions and called attention to large bonuses received by managers responsible for the misconduct. The whistleblower faulted Johnson VAMC senior leadership and called for the removal of responsible individuals from service.

OSC has reviewed the original disclosure, the report, and the whistleblower comments. OSC has determined that the agency's report meets all statutory requirements and that based on the evidence adduced from its investigation, the findings are reasonable. As required by 5 U.S.C. § 1213(e)(3), OSC has sent a copy of this letter, an unredacted version of the agency report, and the whistleblower comments to the Chairmen and Ranking Members of the Senate and House Committees on Veterans' Affairs. OSC has also filed a copy of the letter to the President, redacted reports, and the whistleblower comments in our public file, which is available at www.osc.gov. This matter is now closed.

Respectfully,

Tristan L. Leavitt
Acting Special Counsel

Enclosures