THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

January 13, 2025

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:

Enclosed is the supplemental report as requested in your October 29, 2024, email to the Department of Veterans Affairs (VA). The supplemental report provides additional information related to VA's August 30, 2024, report submitted to the Office of Special Counsel on the investigation at the Perry Point VA Medical Center, Mental Health Residential Rehabilitation Treatment Program located in Perry Point, Maryland.

Thank you for the opportunity to respond.

Sincerely,

Denis McDonough

Enclosure

Department of Veterans Affairs

Supplemental Report for the Office of Special Counsel

Perry Point VA Medical Center

Perry Point, Maryland

OSC File Number DI-24-000195

December 3, 2024

Content Manager 2023-C-53

The Office of the Secretary, Department of Veterans Affairs (VA) received an email from the Office of Special Counsel (OSC) on October 29, 2024, regarding the VA's investigation, led by the Office of the Medical Inspector (OMI), of whistleblower allegations related to the Mental Health (MH) Residential Rehabilitation Treatment Program (RTTP) at the Perry Point VA Medical Center (hereinafter Perry Point) located in Perry Point, Maryland. Specifically, OSC requested additional information with respect to the four questions stated below. Moreover, OSC requested the implementation status of each of the nine recommended corrective actions. As part of the status update, OSC requested OMI include whether Perry Point has on-boarded the four psychiatrists and one social worker that Perry Point had been approved to hire as of August 2024. A response is requested by January 3, 2025.

OSC Question 1

"The report states the whistleblower asserted that approximately 400 patients waited over 30 days to receive a follow-up appointment, and the Office of Medical Inspector (OMI) requested (but did not receive) data for patients discharged from the Perry Point Mental Health Residential Rehabilitation and Treatment Program (MH RRTP) and their next scheduled MH outpatient appointment; the report noted this data did not exist and was not included on the facility's chart audit tool for MH RRTP. See VA August 14, 2024, Report at p. 7. Please explain if the requested data (i.e., data for patients discharged from the MH RRTP and their next scheduled MH outpatient appointment) should exist on the facility's chart audit tool, as anticipated, and, if so, why it did not exist. Please also explain what corrective action will be implemented to ensure that this data will exist in the future."

VA Response

Veterans Health Administration (VHA) Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics, dated September 11, 2008, (applicable at the time of the investigation) required that Veterans receive mental health evaluations within 1 week of discharge from inpatient or residential care settings. While we agree follow-up appointment data should exist to ensure Veteran continuity of care, it is unclear why prior to our investigation it did not exist. OMI discovered that a method to

monitor compliance of this 1-week requirement did not exist at the facility, Veterans Integrated Service Network, or at the national level. We determined that Perry Point did have an existing audit tool that could be modified to assess compliance until VA determines if a national measure is necessary. OMI also proposed a potential solution developed to analyze data from Allegation 2 (below), which is currently under review by VA.

Status: *This action was closed October 24, 2024.*

OSC Question 2

"The report states that OMI requested a review by the Office of Internal Audit (10IA), and 10IA located and reviewed 401 accessible records. Please provide additional details about the 10AI office and what it is; also explain the 401 records that 10IA found, and the data 10IA analyzed to conclude that "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," which the report cites with respect to its conclusions for allegation one. See id. at p. i, 7, and 11."

"Further, in footnote 9, the report states that the data 10IA analyzed and the algorithm used "would be useful to develop a VSSC [VHA Support Service Center] report to measure compliance with requirements in VHA Directive 1162.02." See id. at footnote 9. Please explain what a VSSC report is, how this report measures compliance with the requirements of VHA Directive 1162.02, and whether any corrective action will be taken to ensure that this data is used and a VSSC report is developed as noted."

VA Response

The Office of Internal Audit (10IA) provides *"...an internal audit function [that] gathers information on how an organization is operating. It shows employees and management where they are doing well and recommends where they can improve. Organizations working to become high reliability organizations use internal audits in support of their objectives to foster a continuous improvement culture. The audits and engagements that IA conducts are preventive, not punitive. The findings from IA's reports help programs and the field provide the very best care to Veterans."*[1]

The VSSC (VHA Support Service Center) *"...creates and maintains advanced and secure data platforms, measurement systems, and analytic solutions that help providers work with Veterans and their families to make well-informed decisions."*[2] Currently, VSSC does not include a report to identify 7-day post discharge appointments for MH RRTP.

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1 VA, Oversight, Risk and Ethics, Office of Internal Audit, What We Do, updated August 25, 2022. Available at: https://vaww.ore.med.va.gov/programOffices/ia/iaDefault.aspx, last accessed December 2, 2024.
2 VA, Health Care, Quality and Patient Safety, Analytics and Performance Integration, The VHA Support Service Center (VSSC), updated April 11, 2023. Available at: https://www.va.gov/QUALITYANDPATIENTSAFETY/api/index.asp, last accessed December 2, 2024.

OMI consulted 10IA to analyze the approximately 400 records provided by the whistleblower. 10IA developed a customized algorithm to review the Electronic Health Record for appointments with a mental health provider 7 days after discharge from MH RRTP. When the customized algorithm was applied to the approximately 400 records, 10IA was able to determine that 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, 129 had an appointment after 30 days of discharge, and 16 Veterans had no documented appointment. To ensure appropriate follow up, we directed the facility to review these 16 records. This review was reported on the facility's action plan. The facility did not find evidence of any of these 16 Veterans experiencing negative mental health outcomes related to this issue.

As indicated above, VHA does not have a VSSC report to measure this 7-day requirement defined in VHA Directive 1162.02. OMI believes the 10IA algorithm could be used to provide the metric automatically, rather than the manual method in question 1. This algorithm has been shared with VSSC and is currently under review.

Status: This action was closed October 24, 2024.

OSC Question 3

"On page 9 the report states that of the approximate 400 patients related to the allegation, investigators determined that 223 were treated in calendar year [CY] 2023. Of these 223 patients, 91 had a Joint Patient Safety Report (JPSR). OMI reviewed 56 of these JPSRs, determining none were related to delayed medication management after discharge from the MH RRTP. See id. at p. 9. Please explain why the other 35 JPSRs in [CY] 2023 were not reviewed during the investigation. Also, please explain whether any of these 35 JPSRs were related to delayed medication management after discharge from MH RRTP, and if so, what was the outcome of any JPSRs. Additionally, for the 177 patients remaining in the allegation, which were presumably treated in either calendar year 2022 or 2024, please provide whether any had JPSRs filed, whether any of those JPSRs were related to delayed medication management after discharge from MH RRTP, and if so, what was the outcome of any such JPSRs."

VA Response

Allegation 1 from the report focused on the 400 Veterans not receiving follow up appointments post discharge in calendar year (CY) 2022 and CY 2023, not CY 2024. We reviewed Joint Patient Safety Reports (JPSR) from CY 2023 as this would be the time frame from which Veterans would likely benefit from interventions. We found 223 patients were treated in CY 2023, and of these 223 patients, 91 had a JPSR. OMI reviewed 56 of these 91 JPSRs (61.5%) as a representative sample and did not find any that were related to a delay in appointment availability effecting prescription availability. Finding no concerns from this significant sample size, we did not conduct a complete review of all 91 JPSRs or a complete review of the remaining 177 patients noted in the allegation, all of whom had been treated in CY 2022. To further assess for any serious impact on outcomes, we reviewed all attempted and completed suicide data

within 7 days of discharge from September 2021 through March 2024, which is inclusive of the year range stated in the allegation, and did not find any.

Status: This action was completed on August 6, 2024.This action was closed October 24, 2024.

OSC Question 4

"Please provide the implementation status on each of the nine recommended corrective actions. As part of the status, please include whether Perry Point has on-boarded the four psychiatrists and one social worker that Perry Point had been approved to hire as of August 2024—the hiring status of this personnel is especially important given that the report stated a Perry Point provider had previously attempted to discourage two selectees from accepting positions with the MH Service. See id. at p. 14."

VA Response

The implementation status of the following nine recommendations is as follows:

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

Status: OMI requested Perry Point include an additional process to ensure that appointments remain in the electronic record throughout the MH RRTP treatment stay.

This action is ongoing and remains open. The expected completion date for this action is January 24, 2025.

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

Status: Perry Point completed a thorough review of all 16 Veteran records. Follow up occurred to ensure the Veterans' safety and wellbeing. The facility reported no evidence of negative outcomes post discharge.

Perry Point completed this action September 27, 2024. We closed this action on October 24, 2024.

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

Status: Perry Point submitted evidence of the modified audit tool and educated staff. Audits are ongoing and discussed in staff meetings.

Perry Point completed this action May 6, 2024. OMI closed this action October 24, 2024.

Recommendation 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.

Status: Perry Point established new processes to review the FLOW dashboard regularly by behavioral health nurses. As a result of the review, some Veterans successfully transitioned to outpatient primary care.

Perry Point completed this action May 1, 2024. OMI closed this action October 24, 2024.

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

Status: The facility consulted the appropriate offices (VA Maryland Health Care System (VAMHCS) Ethics Office, Office of General Counsel, VA Center for National Ethics in Healthcare, VAMHCS Employee and Labor Relations and Privacy Office). The consensus was to provide education to the employee on VA policy. VAMCHS provided evidence of education of the required voicemails for VA cellphone and desk phones and a comment on the attestation read, "...In addition, personal cell phone numbers are not to be provided to patients receiving mental health care. If personal cell phone numbers have been given in the past, patients must be given appropriate VA contact phone numbers." The employee signed the attestation on April 11, 2024. OMI requested additional evidence of the attestation to cease provision of benefits assistance by the same employee who was not qualified to do so.

This action is ongoing and remains open. The expected completion date for this action is January 31, 2025.

Recommendation 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.

Status: The facility completed the formal investigation and removed all unauthorized references that inappropriately directed Veterans to contact this employee directly if the Veteran needed assistance. The supervisor issued verbal counseling and obtained staff attestations to ensure understanding of this requirement.

Perry Point completed this action March 19, 2024. OMI closed this action October 24, 2024.

Recommendation 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.

Status: The facility completed the review of encounters and removed two encounter errors to prevent the Veterans from receiving undue billing.

Perry Point completed this action on August 6, 2024. OMI closed this action October 24, 2024.

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

Status: All but two MH RRTP primary therapists completed training on October 11, 2024. OMI requested a final list of staff trained on or before the next action plan due date.

This action is ongoing and remains open. The expected completion date for this action is on or before January 24, 2025.

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

Status: Perry Point hired a 1.0 full-time equivalent Geriatric Psychiatrist who onboarded on June 30, 2024. Posting and recruitment of three additional psychiatrists and one social worker is ongoing. This action remains open.

The expected completion date for this action is on or before September 30, 2025.