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**Analysis of Disclosure, Agency Investigation and Reports,
Whistleblower Comments, and Comments of the Special Counsel**

OSC File Nos. DI-04-2859, DI-05-0026, DI-05-0039, and DI-05-1921

Summary

Four whistleblowers, who have requested anonymity, disclosed to the Office of Special Counsel (OSC) that the U.S. Department of Veterans Affairs (VA), Greater Los Angeles Healthcare System (VAGLAHS), West Los Angeles Medical Center (Medical Center), Los Angeles, California, reduced the number of psychiatric beds available to its patients and closed its Psychiatric Emergency Service (PES) in violation of 38 U.S.C. § 1706. The whistleblowers further alleged that the allocation of psychiatric resources adopted by VAGLAHS management has endangered patients, staff, and the public. According to the whistleblowers, during the frequent bed shortages experienced by VAGLAHS, psychiatric patients presented for emergency care are either admitted to a fictitious ward, Ward 1 East, or are denied immediate treatment and referred to an outpatient facility that is not equipped to treat their serious psychological conditions. The whistleblowers asserted that patients admitted to Ward 1 East are left on gurneys in the Emergency Department (ED) without the supervision of adequately trained nursing staff or psychiatrists for as many as three days. In addition, the whistleblowers alleged that VAGLAHS management is engaging in an ongoing waste of funds in connection with the administration of long-term care contracts, needlessly extending the amount of time patients spend in high-cost hospital wards and refusing to renew cost-effective, long-term care contracts for mentally ill veterans subject to conservatorships. According to the whistleblowers, the policies and practices adopted by VAGLAHS management are detrimental to the mental health of the patients, present a danger to the safety of patients, staff, and the public, and, in some cases unnecessarily consume VA resources devoted to psychiatric care.

In light of the whistleblower's apparent expertise and their first-hand knowledge of many of the incidents disclosed, OSC referred their allegations to the Secretary of Veterans Affairs for investigation by the agency pursuant to 5 U.S.C. § 1213(c) and (d). The Secretary of Veterans Affairs delegated responsibility for investigating the whistleblowers' allegations to Dr. Jonathan B. Perlin, Undersecretary for Health. Undersecretary Perlin submitted a report to OSC on October 13, 2005. The agency's report found that the Medical Center experienced some complications in its provision of psychiatric services after its merger of the PES and ED but that there was little evidence these complications produced lasting conditions in which patients were receiving substandard care. Indeed, the agency noted significant efforts to improve conditions in the ED. In addition, the agency concluded that the whistleblower's allegations regarding the administration of long-term care contracts were largely unfounded. Finally, where the agency identified shortcoming in psychiatric programs at the Medical Center, it made recommendations for improvement.

Having reviewed the agency's submission and comments submitted by one of the whistleblower, I have determined that the agency's report contains all of the information required by statute and is reasonable within the meaning 5 U.S.C. § 1213(e)(2).

The Whistleblowers' Disclosures

The whistleblowers disclosed that VAGLAHS management has engaged in violations of law, rule, or regulation, gross mismanagement, a gross waste of funds, and substantial and specific dangers to public health and safety in connection with the provision of psychiatric services. The whistleblowers are employed by VAGLAHS, and in the course of their employment, they witnessed the alleged maltreatment of psychiatry patients that forms the basis of their disclosure.

The whistleblowers alleged that management at VAGLAHS has impermissibly cut resources devoted to the care of psychiatric patients with harmful consequences. Over the past 10 years, they contended, management reduced the number of beds available for inpatient treatment of psychiatric patients from approximately 366 to 84. According to the whistleblowers, this reduction was not accompanied by a corresponding reduction in the need for inpatient psychiatric services, and as a result, the psychiatric care unit at the Medical Center routinely operates at or above capacity. Moreover, the whistleblowers contended that VAGLAHS management impermissibly eliminated distinctive elements of the emergency psychiatric care it had previously provided, when it closed the Medical Center's PES and routed emergency psychiatric care patients through its general ED. Thus, the whistleblowers maintained that the restructuring of psychiatric services at VAGLAHS violated 38 U.S.C. § 1706(b), which requires that the VA maintain its capacity to treat mentally ill veterans "within distinct programs or facilities."

According to the whistleblowers, VAGLAHS has addressed the recurring bed crises in its psychiatric unit by creating a fictitious ward, Ward 1 East, for some patients and referring other mentally ill patients who are presented for emergency care to a separate outpatient facility called the "Access Center." The whistleblowers maintained that these arrangements have resulted in the provision of substandard care in unsafe conditions.

More specifically, the whistleblowers stated that patients admitted to Ward 1 East are not moved from the ED to a separately located ward. Rather, according to the whistleblowers, they remain on gurneys in the ED for up to three days while awaiting transfer to a true psychiatric ward. Far from a therapeutic environment, the whistleblowers contended that the ED and Ward 1 East present numerous opportunities for patients to injure themselves and others. Moreover, the whistleblowers asserted that the chaotic atmosphere in the ED tends to aggravate the psychiatric condition of mentally ill patients, increasing the likelihood that they will inflict such injury.

Beyond such immediate physical dangers, the whistleblowers alleged that VAGLAHS has not provided adequate psychiatric or medical care to the mentally ill patients who have been admitted to the fictitious Ward 1 East. The whistleblowers stated that without adequate psychiatric staff, psychiatric evaluation of and care for mentally ill patients in the ED and Ward 1 East falls to resident psychiatrists who rotate through the ED once per month. Consequently, the whistleblowers maintained, these patients do not receive the "continuity of care" required for sound treatment. Furthermore, the whistleblowers alleged that the medical staff in the ED is not adequately trained to treat mentally ill patients, and as a result, many of these patients receive inadequate medical clearance and monitoring. In short, the whistleblowers maintain the ED is not properly staffed or equipped treat mentally ill patients.

The whistleblowers further asserted that VAGLAHS management has sought to remedy delays resulting from a shortage of psychiatric resources by referring some patients originally presented to the ED for care to the Access Center, an outpatient facility located approximately one-third of a mile away from the Medical Center's main facility. The whistleblowers contended that the use of the Access Center for these patients has engendered an additional danger to public health and safety. Some of the mentally ill patients referred to the Access Center are, according to the whistleblowers, acutely suicidal or homicidal, and the Access Center lacks personnel who are trained to deal with mentally ill patients presenting with such potentially dangerous psychiatric conditions.

The whistleblowers alleged that the configuration of psychiatric services at the Medical Center violates VA rules and California state law. In particular, the VA Manual concerning "Mental Health Services" requires that VA facilities "promote an optimal degree of safety for patients, staff, and visitors." VA Manual M-2, Part X, Chapter 2, General Administration § 2.11.b. The whistleblowers maintained, however, that conditions in the ED, Ward 1 East, and the Access Center are unsafe for mentally ill patients and staff. Similarly, the whistleblowers asserted that the practice of housing mentally ill patients admitted to Ward 1 East in the ED violates applicable California laws and regulations, which require that psychiatric patients be housed in separate psychiatric units, away from other medical patients. *See Los Angeles County Department of Mental Health, LPS Designation Guidelines and Process for Facilities within Los Angeles County § I.B(1)(g); see also Cal. Welf. & Inst. Code § 5000 et seq.*

In addition, the whistleblowers alleged that VAGLAHS management is engaging in an ongoing waste of funds in connection with the long-term care contracts that it arranges for mentally ill patients who are subject to conservatorships under California law or otherwise require long-term care. The whistleblowers contended that management has adopted inefficient procedures for placing and maintaining patients in long-term care, thereby extending needlessly the amount of time patients spend in high-cost hospital wards. Further, several of the whistleblowers commented that the placement coordinators for VAGLAHS provide a prospective long-term care facility with unnecessary information that shows patients in a bad light and makes them more difficult to place in lower-cost, contracted facilities. In some cases, the whistleblowers contend, management's administration of long-term contracts presents a risk of harm to patients. Specifically, the whistleblowers alleged that VAGLAHS has begun refusing to extend some long-term care contracts for patients subject to conservatorships. The whistleblowers stated that patients whose contracts are not extended are released into the public, where they pose a danger to themselves and others. A high proportion of these patients ultimately require re-hospitalization. When they are presented to the Medical Center for a second time, they require re-stabilization in a high-cost hospital ward before they can be returned to a long-term care facility. According to the whistleblowers, management's administration of long-term care contracts endangers mentally ill veterans and unnecessarily consumes VA resources devoted to psychiatric care.

Given the gravity of the issues involved, the apparent technical expertise of the whistleblowers, and their first-hand knowledge of many of the incidents disclosed, OSC referred the

whistleblowers' allegations to the Secretary of Veterans Affairs for formal investigation by the agency pursuant to 5 U.S.C. § 1213(c) and (d).

The Agency's Investigation and Reports

The Secretary of Veterans Affairs delegated responsibility for investigating the whistleblowers' allegations to Dr. Jonathan B. Perlin, Undersecretary for Health. Undersecretary Perlin in turn appointed an Administrative Board of Investigation (Board) to investigate the allegations, and he submitted a report containing the findings of that investigation on October 13, 2005. The agency reported that while poor planning lead to complications in the merger of the PES and the ED, there was little evidence to substantiate the whistleblowers' allegations that these complications resulted in systematically substandard care.

As a preliminary matter, the agency acknowledged that the number of psychiatric beds available at the Medical Center "has significantly decreased over the past ten years" but maintained that this decrease was justifiable in light of corresponding advances in the pharmacological treatment of mental illness. The agency also found that the reduction in available psychiatric beds was consistent with the interpretation of 38 U.S.C. § 1706 adopted by the Office of the General Counsel for the VA. According to the agency, when read in conjunction with other statutes regulating the provision of healthcare services by the VA, section 1706 must be interpreted as recognizing that "delivery of health care services will be dynamic and change over time" and as allowing the Secretary of Veterans affairs to arrange for the delivery of services in a manner that is "as cost-effective as possible." Thus, the agency maintained, section 1706 allowed for a reduction in beds at the Medical Center in light of advancements mental healthcare. Moreover, the agency determined that bed crises experienced at the Medical Center were a result not of the decrease in psychiatric beds but of shortages in the nursing staff. The agency stated that VAGLAHS management has attempted to address these shortages through recruitment and has established a multidisciplinary Work Group intended to make "recommendations on ways to improve the flow of patients on inpatient units."

The agency further reported that many of the problems experienced in the merger of the PES with the ED were the result of poor planning and a "lack[] of appropriate coordination" by management personnel. Given the history of a previous unsuccessful merger, a significant number of nurses in the PES left the VA when they learned that a merger of the PES with the ED was again being considered, long before planning for that merger could be completed. According to the agency, by early 2004, a nursing shortage in the PES made it unsafe to continue operations in the unit, and as a result, management was forced to merge the PES with the ED without adequate planning. The agency stated that a "Work Group chaired by to staff psychiatrists" is charged with examining problems in the merged ED "on an ongoing basis."

Far from a problem arising out of the merger of the PES and the ED, the agency characterized Ward 1 East as a successful solution to the problem of tracking critical care patients prior to their formal admission to the Medical Center. The agency found that this solution was created prior to the merger of the PES and ED for use in the ED. According to the agency, the VA's computer record systems will not allow the creation of records to track patient care before patients have been

admitted to a ward. Ward 1 East was created to work around this defect in the computer record system and allow for the tracking of patients who could not be admitted due to a temporary lack of critical care beds. The agency's report concludes that Ward 1 East is "an appropriate mechanism to improve patient safety" and recommends its adoption at other VA facilities.

Nevertheless, the agency did acknowledge that immediately following the merger of the PES with the ED, some psychiatric patients were held in the ED under the Ward 1 East designation for "an extended period of time." The agency asserted in its report that management recognized the problematic nature of this practice and "mandate[d] that as soon as a patient was identified as in need of psychiatric admission, a bed was to be found." While the agency represented that current practice in the ED is consistent with this mandate, it recommended that management's mandate be reduced to a written policy.

The agency found "no evidence to substantiate" the whistleblowers' allegations that psychiatric patients treated in the ED systematically receive substandard care. According to the agency, psychiatric care is provided in the ED by a psychiatrist who works half days in the department, a recently hired nurse practitioner with experience in the field, and psychiatric residents who rotate through the ED when the staff psychiatrist is not on duty. The agency maintained that the use of rotating psychiatric residents to provide care when the staff psychologist is not on duty is consistent with practices in other units throughout the Medical Center. Moreover, the Board reviewed incident reports for several of the incidents identified by the whistleblowers as examples of the substandard medical care provided to psychiatric patients in the ED and determined that the incidents were handled appropriately. The Board was unable to locate any evidence of one such incident cited by the whistleblowers. Finally, the agency observed that physical improvements in the ED made over the past year have produced adequate physical separation between medical and psychiatric patients. In sum, the agency determined that psychiatric patients in the ED were receiving an appropriate level of care.

The agency similarly reported that staff in the Access center was properly qualified to provide "urgent care services" to psychiatric patients. Further, the agency reported that Access Center staff indicated in the course of the investigation that the Center rarely received inappropriate referrals and that it was empowered to return any such referrals to the ED. Consequently, the agency found the whistleblowers' allegations regarding the Access Center could not be substantiated.

With respect to the whistleblowers' allegations regarding the placement and maintenance of patients in long-term care, the Board reviewed spreadsheets tracking the placement and readmission of patients and received testimony from several witnesses. The Board found "credible the testimony and evidence" indicating that adequate policies and procedures were in place to manage the placement of patients in long-term care facilities and that contracts with such facilities are "routinely extended when determined to be medically necessary." The agency reported no evidence of waste or any other form of wrongdoing in connection with these placement and made no recommendations to alter or enhance procedures for managing long-term care arrangements.

While the agency conceded that the Medical Center experienced complications in its provision of psychiatric services after the merger of the PES and ED, it found little evidence that

these complications produced lasting conditions in which patients were receiving substandard care. Indeed, the agency noted significant efforts to improve conditions in the ED and the existence of Working Groups charged with devising solutions to known problems. In addition, the agency concluded that the whistleblowers' allegations regarding the administration of long-term care contracts were largely unfounded. Where the agency found continuing shortcomings in psychiatric programs at VAGLAHS it made recommendations for improvement. According to the agency, management agreed to these recommendations

The Whistleblowers' Comments

As required by statute, I forwarded the agency's report to the whistleblowers' for comment, but only one whistleblower submitted comments to my office. In these comments, the whistleblower acknowledged that when the Board visited VAGLAHS, "the situation [in the ED] ... was much better than the chaos, substandard care, and poor morale that immediately followed the merger" of the PES with the ED, but questioned why the agency did not hold management accountable for the poor planning that gave rise to the previously witnessed chaotic conditions in the newly merged ED. The whistleblower also maintained that during the ten years in which VAGLAHS was reducing the number of psychiatric beds available, there was also a "major reduction on mental health spending in the Greater Los Angeles Healthcare System." According to the whistleblower, this diminution of resources yielded an unreasonable reduction in mental health services. For example, the whistleblower stated that VAGLAHS eliminated "professional treatment services for alcohol and drug problems" and began outsourcing such care to inferior "non-professional, non-medical entities." In short, the whistleblower appears to suggest that decisions regarding the allocation of mental health resources within the VAGLAHS system are not being made with a view to the wellbeing of psychiatric patients.

Conclusion

Having reviewed the agency's submission and the comments submitted by one of the whistleblowers, I have determined that the agency's report contains all of the information required by statute and is reasonable within the meaning 5 U.S.C. § 1213(e)(2). While the agency found that poor planning lead to complications in the merger of the PES and the ED, it was unable to substantiate the whistleblowers' allegations that these complications have resulted in systematically substandard care for psychiatric patients. Where the management of VAGLAHS had not already established Working Groups to devise solutions to known problems, the Board recommended improvements to ED procedures. According to the agency, management agreed to these recommendations. In the absence of further evidence, I cannot say that the agency's explanation of the benefits derived from the creation of Ward 1 East, its account of the restructuring of psychiatric resources at VAGLAHS, or its analysis of procedures related to the administration of long-term care contracts is unreasonable. Thus, I have concluded that the agency's report complies fully with the requirements of the statute.