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Washington, D.C. 20036-4505

The Special Counsel

September 19, 2023

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

Re: OSC File No. DI-21-000009

Dear Mr. President:

I am forwarding to you a report transmitted to the Office of Special Counsel (OSC) by the Department of Veterans Affairs (VA) in response to the Special Counsel's referral of a disclosure of wrongdoing at the North Florida/South Georgia Veterans Health Center (NF/SG VHC), Substance Abuse Treatment Team (SATT) Clinic, Jacksonville, Florida. I have reviewed the disclosure, the agency report, and whistleblower comments and, in accordance with 5 U.S.C. §1213(e), I have determined the report contains the information required by statute and the findings appear reasonable.[1] The following is a summary of the allegations, the report, and my findings.

[redacted], a former social worker at the SATT Clinic who consented to the release of his name, disclosed that SATT Clinic leadership required that clinical providers maintain scheduling practices and caseloads that violate VA policy and endanger the health of veterans seeking substance abuse disorder treatment. Specifically, [redacted] alleged that case managers were required to maintain patient caseloads that exceeded the recommended cap of 50 and thus, were unable to schedule appointments with sufficient regularity to positively engage and retain recovering veterans. [redacted] also alleged that the SATT Clinic used numerous scheduling practices that violate VA policy—including blind scheduling, failure to use the electronic waitlist, and failure to meet the required minimum scheduling efforts.

The agency partially substantiated the whistleblower's allegations. The agency did not substantiate that case managers have excessive caseloads, finding instead that the case managers had caseloads between 30-50 veterans actively participating in the SATT Clinic program. Moreover, the caseload lists included many veterans who had been inactive in the SATT clinic program for a long period of time and should have been removed from the lists. The Program Coordinator implemented a census tracker to follow veterans from their start in the program and monitor their progress with treatment and case management needs, which should result in more accurate caseload lists. The agency also found that case managers were not

[1] The whistleblower's allegations were referred to VA Secretary Denis McDonough for investigation pursuant to 5 U.S.C. §1213(c) and (d). The VA Office of the Medical Inspector (OMI) conducted the investigation. Secretary McDonough reviewed and signed the agency report.

utilizing all their available appointments, with 40-60 additional appointments per case manager available each month. Therefore, the agency did not find there is a lack of access for veterans to obtain necessary mental health services or that veterans have been negatively impacted.

The agency substantiated the allegation that the SATT Clinic's scheduling practices violated VA policy. The agency found that SATT Clinics staff members were using government-issued paper calendar books to track veteran appointments and same-day scheduling practices—in direct violation of VHA Directive 1230(3). The SATT Clinic's use of an inefficient and confusing scheduling process, the lack of dedicated scheduling staff for the SATT clinic, and the poor guidance from the Associate Chief for Substance Abuse Disorders were found to be significant contributing factors that led to the scheduling policy violations.

In response to these findings, the agency prioritized recruitment and filled vacancies at the SATT Clinic. SATT Clinic management also implemented weekly and monthly meetings to increase overall awareness and understanding of data regarding provider and case management workload, wait times, consults, scheduling timeliness, and monthly scheduled appointment hours. All SATT Clinic employees also received training on VHA Directive 1230(4), scheduling criteria rules, and Veterans Community Care Program eligibility guidelines. In addition, all schedulers have been realigned under the Medical Administration Service, have completed the required scheduling training, have the required access and scheduling keys for compliance with VA policy, and are assigned one-month rotations to the SATT Clinic to provide more consistent scheduling support.

In his comments, [redacted] continued to assert that case managers had excessive caseloads at the SATT Clinic. He took issue with the way the agency characterized the role of the case manager and how it calculated monthly available appointments, asserting that the duration of treatment and frequency of appointments should be clinically determined by case workers based on patient needs, not productivity targets. He believes that the majority of veterans served by the SATT Clinic disengage due to ineffective case management, rather than successfully completing the program.

After reviewing the original disclosure, the agency report, and whistleblower comments, I am assured that the corrective measures implemented in response to the investigation will improve both oversight and quality of veteran care at the SATT Clinic. I thank [redacted] for bringing these allegations concerning veteran safety to OSC.

Based on the foregoing, I have determined the reports contain the information required by statute 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 whistleblower comments to the Chairs and Ranking Members of the Senate and House Committees on Veterans' Affairs. I have also filed redacted

copies of these documents and the redacted 1213(c) referral letter in our public file, which is available online at www.osc.gov. This matter is now closed.

Respectfully,

Henry J. Kerner
Special Counsel

Enclosures