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The Special Counsel

July 11, 2025

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

Re: OSC File No. DI-24-000195

Dear Mr. President:

I am forwarding to you the reports transmitted to the Office of Special Counsel (OSC) by the Department of Veterans Affairs (VA), in response to the Special Counsel's referral of disclosures of wrongdoing at the Perry Point VA Medical Center (Perry Point VAMC), Perry Point, Maryland. OSC has reviewed the disclosure, agency reports, and whistleblower comments and, in accordance with 5 U.S.C. § 1213(e), I have determined that the reports contain the information required by statute and the findings appear reasonable.[1] The following is a summary of those findings and comments.

[redacted] the Perry Point VAMC's Mental Health Residential Rehabilitation and Treatment Program (MH RTTPs), who consented to the release of [redacted] name, alleged that in 2022 and 2023, approximately 400 patients discharged from the Perry Point VAMC's MH RRTPs did not receive a follow-up appointment within 7 days of discharge in violation of a Veterans Health Administration (VHA) directive. [redacted] also alleged that the Perry Point VAMC's outpatient Mental Health (MH) clinic was not sufficiently staffed to provide patients discharged from the MH RRTPs follow-up appointments within 7 days of discharge or face-to-face evaluations within 14 days, as required by the VHA directive. The reports substantiated the second allegation, but not the first.

The Perry Point VAMC provides specialty health services, including MH RRTPs, which encompass an array of programs and services and involve interactions between patients and providers when overnight stays in residential bed sections are required. Pursuant to VHA Handbook 1160.1, *Uniform Mental Health Services in VA Medical Centers and Clinics*, when

[1] OSC referred the allegations to then-Secretary of Veterans Affairs Denis McDonough for investigation pursuant to 5 U.S.C § 1213(c) and (d). The Office of the Medical Inspector investigated the allegations and then-Secretary McDonough reviewed and signed the agency reports.

veterans are discharged from inpatient or residential care, they must receive follow-up mental health evaluations within one week of discharge and must be seen for face-to-face evaluations within two weeks. Though the VA rescinded this handbook April 27, 2023, the reports state that it applied to the allegations until April 26, 2023.

The agency investigation substantiated that the outpatient MH clinic is not sufficiently staffed to provide follow-up appointments to patients discharged from the MH RRTPs. The reports identified eight vacancies within the Perry Point outpatient MH clinic and only two prescribing providers, which created a six-month wait time for a clinic appointment. The reports indicated that during the investigation, referrals to Care in the Community increased and two nurse practitioners were hired in the outpatient MH clinic, which increased appointment availability. Furthermore, management prioritized filling the remaining vacancies. To this end, a Geriatric Psychiatrist on-boarded June 30, 2024, and recruitment of three additional psychiatrists and one social worker is ongoing. Management anticipates completing this process on or before September 30, 2025.

The investigation did not substantiate that approximately 400 patients failed to receive a follow-up appointment within seven days of discharge in 2022 and 2023. The investigation found that of the 400 patients at issue, 135 had appointments within the 7 days of discharge, 120 had appointments within 30 days of discharge, 129 had appointments after 30 days of discharge, and 16 had no evidence of an appointment after discharge.[2] The reports explained that upon discharge from MH RRTPs patients must receive a consult for their follow-up appointments with a MH prescriber and MH therapist. Sometimes staff entered consults in the system 3 to 14 days before discharge, but these consults became "idle" and negatively affected performance metrics. Other employees entered the consult on the day of discharge but doing so resulted in an appointment later than seven days in violation of VHA Directive 1162.02. The reports also explained that upon discharge the MH RRTP psychiatrist provides patients with medication for up to 90 days. The residential psychiatrist bridges any gap between a patient's last refill and an appointment with a MH prescriber through office or telephone visits. Bridging can last from 30 days to 1 year. And while clinically stable patients may transition from MH providers to their Patient Aligned Care Team (PACT) for continued medication management via a program called FLOW[3], the reports stated that the Perry Point MH RRTPs rarely used FLOW and the failure to do so could have a negative impact on medication management wait times.

As a result of these findings, the Perry Point MH service standardized the process for scheduling a post-discharge MH appointment by entering a consult before the day of discharge and, thereafter, entering a comment every 14 days to keep it from becoming idle. The reports state that this should improve follow-up appointment times as the appointments will remain in the electronic health record throughout the MH RRTP inpatient treatment stay. Perry Point MH

[2] Additional review of these 16 patients' charts found no evidence they experienced negative mental health outcomes due to a lack of follow up after discharge.
[3] FLOW is not an acronym.

nurses will also regularly review the FLOW dashboard to determine if any patients can be transitioned to PACT care for continued medication management.

Finally, the reports noted that the investigation revealed additional issues including that a Perry Point MH provider used a personal cell phone to communicate with patients in violation of VA directives, which blurred professional boundaries because patients contacted the provider on this phone outside of normal business hours to discuss benefits, and a MH provider miscoded outpatient visits. The reports state that the VAMC took appropriate corrective action.

In [redacted] comments, [redacted] disagreed with the findings and conclusions regarding the unsubstantiated allegation. [redacted] also criticized the investigation for not including 2021 data or interviewing the Program Coordinators of the Perry Point Walk-in Clinic or Harm Reduction Program. [redacted] further objected to how the investigation calculated provider productivity, assessed the follow-up appointment data, and its failure to address the reasons for the understaffing.

I thank the whistleblower for bringing these important issues to OSC. In accordance with 5 U.S.C. § 1213(e) I have determined that the reports contain the information required by statute and the findings appear reasonable. I expect the Perry Point VAMC and MH leadership to continue their efforts to appropriately staff the Perry Point outpatient MH clinic.

As required by 5 U.S.C. § 1213(e)(3), I have sent copies of this letter, the agency reports, and whistleblower comments to the Chairmen and Ranking Members of the Senate and House Committees on Veterans' Affairs. OSC has also filed redacted copies of these documents and the redacted letter that referred the matter to the VA in OSC's public file, which is available online at www.osc.gov. This matter is now closed.

Respectfully,

Charles N. Baldis
Senior Counsel and Designee
of Acting Special Counsel Jamieson Greer

Enclosures