THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

August 30, 2024

The Honorable Hampton Dellinger
Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW, Suite 300
Washington, DC 20036

Re: Office of Special Counsel File No. DI-24-000195

Dear Mr. Dellinger:

I am responding to your December 19, 2023, letter to the Department of Veterans Affairs (VA) regarding whistleblower allegations that the Perry Point VA Medical Center (hereafter Perry Point) located in Perry Point, Maryland engaged in conduct that may constitute a violation of law, rule, or regulation and a substantial and specific danger to public health and safety.

The Under Secretary for Health directed the Office of the Medical Inspector to assemble and lead a VA team to conduct an investigation. We conducted a site investigation on this matter March 5-7, 2024.

We substantiate one and do not substantiate one of the whistleblowers' allegations. We make eight recommendations to Perry Point. The signed report will be sent to Perry Point with a request for an action plan.

Thank you for the opportunity to respond.

Sincerely,

Denis McDonough

Enclosure

DEPARTMENT OF VETERANS AFFAIRS

Washington, DC

Report to the
Office of Special Counsel
OSC File Number DI-24-000195

Perry Point VA Medical Center
Perry Point, Maryland

Report Date: August 14, 2024

Content Manager 2023-C-53

Executive Summary

The Office of the Secretary of the Department of Veterans Affairs (VA) received a referral from the Office of Special Counsel on December 19, 2023, for a formal resolution. Subsequently, the Under Secretary for Health directed the Office of the Medical Inspector to assemble and lead a VA team to investigate allegations concerning the Perry Point VA Medical Center (hereinafter Perry Point), in Perry Point, Maryland. The whistleblower, who consented to the release of their name, alleged Veterans were not receiving prompt follow-up appointments after discharge, and the outpatient Mental Health (MH) clinic was understaffed which may constitute a violation of law, rule, or regulation, and a substantial and specific danger to public health and safety. We conducted a site visit to Perry Point on March 5, 2024, through March 7, 2024, to investigate these allegations.

Specific Allegations of the Whistleblower

1. *In 2022 2023, approximately 400 patients discharged from the MH RRTPs did not receive a follow-up appointment within seven days of discharge in violation of VHA directives.*

2. *The outpatient mental health clinic is not sufficiently staffed to provide patients discharged from the MH RRTPs their first follow-up appointment within seven days of discharge or a face-to-face evaluation within fourteen days of discharge as required by VHA directives.*

We **substantiate** allegations when the facts and findings support that the alleged events or actions took place and **do not substantiate** allegations when the facts and findings showed the allegations are unfounded. We are **unable to substantiate** allegations when the available evidence was insufficient to support conclusions with reasonable certainty about whether the alleged event or action took place.

After careful review of the findings, we make the following conclusions and recommendations:

Conclusions for Allegation 1

- We **do not substantiate** in calendar year (CY) 2022 and CY 2023, approximately 400 patients discharged from the MH Residential Rehabilitation Treatment Programs (RRTP) did not receive a follow-up appointment within 7 days of discharge in violation of Veterans Health Administration (VHA) directives.

- We determined that in the 400 Veteran charts reviewed, 135 had appointments with a mental health provider within 7 days of discharge, 120 had an appointment after 7 days but within 30 days, 129 had an appointment in greater than 30 days, and 16 had no evidence of an appointment.

- We find no evidence of patient harm related to patients not being scheduled for a follow-up appointment with an MH provider within 7 days of discharge.

- In 25 records reviewed from CY 2022 and CY 2023, all had a documented post-discharge follow-up engagement call with their MH RRTP provider.

- There was no method to access the time from discharge from MH RRTP to the first follow-up outpatient MH appointment, and this information was not on the facility's chart audit tool for MH RRTP.

- The FLOW Program intended to transfer Veterans from mental health to Patient Aligned Care Team (PACT) once stabilized is poorly used.

- The use of a personal cell phone by a psychiatrist to communicate with Veterans violated the Patient Safety Notice sent by the Chief of Mental Health Clinical Center, potentially exposed Veterans to risks of protected health information and personally identifiable information disclosure, and appears to be a practice boundary concern. Additionally, the same psychiatrist has met with Veterans on the weekend at VA to discuss their benefits which raises concerns about professional boundaries and practicing within scope of duties.

Recommendations to Perry Point

1. Standardize the process of obtaining a scheduled post-discharge MH appointment by entering a consult earlier than the day of discharge.

2. Review the 16 Veteran records with no evidence of an appointment and ensure appropriate follow up.

3. Modify the MH RRTP audit tool to include assessment of the discharged Veteran's first MH follow-up appointment.

4. Evaluate Veterans on the FLOW dashboard to decide if any would be within the PACT provider's scope of care and transition as appropriate.

5. Request medical ethics consultation for potential practice boundary concerns.

6. Conduct a formal investigation of the use of a personal cell phone for Veteran care and ensure communications are compliant with law and VA policies. Take appropriate administrative action, as necessary.

Conclusions for Allegation 2

- **We substantiate** the Perry Point outpatient MH clinic is not sufficiently staffed to provide patients discharged from the MH RRTP their first follow-up appointment within 7 days.

- We noted that one provider consistently miscoded outpatient visits as inpatient visits.

- The Post Discharge Engagement-1 metric does not measure the 7-day requirement defined in VHA Directive 1162.02 but does provide evidence of engagement with the Veteran post discharge from the MH RRTP.

- Perry Point mental health clinic remains short staffed by eight positions.

Recommendations to Perry Point

7. Conduct coding audits for all MH RRTP providers from the beginning of fiscal year 2023 through March 2024. Investigate non-compliance with law and policy and take appropriate administrative action.

8. Provide education and retraining on coding practice and procedures for MH RRTP providers (if necessary) after audit.

9. Prioritize filling the current vacancies in the Perry Point Outpatient MH clinic.

Summary Statement

We developed this report in consultation with other VHA and VA offices to address the Office of Special Counsel's concerns that Perry Point engaged in conduct that may constitute a violation of law, rule, or regulation; gross mismanagement; abuse or authority; or a substantial and specific danger to the public health or safety. We reviewed the allegations and determined the merits of each. We determined that there are discrepancies with compliance to VHA Directives relating to scheduling appointments post discharge from Perry Point programs, medical coding violations, and potential boundary and ethical issues with one specific provider.

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I. Introduction

The Office of the Secretary of the Department of Veterans Affairs (VA) received a referral from the Office of Special Counsel on December 19, 2023, for a formal resolution. Subsequently, the Under Secretary for Health directed the Office of the Medical Inspector to assemble and lead a VA team to investigate allegations concerning the Perry Point VA Medical Center (hereinafter Perry Point), in Perry Point, Maryland. The whistleblower, who consented to the release of their name, alleged Veterans were not receiving prompt follow-up appointments after discharge, and the outpatient Mental Health (MH) clinic was understaffed which may constitute a violation of law, rule, or regulation, and a substantial and specific danger to public health and safety. We conducted a site visit to Perry Point on March 5, 2024, through March 7, 2024, to investigate these allegations.

II. Facility Profile

Perry Point, which is part of Veteran's Integrated Service Network (VISN) 5, is one of the three medical centers in VA Maryland Health Care System. These medical centers include Baltimore (Central Baltimore City), Loch Raven (Northern Baltimore City) and Perry Point (Cecil County), Maryland. Perry Point offers primary care, tertiary psychiatric care, rehabilitation, long-term care, hospice, and general nursing home care. Perry Point also provides specialty health services, including MH care and three mental health residential rehabilitation treatment programs with 30 beds each (90 total beds), audiology and speech, dental services, care for Veterans with posttraumatic stress disorder, vocational rehabilitation, and more.[1]

III. Specific Allegations of the Whistleblower

1. *In 2022 and 2023, approximately 400 patients discharged from the MH RRTPs did not receive a follow-up appointment within seven days of discharge in violation of VHA directives.*

2. *The outpatient mental health clinic is not sufficiently staffed to provide patients discharged from the MH RRTPs their first follow-up appointment within seven days of discharge or a face-to-face evaluation within fourteen days of discharge as required by VHA directives.*

IV. Conduct of Investigation

The VA team conducting the investigation consisted of a Senior Medical Inspector and two Clinical Program Managers, all from the Office of the Medical Inspector, and a National MH Quality Improvement and Implementation consultant from VHA Office of Mental Health and Suicide Prevention. We reviewed relevant policies, procedures,

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1 VHA Support Service Center, Trip Pack, VA Maryland Health Care System, undated. Available at: https://reports.vssc.med.va.gov/ReportServer/Pages/ReportViewer.aspx, last accessed May 8, 2024. ***Note**: This is an internal VA website that is not available to the public.*

professional standards, reports, memorandums, and other documents listed in attachment A. We interviewed the whistleblower on February 8, 2024.

We conducted an entrance brief on March 5, 2024, with the following VISN 5 and Perry Point leadership:

- Network Director, VISN 5;
- Deputy Network Director, VISN 5;
- Interim Chief Medical Officer, VISN 5;
- Deputy Chief Medical Officer, VISN 5;
- Deputy Quality Management Officer, VISN 5;
- Accreditation Specialist, VISN 5;
- Medical Center Director;
- Executive Assistant to the Deputy Medical Center Director;
- Deputy Medical Center Director;
- Chief Quality Officer;
- Associate Director Patient Care Services, (acting);
- Executive Assistant to Chief of Staff;
- Assistant Director; and
- Associate Director, Operations.

We interviewed the following Perry Point staff:

- Medical Center Director;
- Chief of Staff;
- Chief Quality Officer;
- Chief of MH;
- Deputy Chief of Psychiatry;
- Psychologist, Director of MH;
- Physician, Outpatient MH;
- Social Worker, MH;
- Interim Nurse Manager, MH RRTP;
- Psychiatrist, MH RRTP;
- Deputy Director/Social Worker, Outpatient MH;
- Clinical Psychologist, VISN5 MH Lead;

- Nurse Manager, Domiciliary and Outpatient MH Clinic;
- Registered Nurse, MH RRTP;
- Registered Nurse, Outpatient MH Clinic;
- Social Worker, Domiciliary, Homeless, and Transitional Housing;
- Clinical Pharmacist, MH;
- Psychiatrist, MH RRTP and Substance Use Disorder Rehabilitation;
- Psychologist, Chief of MH RRTP;
- Physician Assistant, Substance Abuse RRTP;
- Supervisor, Medical Support Assistant;
- Group Practice Manager;
- Patient Safety Specialist;
- Medical Support Assistant/Scheduler, Outpatient MH; and
- Deputy Director, Outpatient MH.

We conducted an exit brief on March 7, 2024, with the following VISN 5 and Perry Point leadership:

- Network Director, VISN 5;
- Deputy Network Director, VISN 5;
- Interim Chief Medical Officer, VISN 5;
- Deputy Chief Medical Officer, VISN 5;
- Deputy Quality Management Officer, VISN 5;
- Accreditation Specialist, VISN 5;
- Medical Center Director;
- Executive Assistant to the Deputy Medical Center Director;
- Deputy Medical Center Director;
- Chief Quality Officer;
- Associate Director Patient Care Services, (acting);
- Executive Assistant to Chief of Staff;
- Assistant Director; and
- Associate Director, Operations.

V. Background, Findings, Conclusions, and Recommendations

Allegation 1

In 2022 and 2023, approximately 400 patients discharged from the MH RRTPs did not receive a follow-up appointment within seven days of discharge in violation of VHA directives.

Background

The MH Residential Rehabilitation and Treatment Program (RRTP) is the umbrella term for the array of programs and services that comprise MH residential care. The term MH RRTP refers to those programs currently designated as Domiciliary RRTPs which may include domiciliary care for homeless Veterans, Domiciliary Substance Use Disorder Programs, Domiciliary Posttraumatic Stress Disorder Programs, General Domiciliary Programs, and Compensated Work Therapy/Transitional Residence Program. Perry Point provided 1,477 bed days of care in MH RRTP in fiscal year (FY) 2022, 1,495 bed days of care in FY 2023, and 2,942 bed days of care through May of FY 2024.

Residential care involves encounters between Veterans and providers within the VA health care system that require an overnight stay in residential bed sections. Each point of service receives a residential care rating within VHA site classifications based on the services provided at that location. Although some residential care is also classified as extended care, two programs are specifically classified as "residential care" in the site classification: residential rehabilitation and domiciliary care (all residential rehabilitation programs are types of domiciliary care). Residential care is distinct from VA outpatient, inpatient (acute and psychiatry, medicine, rehabilitation, and surgery beds), and institutional extended care (community living centers).

VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics, dated September 11, 2008,[2] paragraph 14 (Care Transitions) subparagraph c(1) and c(4) states:

> *"Facilities must ensure continuity of care during transitions from one level of care to another. When veterans are discharged from inpatient or residential care settings, they must:*
>
> *c. Receive follow-up mental health evaluations within 1 week of discharge.*
>
> *(1) Facilities are strongly encouraged to provide follow-up within 48 hours of discharge.*

2 VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics, dated September 11, 2008, was rescinded April 27, 2023. ***Note**: This handbook remained applicable to Allegation 1 until April 26, 2023.*

(4) In all cases, veterans must be seen for face-to-face evaluations within 2 weeks of discharge. When veterans refuse these evaluations, the refusal must be documented."

VHA Directive 1162.02, Mental Health Residential Rehabilitation Treatment Program, dated July 15, 2019, requires staff to be responsible for ensuring that access barriers to continuing outpatient care (for example: distance, transportation, scheduling) are reduced or eliminated. "*Staff must ensure that the Veteran is scheduled to be seen by a mental health provider within 7 calendar days of discharge. The appointment must be scheduled with the Veteran notified of the appointment prior to discharge. The Veteran must be introduced to, and continuing needs reviewed with the receiving outpatient clinician in person, by phone, or by video conferencing prior to a planned discharge to ensure a seamless transition.*"[3] This directive further established a process for when a Veteran chooses to participate in an intensive community MH Recovery Program as part of the discharge planning process from the MH RRTP Program, a warm hand off must be arranged in advance of the MH RRTP discharge date.

The Assistant Under Secretary for Health for Operations issued a memorandum dated July 7, 2020, Mental Health Guidance for the Coronavirus (COVID-19) Pandemic. The purpose of this memorandum was *"to provide updated guidance from the VHA Office of Mental Health and Suicide Prevention (OMHSP) to support patient care and safety during and beyond the COVID-19 pandemic response."* This memorandum stated, *"During the COVID-19 pandemic response, all outpatient mental health visits should be conducted via virtual modalities as clinically appropriate and technologically feasible."* This guidance authorized the use of VA Video Connect (VVC) virtual care management: *"To provide Veterans a consistent, safe, and secure video experience, VVC is the preferred technology for video visits. Alternate video technologies should be used only as back-up/secondary options for care when VVC or Virtual Care Manager (VCM) are not available or cannot support a required use case or clinical need."* If the Veteran requires an in-person visit based on clinical need and could not be performed virtually, the Veteran should be scheduled accordingly.

VHA Directive 1160.01, Uniform Mental Health Services in VHA Medical Points of Service, dated April 27, 2023, (which replaced VHA Handbook 1160.01), removed the requirement for follow-up MH evaluations within 1 week of discharge and a face-to-face evaluation within 2 weeks of discharge. Paragraph 9f(3) of this directive states:

"(3) Discharge. VA medical facilities must implement and maintain a systematic (i.e., not an individual or position dependent) process for tracking Veterans following discharge from inpatient or residential care settings in order to facilitate engagement in post-discharge continuing care. VA medical facilities are encouraged to utilize clinical tools developed by OMHSP to facilitate care coordination and engagement. At the time of discharge, Veterans must:

[3] VHA Directive 1162.02, Mental Health Residential Rehabilitation Treatment Program, dated July 15, 2019.

(a) Receive information about how they can access mental health care on an emergency basis.

*(b) Be given confirmed scheduled appointments for post-discharge engagement. (**Note**: When Veterans decline follow-up mental health services, this must be documented. When Veterans miss scheduled appointments, there must be appropriate clinical follow-up and documentation in the [electronic health record] EHR."*[4]

VHA Directive 1160.01, defines MH providers as psychiatrists, psychologists, certified nurse practitioners, certified nurse specialists, physician assistants, marriage and family therapists, licensed professional MH counselors, clinical pharmacist practitioners, vocational rehabilitation counselors and licensed clinical social workers assigned to MH programs (regardless of how that program is administratively aligned).[5]

VHA Directive 1232(5), Consult Processes and Procedures, dated August 24, 2016, defines scheduled consult status as: "*...an appointment [that] has been made and linked to the consult request. Scheduled status automatically sends an alert to the sending provider.*"[6]

The Patient Aligned Care Team (PACT) is the interdisciplinary foundation of VA health care system, including MH care. PACT providers manage and provide MH care to their patients as part of their normal practice. Primary Care Mental Health Integration providers are integrated into PACT and provide consultation to PACT providers, as well as time-limited MH services for conditions that can be managed within PACT, based on staffing and expertise. Primary Care Mental Health Integration is considered the least intensive of direct MH clinical care services along the continuum of care. Many Veterans are likely to receive all their needed MH services in the PACT setting.

VHA Directive 1230, Outpatient Scheduling Management, dated June 1, 2022, states the medical facility scheduler is responsible for (among other items): "Reviewing community care eligibility and offering Veterans the choice to schedule an appointment in the community, if eligible, in collaboration with the health care provider."[7] VA Handbook 6500.10, Mobile Device Security Policy, February 15, 2018, Appendix D(Mobile Device Rules of Behavior) paragraph 2f specifically states: *"I will also not use personally owned mobile devices to store or send VA data."*[8]

Findings

During interviews, the whistleblower stated that none of the approximately 400 Veterans received a follow-up appointment within 7 days of discharge in violation of VHA directives. As part of discharge and transition planning, VHA Directive 1162.02, requires a scheduled appointment with an MH provider within 7 calendar days of discharge with

[4] VHA Directive 1160.01, Uniform Mental Health Services in VHA Medical Points of Service, dated April 27, 2023.
[5] Ibid.
[6] VHA Directive 1232(5), Consult Processes and Procedures, dated August 24, 2016.
[7] VHA Directive 1230, Outpatient Scheduling Management, dated June 1, 2022.
[8] VA Handbook 6500.10, Mobile Device Security Policy, February 15, 2018.

the Veteran notified of the appointment prior to discharge. The Veteran must be introduced to, and the continuing needs reviewed with the receiving outpatient clinician in person, by phone, or by video conferencing prior to planned discharge to ensure a seamless transition. The whistleblower asserted that 404 patients waited over 30 days to receive a follow-up appointment. We requested data on Veterans discharged from MH RRTP and the next scheduled MH outpatient appointment and determined that this information does not exist, including on the facility's chart audit tool for MH RRTP.

We selected a random sample of 25 names from the list of 404 patients for CY 2022 and CY 2023 and reviewed the EHR. We reviewed 12 MH RRTP discharge summaries for CY 2022 and 13 from CY 2023. All 25 Veterans had follow-up engagement calls, not a scheduled MH appointment, from an MH RRTP provider within 7 days of discharge. We requested a review by the Office of Internal Audit who located 401 accessible records. 135 Veterans had appointments within 7 days of discharge with a mental health provider, 120 had an appointment after 7 days but within 30 days of discharge, and 129 had an appointment after 30 days of discharge. 16 Veterans had no documented appointment.[9]

We examined Perry Point outpatient MH individual clinic wait times data from FY 2022 to March 7, 2024. The average wait times for a new patient appointment in the Perry Point outpatient MH individual clinic (502 stop code) decreased from 28.3 days in FY 2022 to 24 days in FY 2023 and 22.2 days in FY 2024 up to March 7, 2024. In that same MH clinic for established patients, the average wait times increased from 7.5 days in FY 2022 to 14.4 in FY 2023 and 14.5 days in FY 2024 up to March 7, 2024. This data reflects appointments for all Veterans trying to access the MH outpatient clinic with an MH provider and does not separate those needing an appointment after MH RRTP discharge (refer to table 1 on page 8).

[9] Data was analyzed by the Office of Internal Audit (10IA), and the algorithm would be useful to develop a VSSC report to measure compliance with requirements in VHA Directive 1162.02

Completed – New – Create – % Appointments 0 to 28 days. Completed – New-Create – Average Wait Time. Completed – Est (established) – Patient Indicated Date (PID) – % Appointments 0 to 28 Days.				
Primary Clinic Stop Group		FY 2022	FY 2023	FY 2024
(502) MH Individual Clinic	Completed – New – % Appointments 0 to 28 days	45.26%	61.54%	69.57%
(502) MH Individual Clinic	Completed – New – Average Wait Time	28.3	24.0	22.2
(502) MH Individual Clinic	Completed Est – PID – % Appointments 0 to 28 days	91.86%	82.92%	82.37%
(502) MH Individual Clinic	Completed Est – PID – Wait Time	7.5	14.4	14.5

Table 1 Perry Point (502) MH Clinic Wait Times (FY 2022, FY 2023, and FY 2024)

According to interviewees, at discharge from MH RRTP there are often three follow-up appointments to make: primary care, MH prescriber, and MH therapist. For MH, this process commonly involves a consult. Interviewees told us a warm hand off between the MH RRTP provider and the outpatient provider is rare. Our EHR review revealed most consults for follow-up appointments were entered the day of discharge. Interviewees also shared that a primary care appointment is easiest to make by scheduling or by phone call. The Tele-mental Health Clinical Resource hub, MH clinics at other VA sites such as Baltimore, and community care are other options for MH referrals. Additionally, the Perry Point outpatient MH clinic created three unscheduled walk-in slots per day (one for psychotherapy and two for medications).

We learned some MH providers occasionally enter consults for outpatient MH 3 to 14 days prior to discharge. In these instances, the MH RRTP social worker notifies the scheduler of the consult for their action. This process helps decrease the post-discharge wait time for appointments but can result in identification of a consult as *"idle"* (inactive for too long). Idle consults negatively affect facility performance metrics. If the MH provider waits until discharge to enter the consult to avoid affecting the idle consult metric, the Veteran will most often wait longer than 7 days for an appointment which is inconsistent with guidance contained in VHA Directive 1162.02 (current average wait time is 22.2 days for a new patient appointment). However, the schedulers learned if they enter a comment every 14 days, it prevents the consult from becoming idle. This initiative on the part of the scheduler should improve prompt Veteran follow-up appointments after discharge and improve compliance with VHA Directive 1162.02.

VHA Directive 1230 refers the medical facility scheduler to the Office of Community Care Field Guidebook as a reference when determining community care eligibility.[10] The Field Guidebook states if an MH patient cannot get a scheduled appointment within 20 days, the Veteran is eligible for Care in the Community. Perry Point community care data (refer to table 2 below) shows that in FY 2023, the average wait time in the community for a psychotherapy appointment was 88.9 days and improved to 27.3 days in FY 2024 (to March 7, 2024). In FY 2023, the average wait time in the community for a psychiatrist appointment was 22.2 days and improved to 17 days in FY 2024 (to March 7, 2024). The referrals to community care showed a marked increase from FY 2023 to FY 2024 (to March 7, 2024) from 169 referrals to 514 referrals for psychotherapy and from 27 referrals to 104 referrals for psychiatrists.

Care in the Community	FY 2023	FY 2024
Psychotherapy Wait Time (days)	88.9	27.3
Psychiatrist Appointment (days)	22.2	17
# of Community Care Referrals - Psychiatrist	27	104
# of Community Care Referrals - Psychotherapy	169	514

Table 2 Care in the Community Data

No interviewees were aware of patient harm related to delayed post discharge appointments from MH RRTP with an outpatient MH provider. Of the approximately 400 Veterans in the allegation, 223 were from CY 2023. 91 of these 223 had a Joint Patient Safety Report. We reviewed 56 of the 91 Joint Patient Safety Reports and none were related to delayed medication management after discharge from the MH RRTP (the concern raised by the whistleblower). From the beginning of FY 2022 up to March 7, 2024, there were no completed suicides or suicide attempts within 7 days of discharge from residential treatment. There were three attempted suicides within 30 days of discharge from residential treatment unrelated to lack of engagement post discharge from MH RRTP. All three patients were actively engaged with multiple specialties at Perry Point prior to and after these events.

We noted (during EHR reviews) that patient discharge instructions include documentation of future appointments, medications, follow-up labs (if needed), information resources, medications refills phone number, appointment call line, suicide crisis call line, and instruction for emergencies (call 911). Veterans are provided with discharge medications for up to 90 days (depending on the medication) by the discharging MH RRTP psychiatrist. If there is a gap between the last refill and an appointment with an outpatient psychiatrist or other MH prescriber, the residential

10 VHA Office of Integrated Veteran Care, Community Care Field Guidebook, Chapter 2: Defining Eligibility, updated April 19, 2023. Available at: https://dvagov.sharepoint.com/sites/VHAOCC/CNM/CI/OCCFGB/SitePages/FGB.aspx, last accessed May 10, 2024. ***Note:*** *This is an internal VA SharePoint website that is not available to the public.*

psychiatrist provides continued coverage of psychiatric medication needs (called *"bridging"*).

At Perry Point, bridge coverage ranges from 30 days to 1 year. The provider may see the Veteran in the office or by phone for their follow-up needs. These encounters are not scheduled in advance. The process for bridging medications is not consistent between psychiatrists.

Clinically eligible Veterans can transition from outpatient MH providers to PACT teams. Project "FLOW" (not an acronym) is a program that uses an evidenced-based approach to identifying recovered and stabilized Veterans who may be good candidates to transition from specialty MH to primary care management.[11] We reviewed the MH FLOW dashboard data specific to Perry Point as of March 5, 2024, and determined that approximately 300 Veterans were potentially eligible to transition back to PACT. Interviewees told us patients engaged in MH services requiring medication management at Perry Point rarely transition back to their PACT providers for ongoing medication management once stabilized. This negatively affects outpatient wait times for psychiatry medication management services. Non-MH providers we interviewed conveyed concerns that management of complex antipsychotics regimens to manage complex MH diagnoses such as bipolar disorder, substance abuse disorder, or schizophrenia are beyond the scope of practice for PACT providers.

During our tour of the MH RRTP units, we discovered a white board located in the main hallway in building 364b which had a cell phone number for the MH RRTP psychiatrist. We asked about this finding, and staff told us Veterans use this number to contact the psychiatrist whenever they feel the need. The cell phone number on the white board was not the VA cell phone number assigned to the psychiatrist around January 2024 according to the office of information technology at Perry Point. We questioned the psychiatrist about this cell phone number written on the white board and were told it was used to communicate with both admitted and discharged MH RRTP Veterans and nursing staff on the unit. This included contacts outside of normal business hours. Perry Point has an on-call psychiatrist; however, this cell phone access is in addition to that process. According to the psychiatrist, they bought a personal cell phone (prior to the VA issued phone), specifically as a means for Veterans to make contact. A personal cell phone does not secure protected health information, or personally identifiable information protections that are integral to a VA-issued cell phone. Additionally, there are concerns about poorly defined boundaries between Veterans and the psychiatrist conducting VA business on a personal cell phone and in place of assigned on-call providers. Additionally, we determined that the same psychiatrist has met with Veterans on the weekend at VA to discuss their benefits which also raises concerns about professional boundaries and practicing within the scope of their duties.

We obtained a Patient Safety Alert, Issued by VHA Central Office, AL22-04, dated August 31, 2022, which states: *"The Chief of Mental Health or equivalent shall ensure*

11 NIH, National Library of Medicine, National Center for Biotechnology Information, FLOW: Early results from a clinical demonstration project to improve the transition of patients with mental health disorders back to primary care, dated March 14, 2019. Available at: https://pubmed.ncbi.nlm.nih.gov/30869978/, last accessed May 10, 2024.

that policy reflects that mental health staff members' personal cell phone numbers are not to be given out to patients receiving mental health care. In addition, if personal cell phone numbers have been given in the past, patients must be given appropriate VA contact phone numbers that..." (play the appropriate voicemail message defined in action 2 of this alert). The Chief of MH emailed the aforementioned Patient Safety Alert to all Perry Point MH staff on October 27, 2022. The Patient Safety Alert required an attestation from the Chief of MH that read: *"The MHCC [Mental Health Clinical Center] attests that mental health staff members' personal cell phone numbers have not been given out to patients receiving mental health care and appropriate numbers have been provided to Veterans."* This attestation was not accurate given the use of a psychiatrist's personal cell phone for communication with Veterans as described above.

Conclusions for Allegation 1

- We **do not substantiate** in CY 2022 and CY 2023, approximately 400 patients discharged from the MH RRTPs did not receive a follow-up appointment within 7 days of discharge in violation of VHA directives.

- We determined that in the 400 Veteran charts reviewed, 135 had appointments within 7 days of discharge with a mental health provider, an additional 120 had an appointment after 7 days but within 30 days, 129 had an appointment after 30 days, and 16 had no evidence of an appointment. For clarity, there is no requirement for the 7-day post discharge appointment to be with a psychiatrist, it can be with any mental health provider.

- We find no evidence of patient harm related to patients not being scheduled for a follow-up appointment with an MH provider within 7 days of discharge.

- In 25 records reviewed from CY 2022 and CY 2023, all had a documented post-discharge follow-up engagement call with their MH RRTP provider.

- There was no method to access the time from discharge from MH RRTP to the first follow-up outpatient MH appointment, and this information was not on the facility's chart audit tool for MH RRTP.

- The FLOW Program intended to transfer Veterans from mental health to PACT once stabilized is poorly used.

- The use of a personal cell phone by a psychiatrist to communicate with Veterans violated the Patient Safety Notice sent by the Chief of MHCC, potentially exposed Veterans to risks of protected health information and personally identifiable information disclosure, and appears to be a practice boundary concern. Additionally, the same psychiatrist has met with Veterans on the weekend at VA to discuss their benefits which raises concerns about professional boundaries and practicing within scope of duties.

Recommendations to Perry Point

1. Standardize the process of obtaining a scheduled post-discharge MH appointment by entering a consult earlier than the day of discharge.

2. Review the 16 Veteran records with no evidence of an appointment and ensure appropriate follow up.

3. Modify the MH RRTP audit tool to include assessment of the discharged Veteran's first MH follow-up appointment.

4. Evaluate Veterans on the FLOW dashboard to decide if any would be within the PACT provider's scope of care and transition as appropriate.

5. Request medical ethics consultation for potential practice boundary concerns.

6. Conduct a formal investigation of the use of a personal cell phone for Veteran care and ensure communications are compliant with law and VA policies. Take appropriate administrative action, as necessary.

Allegation 2

The outpatient mental health clinic is not sufficiently staffed to provide patients discharged from the MH RRTPs their first follow-up appointment within seven days of discharge or a face-to-face evaluation within fourteen days of discharge as required by VHA directives.

Background

VHA Directive 1161, Productivity and Staffing in Clinical Encounters for Mental Health Providers, dated April 28, 2020, provides guidelines for outpatient MH staffing. Paragraph 2b(2) states:

> *"To ensure treatment is available to provide timely access to care, high-quality mental health services, and patient and employee satisfaction, facilities should make available a minimum of 7.72 outpatient clinical full-time equivalent (FTE) per 1,000 Veterans receiving mental health care. A minimum of 1.22 psychiatrist FTE assigned to clinical duties per 1,000 Veterans receiving outpatient mental health care is recommended."*[12]

Findings

We reviewed the outpatient MH staff to treated patient ratio, as well as the number of MH prescribers per 1,000 MH in specialty MH clinic metrics as reported in the first quarter (Q1) of FY 2024. In the Mental Health Information System, Measure Components Summary, we observed the larger Maryland VA Health Care System,

12 VHA Directive 1161, Productivity and Staffing in Clinical Encounters for Mental Health Providers, dated April 28, 2020.

(which includes Perry Point) has 8.96 FTE per 1,000 Veterans in outpatient MH, and 1.26 prescriber FTE per 1,000 Veterans receiving outpatient MH care. This exceeds the ratios defined in VHA Directive 1161. These metrics are not available specifically for Perry Point, however Veterans discharged from the Perry Point MH RRTP have access to follow-up MH appointments in all locations served by the Maryland VA Health Care System.

We reviewed current vacancies at Perry Point and discovered eight vacant positions for the MH clinic. Of the eight positions, the Executive Resource Management Council Committee approved seven positions that are pending next steps. These eight positions include four psychiatry positions, two nurse practitioner positions, one social worker associate, and one MH Clinic position for a social worker that is pending approval.

Interviewees told us in the past, MH clinic appointments could be made within 30 days, but this became more difficult after the loss of multiple providers, and eventually took over 6 months to get an appointment. As a result of these long wait times, Perry Point outpatient MH clinic stopped accepting new patients. In CY 2021, there were seven prescribing providers, but in CY 2023, there were only two, one nurse practitioner and one psychiatrist who spend only 60% of their time in the outpatient MH clinic. As discussed earlier in Allegation 1, the MH RRTP psychiatrist would provide a bridge until the Veteran could be seen by the outpatient MH prescribing provider. According to interviewees, the increase in referrals to Care in the Community and the hiring of 2 new nurse practitioners in the last 3 months in outpatient MH clinic increased new patient appointment availability. The MH outpatient clinic now has four prescribers.

We reviewed productivity data for MH prescribers and discovered a provider used the MH RRTP clinic to document encounters with Veterans while the Veterans are in an outpatient status (discharged from MH RRTP). This is concerning since the MH RRTP encounter would be coded incorrectly. We requested the clinic name, stop code, and current procedural terminology (CPT) code used for an encounter completed by this provider for a Veteran (name provided by the whistleblower) discharged from MH RRTP and receiving bridge care while awaiting an MH outpatient prescriber appointment. The EHR review showed the Veteran was discharged from the MH RRTP Program on June 1, 2023. There was a telephone encounter with the bridge provider on June 26, 2023, to address a medication refill request. The provider used clinic name "PP MH RESIDENTIAL PSYCHIA," an MH RRTP clinic stop code 586 and a CPT code 99309 (face to face visits only lasting 30 minutes). Since this was a telephone encounter, a face-to-face visit CPT code is inappropriate. Use of this CPT code inflates the provider's productivity metrics, and if billed to a third-party insurance, could constitute fraud.

We reviewed the MH profile summary data and determined that this provider only used MH RRTP clinics for the past 12 months. This data may include other erroneous documentation and coding for the past 12 months for any outpatient Veteran seen by this provider. Of note, the provider's productivity is 39% of target achieved for encounter, and the provider is 153% below capacity on the Office of Productivity, Efficiency, and Staffing capacity report.

Multiple interviewees mentioned their improvement in their MH Post Discharge Engagement (PDE-1) Strategic Analytics for Improvement and Learning metric. Overall, the greater VA Maryland Health Care System has shown steady sustained gains in the PDE-1 metrics over the past 2 FYs. Current PDE-1 metric data for Q4 of FY 2023 shows the facility with a score of 81.63%, just under the national score of 84.3% for the 90th percentile. The rationale for the PDE-1 metric is to track Veterans who are at higher risk for negative outcomes after leaving an inpatient or residential care setting. The PDE-1 requirement is 2 contacts by MH within 30 days after discharge, unless the Veteran is high risk for suicide which requires 4 contacts. This PDE-1 engagement is different from the requirement defined in VHA Directive 1162.02 for an appointment with an MH provider within 7 calendar days of discharge from MH RRTP.

We were told during interviews that a provider inappropriately contacted two newly selected prescribing providers to work at Perry Point and tried to discourage them from accepting a position with the Perry Point MH clinic, despite the known MH outpatient clinic staffing shortages. One selectee declined to work at Perry Point but did accept a position in Baltimore. The other selectee accepted the Perry Point position with the stipulation that they not work on the same unit as the provider who contacted them. We confirmed the facility was both aware of these issues and that they were addressed by leadership.

Conclusions for Allegation 2

- We **substantiate** the Perry Point outpatient MH clinic is not sufficiently staffed to provide patients discharged from the MH RRTP their first follow-up appointment within 7 days.
- We noted that one provider consistently miscoded outpatient visits as inpatient visits.
- The PDE-1 metric does not measure the 7-day requirement defined in VHA Directive 1162.02 but does provide evidence of engagement with the Veteran post discharge from the MH RRTP.
- Perry Point mental health clinic remains short staffed by eight positions.

Recommendations to Perry Point

7. Conduct coding audits for all MH RRTP providers from the beginning of FY 2023 through March 2024. Investigate non-compliance with law and policy and take appropriate administrative action.
8. Provide education and retraining on coding practice and procedures for MH RRTP providers (if necessary) after audit.
9. Prioritize filling the current vacancies in the Perry Point Outpatient MH clinic.

VI. Summary Statement

We developed this report in consultation with other VHA and VA offices to address the Office of Special Counsel's concerns that Perry Point engaged in conduct that may constitute a violation of law, rule, or regulation; gross mismanagement; abuse or authority; or a substantial and specific danger to the public health or safety. We reviewed the allegations and determined the merits of each. We determined that there are discrepancies with compliance to VHA Directives relating to scheduling appointments post discharge from Perry Point programs, medical coding violations, and potential boundary and ethical issues with one specific provider.

Attachment A
List of References

Mental Health Guidance for Coronavirus (COVID-19) Pandemic Response, dated July 7, 2020. Available at: https://dvagov.sharepoint.com/sites/VHAPTSDMentoring/Functional%20Statements/Forms/AllItems.aspx, last accessed July 31, 2024. ***Note**: This is an internal VA SharePoint website that is not available to the public.*

NIH, National Library of Medicine, National Center for Biotechnology Information, FLOW: Early results from a clinical demonstration project to improve the transition of patients with mental health disorders back to primary care, dated March 14, 2019. Available at: https://pubmed.ncbi.nlm.nih.gov/30869978/, last accessed May 10, 2024.

Patient Safety Alert, Issued by VHA Central Office, AL22-04, dated August 31, 2022. Available at: https://dvagov.sharepoint.com/sites/vhancps/Lists/AlertsAdvisoriesandNoticesTracker/Attachments/149/AL22-04.pdf, last accessed July 31, 2024. ***Note**: This is an internal VA SharePoint website that is not available to the public.*

VA Handbook 6500.10, Mobile Device Security Policy, Rules of Behavior, dated February 15, 2018.

VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics, dated September 11, 2008, was rescinded April 27, 2023. ***Note**: This handbook remained applicable to Allegation 1 until April 26, 2023.*

VHA Directive 1160.01, Uniform Mental Health Services in VHA Medical Points of Service, dated April 27, 2023

VHA Directive 1161 Productivity and Staffing in Clinical Encounters for Mental Health Providers, dated April 28, 2020.

VHA Directive 1162.02, Mental Health Residential Rehabilitation Treatment Program, dated July 15, 2019.

VHA Directive 1232, Consult Processes and Procedures, dated August 23, 2016.

VHA Office of Integrated Veteran Care, Community Care Field Guidebook, Chapter 2: Defining Eligibility, updated April 19, 2023. Available at: https://dvagov.sharepoint.com/sites/VHAOCC/CNM/CI/OCCFGB/SitePages/FGB.aspx, last accessed May 10, 2024. ***Note**: This is an internal VA SharePoint website that is not available to the public.*

Attachment B
List of Acronyms

CPT	current procedural terminology
CY[2]	calendar year
EHR[1]	electronic health record
FTE[1]	full-time equivalent
FY	fiscal year
MH	Mental Health
MHCC[1]	Mental Health Clinical Center
OMHSP[1]	Office of Mental Health and Suicide Prevention
PACT	Patient Aligned Care Team
PDE	Post Discharge Engagement
PID	Patient Indicated Date
RRTP[2]	Residential Recovery Treatment Program
VA	Veterans Affairs
VCM[1]	Virtual Care Manager
VHA[2]	Veterans Health Administration
VISN	Veterans Integrated Service Network
VVC[1]	VA video conferencing

[1]Note: Acronym first defined as part of direct quote contained in this report.
[2]Note: Acronym first defined in report allegation.

Table B-1 List of Acronyms