THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

August 13, 2018

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

Re: OSC File No. DI-18-0169, DI-18-0225, DI-18-0226

Dear Mr. Kerner:

I am responding to your January 16, 2018, letter to the Secretary regarding allegations made by whistleblowers at the Department of Veterans Affairs (VA) Richard L. Roudebush VA Medical Center, Indianapolis, Indiana, that employees may have engaged in conduct that constitutes gross mismanagement and a substantial and specific danger to public health. I have signed the enclosed report and will take any actions deemed necessary as referenced in 5 United States Code § 1213(d)(5).

The Executive in Charge directed the Office of the Medical Inspector to assemble and lead a VA team to conduct an investigation. We substantiated both of the whistleblowers' allegations. First, Social Work Service leadership, including the Chief and Assistant Chief, directed social workers to stop entering home health care consults into the Computerized Patient Record System due to concerns about social workers working outside their scope of practice. We found this decision led to a system breakdown, as the transition was not implemented with key services in a collaborative and cohesive manner, allowing time for coordination and education. Second, the lack of adequate planning, training, and communication resulted in a significant delay in at least one Veteran's case with potential harm for others. We make 17 recommendations to the Medical Center and 2 to Veterans Integrated Service Network 10.

Thank you for the opportunity to respond.

Sincerely,

Robert L. Wilkie

Robert L. Wilkie

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
Washington, DC

Department of Veterans Affairs (VA) Report to the Office of Special Counsel OSC File Numbers DI-18-0169, DI-18-0225, and DI-18-0226

Richard L. Roudebush VA Medical Center
Indianapolis, Indiana

Report Date: July 11, 2018

2018-D-493

Executive Summary

The Executive in Charge, Office of the Under Secretary for Health, requested that the Office of the Medical Inspector (OMI) assemble and lead a Department of Veterans Affairs (VA) team to investigate allegations lodged with the Office of Special Counsel (OSC) concerning the Richard L. Roudebush VA Medical Center (Indianapolis) in Indianapolis, Indiana. Three staff members (the whistleblowers) who requested confidentiality alleged that employees may have engaged in conduct that constitutes gross mismanagement and a substantial and specific danger to public health. Specifically, they claimed that the Chief, Social Work Service (SWS), directed social workers to stop entering home health care consults into the Computerized Patient Record System (CPRS) without ensuring that other staff members were adequately trained to perform this function, and that the lack of adequate planning, training, and communication has resulted in significant delays and apparent harm to Veterans. We conducted a site visit to Indianapolis February 12–15, 2018.

Specific Allegations of the Whistleblowers

1. Employee 1 *the chief of Social Work, directed social workers to stop entering home health care consults (consults) into the Computerized Patient Record System (CPRS) without ensuring other staff were adequately trained or able to perform this function; and*

2. *The lack of adequate planning, training, and communication has resulted in significant delays and apparent harm to Veterans.*

We **substantiated** allegations when the facts and findings supported that the alleged events or actions took place and **did not substantiate** allegations when the facts and findings showed the allegations were unfounded. We **were not able to substantiate** allegations when the available evidence was not sufficient to support conclusions with reasonable certainty about whether the alleged event or action took place.

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

Conclusions for Allegation 1

- We **substantiate** that SWS leadership, including the Chief and Assistant Chief, directed social workers to stop entering home health care consults into CPRS due to concerns about social workers working outside their scope of practice. We found this decision led to a system breakdown, as the transition was not implemented with key services in a collaborative and cohesive manner, allowing time for coordination and education. The system remains fragmented among Patient Aligned Care Teams (PACT), and there are still silos at Indianapolis, as evidenced by the last-minute Geriatric and Extended Care team notification during our site visit.

- SWS leadership made a concerted effort to assist the facility; however, SWS and owners of the process lacked a systematic approach to ensure a smooth transition from social workers completing home health care consults to other offices and disciplines assuming responsibility for these consults.

- We **substantiate** that the Chief, SWS, and owners of the process did not make a concerted effort to train and educate all staff members involved. We found evidence of insufficient and variable training and the absence of a contingency plan, resulting in significant challenges. There was also no quality assurance mechanism in place to verify whether the new practice was working.

- There was a lack of assigned Utilization Management (UM) nursing staff to support the rollout of the inpatient pilot plan and no contingency plan to handle staff absences.

- There was inadequate social work and nursing staff to provide appropriate and timely processing of consults; this included numerous social work vacancies, limited UM nurses to assist social workers with completing consults, and only two Referral Nurses to complete the final review and oversee the management of consults.

- We are concerned that there are insufficient resources available to cover the workload including ensuring that the medical residents working on the teaching services are properly trained in the consult process.

Recommendations to Indianapolis

1. Review the current method of processing home health care consults and restructure the process to allow consults to be easily entered and processed.
    a) Write a consult standard operating procedure (SOP) for use throughout Indianapolis.
    b) Upon completion of the SOP, develop a systematic training plan for key staff, including system redesign, quality, social workers, nursing, and medicine staff, to effectively implement this process throughout Indianapolis.
    c) Create a method to consistently monitor the accuracy, timeliness, and effectiveness of the process.

2. Ensure that all involved staff members are educated and trained in the consult process; verify that this has been completed.

3. Fill SWS vacancies.

4. Develop a contingency plan to provide adequate social work coverage in all Indianapolis programs.

5. Request a consultative site visit from the Veterans Health Administration (VHA) National Social Work Program Office to assess the provision of social work services throughout the facility.

Recommendation to Veterans Integrated Service Network (VISN) 10

1. Assess Indianapolis social work vacancy rates and work with the facility to ensure resource availability supports appropriate social work staffing levels.

Conclusions for Allegation 2

- We **substantiate** that the lack of adequate planning, training, and communication resulted in a significant delay in at least one Veteran's case with potential harm for others.

- In the above Veteran's case, we could not find evidence that a clinical or institutional disclosure was completed.

- Indianapolis staff members did not follow up with the Veteran to ensure that the consult for in-home wound care was completed.

- There was a reported delay in processing the home care consults, which preceded the change in the consultation process.

- Two Referral Nurses may not be sufficient to handle all Indianapolis referrals, especially if one nurse is absent. There is currently no contingency plan for Referral Nurse coverage when both nurses are not at work.

Recommendations to Indianapolis

6. Ensure that Veterans who are identified as having experienced delays in the consult process receive appropriate care; address as indicated.

7. Conduct an outside peer review on the identified Veteran who did not receive timely wound care leading to readmission; specifically, review the home health consult and the timeliness of the follow up. Conduct a clinical or institutional disclosure, if warranted.

8. Take appropriate administrative, educational, or disciplinary action regarding the delay in care for the identified Veteran.

9. Ensure sufficient staffing to enable consults to be processed in a timely manner, specifically addressing the current process of two Referral Nurses managing all Indianapolis Non-VA Care Coordination (NVCC) consults.

10. Revisit the practice of simply discontinuing incomplete consults and improve communication to expedite the completion process for Veterans with clinical needs.

11. Develop a monitoring process to track NVCC consults, ensuring that Veterans are not lost during the processing of consults to ensure that they receive timely care.

12. Review the process for nurse post-discharge follow up with Veterans to ensure that calls are repeated and follow-up actions are implemented until the plan for home care is put in place, e.g., wound care nurse is providing care.

13. Review and revise the discharge documentation as needed to instruct Veterans to contact Indianapolis if a scheduled home health staff member does not come to the Veteran's home or if any element of the discharge plan is unfulfilled.

Conclusions for Additional Findings

- Social workers and staff in SWS and other departments described the Chief, SWS, as lacking in communication skills and expressed fear of retaliation, favoritism, and a hostile work environment.

- All Employee Survey (AES) scores and turnover rate are concerning and reinforce the troubling statements made by interviewees.

- Relative Value Units (RVU) are currently being used to evaluate social workers on their annual Performance Plans, and these metrics were neither pilot tested nor reviewed and approved by Indianapolis leadership. It is unclear whether the use of RVUs for employee evaluation is accurate or based on sound methodology and may be producing results contrary to its intended aims.

Recommendations to Indianapolis

14. Review concerns regarding the Chief, SWS, and address as appropriate.

15. Review the results of AES and develop and implement a corrective action plan to address problem areas if one has not already been developed.

16. Work with Human Resources (HR) to review the SWS staff turnover rate and their reasons for leaving at such a high rate; develop a plan to reduce turnover.

17. SWS leadership should review best practices from other VA medical centers on productivity performance measures for both clinical social workers and supervisors and evaluate for possible adaptation; pilot test measures and obtain approval from Indianapolis leadership prior to implementation.

Recommendation to VISN 10

2. Review Indianapolis' SWS productivity metrics and the use of RVUs as an assessment tool for social work performance; ensure the accuracy and validity of these data and their suitability for achieving the aims of the SWS.

Summary Statement:

OMI developed this report in consultation with other VHA and VA offices to address OSC's concerns that Indianapolis employees may have engaged in conduct that constitutes gross mismanagement and a substantial and specific danger to public health. In particular, VHA HR has examined personnel issues to establish accountability and the National Center for Ethics in Health Care has provided a health care ethics review. While we found no violations of VA or VHA policy and no gross mismanagement, we did find evidence to substantiate the allegation that a substantial and specific danger to public health exists at Indianapolis based upon the findings from Allegation 2.

Table of Contents

I. Introduction

The Executive in Charge, Office of the Under Secretary for Health, requested that the Office of the Medical Inspector (OMI) assemble and lead a Department of Veterans Affairs (VA) team to investigate allegations lodged with the Office of Special Counsel (OSC) concerning the Richard L. Roudebush VA Medical Center (Indianapolis) in Indianapolis, Indiana. Three staff members (the whistleblowers) who requested confidentiality alleged that employees may have engaged in conduct that constitutes gross mismanagement and a substantial and specific danger to public health. Specifically, they claimed that the Chief, Social Work Service (SWS), directed social workers to stop entering home health care consults into the Computerized Patient Record System (CPRS) without ensuring that other staff members were adequately trained to perform this function and that the lack of adequate planning, training, and communication has resulted in significant delays and apparent harm to Veterans. We conducted a site visit to Indianapolis February 12–15, 2018.

II. Facility Profile

Indianapolis, part of Veterans Integrated Service Network (VISN) 10, is a tertiary care academic teaching facility located in Indianapolis, Indiana. It serves more than 66,000 Veterans in 14 counties encompassing more than 15,000 square miles. Indianapolis provides acute inpatient medical, surgical, psychiatric, neurological, and rehabilitation care, as well as both primary and specialized outpatient services. It has a 50-bed Domiciliary Residential Rehabilitation Treatment Program in Lawrence, Indiana, and operates six Community-Based Outpatient Clinics throughout Central Indiana. SWS is authorized 84.2 full-time employee equivalents (FTEE) of which 65.2 FTEE are social workers. There were 14 social work vacancies at the time of our site visit.

III. Specific Allegations of the Whistleblowers

1. Employee 1 *the chief of Social Work, directed social workers to stop entering home health care consults (consults) into the Computerized Patient Record System (CPRS) without ensuring other staff were adequately trained or able to perform this function; and*

2. *The lack of adequate planning, training, and communication has resulted in significant delays and apparent harm to Veterans.*

IV. Conduct of Investigation

The VA team conducting the investigation consisted of a Senior Medical Investigator, and a Clinical Program Manager, both of OMI; the VISN 1 Director for Geriatrics and Extended Care (GEC); and an Employee and Labor Relations, Human Resources (HR) Specialist. We reviewed relevant policies, procedures, professional standards, reports, memorandums, and other documents listed in Attachment A. We held an entrance briefing with the following members of the Indianapolis leadership team:

- Associate Director/Acting Indianapolis Director (MCD)
- Chief of Staff (CoS)
- Acting Associate Director, Patient Care Services (ADPCS)
- Assistant MCD
- Service Chief, HR
- Administrative Officer for the ADPCS

Our team held a teleconference with two of the whistleblowers on February 8, 2018, and conducted face-to-face interviews with all three at Indianapolis during the site visit, after OSC informed us that the third whistleblower requested to be interviewed. We interviewed the following Indianapolis employees:

- CoS
- Acting ADPCS
- Manager of the Business Service and Lead for Care in the Community
- Director, Quality, Safety, and Value (QSV)
- Acting Chief, Clinical Excellence
- Equal Employment Opportunity Specialist
- Risk Manager
- Employee/Labor Relations, HR Specialist
- Two Union Stewards
- Program Analyst
- Chief, SWS
- Assistant Chief, SWS
- Vocational Rehabilitation Coordinator/Supervisor
- Six Licensed Clinical Social Workers (LCSW), Inpatient
- LCSW, Indy West Patient-Aligned Care Team (PACT)
- LCSW, PACT, Green Team
- LCSW, PACT, Blue Team
- LCSW, GEC (2)
- LCSW, Mental Health (MH)
- LCSW, Emergency Department (ED)
- Chief, Medicine
- Chief, Ambulatory Care
- Staff Physicians, Inpatient (3)
- PACT Nurse Manager (NM)
- Home Based Primary Care (HBPC) NM and Acting Non-Institutionalized Care Coordinator
- NM, Inpatient
- LCSW, MH Intensive Care Case Manager
- Utilization Nurse
- HBPC Referral Nurses (2)
- RN, Inpatient
- RN, Indy West PACT

- RN, PACT (Green or Blue Team)

Our team held an Exit Briefing with the following members of the Indianapolis and VISN 10 leadership teams:

- Quality Management Officer, VISN 10
- Acting MCD
- CoS
- Associate Director
- Acting ADPCS
- Assistant MCD
- Service Chief, HR
- Risk Manager

V. Findings, Conclusions and Recommendations

Allegation 1: Employee 1 *the chief of Social Work, directed social workers to stop entering home health care consults (consults) into the Computerized Patient Record System (CPRS) without ensuring other staff were adequately trained or able to perform this function.*

Background

Veterans Health Administration (VHA) Handbook 1110.02 outlines procedures to ensure social work professional practices and services provided to Veterans are consistent with practice standards defined by VHA SWS and by recognized social work professional organizations; and to ensure that social work practice issues and standards are addressed appropriately at each VHA medical facility.[1] VHA employs more than 13,000 Masters-prepared social workers. Those hired after August 14, 1991, are required by Federal law to be licensed to practice independently. They provide a major link between the VHA health care systems and their communities through the development and utilization of community resources and services in support of established treatment goals for Veterans and their families. They also provide case management services for Veterans, serve as a liaison with family members and oversee the provision of caregiver assistance and family support services. This Handbook delegates oversight for the professional practice of social work to the facility Social Work (SW) Chief/Executive as designated by the MCD.

Per VHA Directive 1232 (1), in regard to Non-VA Care Coordination (NVCC), "a NVCC consult is a request for hospital care and/or medical services to be purchased in the community when the care/services cannot be physically furnished by VA facilities; the Veteran cannot safely travel due to medical reasons; care cannot be furnished in a timely manner in VA facilities; or care cannot be furnished due to geographic

[1] VHA Handbook 1110.02, *Social Work Professional Practice*, January 15, 2014.

inaccessibility.[2] Non-VA consult/referrals are designated as administrative consults but are completed as a clinical consult with a consult result note (NON-VA CARE CONSULT RESULT NOTE) in CPRS and the scanning and attachment to this note title of any report or clinical documentation provided by the non-VA provider or non-VA facility." NVCC consults should be flagged as administrative, based on guidance from the Chief Business Office as stated in [the] NVCC Standard Operating Procedure [SOP] on Non-VA Care Referral Review. The NVCC consult template is an interdisciplinary form with sections that can be completed by multiple disciplines. The home health care consult is one type of NVCC consult.

Historically, Indianapolis social workers independently completed each section of the home health care consult, as well as other consults, using a GEC referral template in CPRS. In early 2013, several emails between the current Assistant Chief, SWS, and PACT leadership discussed the role of social workers in completing the consult process. In a March 2013 email, the Assistant Chief, SWS, stated his concern that social workers were working outside of their scope of practice when completing consults for medical treatment (such as those for intravenous (IV) medication and wound care), since they were completing all aspects of the consult under the signature of the patient's assigned physician. He also shared information from other VHA facilities about how SWS leaders were handling coordination with PACT leadership and provided written guidelines in an email to the Associate Chief Nurse Executive (ACNE) for Primary Care (PC); Chief, Ambulatory Care, and Chief, GEC, outlining who would complete the process and that the entire PACT teamlet (which includes the physician, nurse, and social worker) will own the GEC referral process when a patient requires wound care, IV, and blood draw services.

In April 2016, the GEC Social Work Supervisor implemented the NVCC template as mandated by VHA. The then newly-assigned Chief, SWS, documented concerns about SWS staff members knowing how to complete the new NVCC consults without sufficient training, as well as concerns about social workers functioning outside their scope of practice in this process. Until a meeting could be convened to discuss the new consult process, the GEC SW Supervisor instructed staff members to contact the home health office for assistance in completing the consults to ensure that each was completed correctly. He then requested a meeting to review the process with GEC and SWS. The GEC SW Supervisor and SWS staff members emailed all social workers to provide guidance explaining how to complete the NVCC consult; however, this was sent out after the NVCC process had already been implemented. In addition, the GEC SW Supervisor made attempts to provide training at a SWS staff meeting, but was unsuccessful due to several scheduling conflicts.

On May 20, 2016, the National Director, SW Care Management, distributed a memo to all social workers providing direct patient care, *Medical Documentation Requirements for Beneficiary Travel*, that outlined expectations for Veteran travel benefits and the social workers' role in completing travel consults. The memo noted that "social workers

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[2] VHA Directive 1232 (1), *Consult Processes and Procedures*, August 24, 2016, Amended September 23, 2016, p 2.

cannot [make] clinical determinations for beneficiary travel when the reason for travel is outside their scope of practice (i.e., for medical diagnoses). Social workers can make clinical determinations for travel related to diagnoses that are within their scope of practice (i.e., MH disorders), assuming these are allowable within their license/scope." In a May 23, 2016, email to SWS staff members, the Chief, SWS, was still receiving feedback from several of his employees on their concerns of the impending transition to completing the NVCC home health care consults. He admitted that he had not adequately prepared for a smooth transition and was working with sections to avoid delays in patient care. At the time, he directed them to continue to complete the consults until further notice.

In June 2016, the Chief, SWS, collaborated with Medical Services regarding the transition of the consult process and discussed the training of interns and residents. Medical Services leadership agreed to have social workers assist with the process. However, a July 18 email contained evidence that "providers were resistant to the change in process." Despite this concern, a July 28 memo was sent notifying SWS staff members that the transition would begin the next day.

From July 2016 through March 2017, there were attempts to schedule meetings and conduct training on the consult process with interfacility emails shared between the first line supervisors. SWS and PACT leadership provided guidance to the PC social workers and PACT staff, and the GEC staff provided periodic training. Although social workers received an email with an outline of the portion of the NVCC consult they were to complete, inpatient and GEC social workers, nursing, and medical staff had a limited responsibility for this part of the process, and thus, completion of the consult process varied by team. We also learned that GEC and some PACT social workers continued to independently enter and complete the consults.

Findings

The whistleblowers alleged that on or about March 1, 2017, the Chief, SWS, directed that social workers should no longer enter consults into CPRS and that he failed to establish who would assume this duty or provide training to those assigned employees. The Chief, SWS, confirmed this direction in our interview with him.

We found that he has held this position for the past 2 years and has made several attempts to meet with PACT leadership and specific clinics, in conjunction with the Assistant Chief, SWS, to discuss the consult process. On March 7, 2017, he emailed the Chief, Ambulatory Care, and the ACNE for PC regarding social work support in the PACT, notifying them that he was aware that they were working on refining PC processes as PC leadership, and that he wanted to revisit a previous discussion on the best person to complete skilled-care consults. He reiterated, as did the Assistant Chief, SWS, that these consults require that medical information be included: that is outside the scope of practice of social workers, and thus he wanted the social workers to discontinue this process. He noted that in the past the PACT and SWS leadership had discussed trialing with specific PACTs, and that he was not sure of how or where to

coordinate these efforts. He also referenced an attachment from another VA facility that had a multidisciplinary consult process in place. This documentation did not include plans to transition areas other than the PACTs.

On May 3, 2017, one of the PACT social workers sent a document entitled "NVCC reminders/order examples," to the Assistant Chief, SWS, providing guidance on how the RN was to complete parts of the consult, and on May 10, he emailed the two HBPC Referral Nurses who have the primary role and responsibility of reviewing all completed NVCC consults, detailing how to prioritize and refer such consults to the appropriate agency once the consult has been completed. He outlined the process that should be followed by PACT teamlets to transition the social workers from completing the entire consult, and on May 16, he emailed social work staff members that the GEC staff had provided written guidance on how to complete NVCC consults, and that it had been uploaded and available on VA PULSE for any staff.

On May 17, 2017, SWS leadership notified all social workers of a change in the local consult policy in Medical Center Memorandum (MCM) 122-09.[3] "This policy outlines the consults/orders social workers are authorized to enter under their license. Significant changes include [that] social workers will no longer enter consults/orders under another professional's name/credentials, which include, but are not limited to, NVCC consults. There are some areas that are actively working with their clinics to transition this responsibility to a medical provider (Dialysis, Oncology, and PACT). This policy is signed and effective immediately for all other program areas." Social workers stated that their input had not been solicited regarding this policy and that they were also not told who would be responsible for initiating the process on the inpatient units or who would educate the clinical staff. MCM states that social workers will function within the limits of the Social Work Scope of Practice, entering only consults and/or orders explicitly enumerated within, under the authorization of the Executive Committee of the Medical Staff. Under Section 5C, 12 types of consults are listed, but not the NVCC consult. According to VHA Directive 1232 (1), NVCCs are considered administrative consults and can be completed by LCSWs, but the local social work policy prohibits this practice. At the time of our visit, we consulted with the National Director, SW Care Management, and she responded that the VHA program office had not issued guidance to the field specifying that social workers are no longer allowed to enter home health consults into CPRS.

On May 18, 2017, another memo from the Assistant Chief, SWS, to social workers identified coordination efforts and future steps with PACT Leadership. This memo included a flow chart for social workers to follow, but implementation of these processes was poorly coordinated, resulting in various methods being adopted throughout Indianapolis. In some areas, the PACT team completed different portions of the consult; on some inpatient units where staff reported that the process worked well, the Hospitalist sat side by side with the nurse who used a "cheat sheet" developed by the

[3] Richard L. Roudebush Veterans Affairs Indianapolis, Social Work Memorandum 122-09, *Social Work Service Guidelines To Consults and Orders*, July 2017.

inpatient social workers to complete the consult. GEC social workers continued to complete the consult in its entirety, a violation of their own local consult policy. We noted that these social workers continued to follow the past process of entering and completing the entire consult. During the site visit, SWS leadership sent an email to these GEC staff members, directing them to stop independently completing consults. Many stated that the process seemed to work well when social workers were responsible for initiating and ensuring completion of home health consults.

At the time of our site visit, there were 14 (22 percent) social work vacancies. In the midst of social worker staffing issues, UM leadership offered to pilot a project using the five UM nurses to assist with the consult entry process with inpatient social workers. On Friday, July 14, 2017, the social workers met for approximately 45 minutes with UM nursing leadership to discuss starting this pilot, in which the UM nurse and a social worker would jointly complete the home health consults. Some interviewees stated that the meeting was unproductive, that the nurses and social workers did not go through the flow sheet together, that each discipline's role was not defined, and that the Chief, SWS, left prior to the end of the meeting. Despite this, the new process went into effect the following Monday, July 17. Interviewees also stated that they were provided an inaccurate list of the UM nurses' names and phone numbers and had to wait almost a week before a corrected list was generated. UM nurse leadership shared that at the time of the pilot most of their staff were on limited duty restriction and using the Family Medical Leave Act (FMLA) due to personal illnesses. At that time, when one of these nurses called in sick, UM leadership did not have a backup nurse, and there were many times when more than one nurse used unexpected leave or FMLA. By October 2017, SWS leadership noted that there were numerous complaints regarding UM nurse staffing due to absences and that there were problems with balancing the distinct roles to complete consults. As a result, the pilot was discontinued that November.

Although we found evidence that SWS leadership made increased efforts to provide information about the change in the consult process to many staff members at numerous times, neither SWS nor Indianapolis established a uniform process for social workers and all involved disciplines. SWS leadership reported that the transition occurred over the course of a year as they were being flexible to the medical providers in the various sections who coordinated with the GEC office that was providing the training. The Chief, SWS, stated that he had ongoing discussions about consult issues in staff meetings; however, we found no mention of these discussions in our review of meeting minutes. SWS leadership provided periodic consultative support to some nurses and physicians; however, the rollout process was inconsistent and fragmented. While notification of the change in practice and proposed training was sent by email to various staff at different times, it is clear that system redesign, quality, nursing, medical, GEC, and SWS leadership were not all engaged in a process that would have ensured a smooth, systematic transition to the new practice throughout Indianapolis.

Conclusions for Allegation 1

- We **substantiate** that SWS leadership, including the Chief and Assistant Chief, directed social workers to stop entering home health care consults into CPRS due to concerns about social workers working outside their scope of practice. We found this decision led to a system breakdown, as the transition was not implemented with key services in a collaborative and cohesive manner, allowing time for coordination and education. The system remains fragmented among PACTs and there are still silos at Indianapolis, as evidenced by the last-minute GEC team notification during our site visit.

- SWS leadership made a concerted effort to assist the facility; however, SWS and owners of the process lacked a systematic approach to ensure a smooth transition from social workers completing home health care consults to other offices and disciplines assuming responsibility for these consults.

- We **substantiate** that the Chief, SWS, and owners of the process did not make a concerted effort to train and educate all staff members involved. We found evidence of insufficient and variable training and the absence of a contingency plan, resulting in significant challenges. There was also no quality assurance mechanism in place to verify whether the new practice was working.

- There was a lack of assigned UM nursing staff to support the rollout of the inpatient pilot plan, and no contingency plan to handle staff absences.

- There was inadequate SW and nursing staff to provide appropriate and timely processing of consults; this included numerous social work vacancies, limited UM nurses to assist social workers with completing consults, and only two Referral Nurses to complete the final review and oversee the management of consults.

- We are concerned that there are insufficient resources available to cover the workload including ensuring that the medical residents working on the teaching services are properly trained in the consult process.

Recommendations to Indianapolis

1. Review the current method of processing home health care consults, and restructure the process to allow consults to be easily entered and processed.
    a) Write a consult SOP for use throughout Indianapolis.
    b) Upon completion of the SOP, develop a systematic training plan for key staff, including system redesign, quality, social workers, nursing, and medicine staff, to effectively implement this process throughout Indianapolis.
    c) Create a method to consistently monitor the accuracy, timeliness, and effectiveness of the process.

2. Ensure that all involved staff members are educated and trained in the consult process; verify that this has been completed.

3. Fill SWS vacancies.

4. Develop a contingency plan to provide adequate social work coverage in all Indianapolis programs.
5. Request a consultative site visit from the VHA National Social Work Program Office to assess the provision of SW services throughout the facility.

Recommendation to VISN 10

1. Assess Indianapolis SW vacancy rates and work with the facility to ensure resource availability supports appropriate SW staffing levels.

Allegation 2

The lack of adequate planning, training, and communication has resulted in significant delays and apparent harm to Veterans.

Findings

The OSC letter noted that there has been an increased delay in Veterans receiving home health care due to the recent inconsistency and uncertainty regarding the process of entering consults into CPRS. The whistleblowers provided three examples of Veterans who may have had delays in care or in obtaining a timely consult, though they could only provide the patient identifiers for one of the three. We reviewed the electronic health record (EHR) of this Veteran, "who did not receive immediate wound care after discharge because a consult was not entered and who, as a result, required a below-the-knee amputation."

The Veteran was admitted to Indianapolis from the ED on Patient 1 2017, with a diagnosis of diabetic ketoacidosis (DKA), an ulcerated foot abscess, and sepsis. We reviewed this Veteran's inpatient care in its entirety and noted that these diagnoses were listed on his discharge in addition to confirmation that he did not have evidence of osteomyelitis. During his admission, the Veteran was treated for the diabetic foot abscess and DKA. He was discharged on Wednesday, Patient 1. A social worker entered a home care consult for iodoform packing of the foot wound twice a day and to follow up with the podiatrist in 1 week. His EHR showed that the home care consult was discontinued twice on the day of discharge: the first consult was "incomplete," because it lacked the complete time period for the dressing changes. No reason was given for the cancellation of the second consult. The first consult requested iodoform dressing changes *twice* a day, but subsequent consults, including the second for which no explanation for its cancellation was provided, were for *daily* dressing changes. A third consult placed on Thursday, Patient 1 at 1:58 p.m., was not acted upon until the next day at 11:28 a.m. Although nursing made a follow-up phone call to the patient on Patient 1 there was no documentation of whether the home health aide was coming to change the wound dressing or packing. On Sunday, Patient 1 the patient returned to

the ED for a dressing change since he had been unable to change the dressing by himself for the 3 days post-discharge.

The ED staff members changed his dressing and instructed him to call his PACT provider the next morning. We found no evidence in the EHR that he followed these instructions. Due to little improvement in the appearance of his foot wound and continued poor control of his diabetes, he went to his PACT provider on Patient 1 and was readmitted through the ED with a diagnosis of osteomyelitis. The Referral Nurse responsible for the consult stated that the third completed consult was referred to the outside agency at 11:28 a.m. on Friday, June 16. She stated that the agency had not told her they could not do the dressing over the weekend; had they done so, she would have found another agency that could start right away. Only during our site visit did she become aware that the home care agency had not initiated the requested wound care, and we found no documentation of clinical disclosure regarding the Veteran's care. The worsening infection leading to osteomyelitis and subsequent amputation appears to have been related to the delay of the dressing changes by the home care agency.

We reviewed additional cases where there appeared to have been delays in the timeliness of processing consults, but found no evidence of negative clinical outcomes such as readmission, higher levels of care, or hospitalization. In addition to reviewing the patient EHRs, we also reviewed the Patient Advocate Tracking System related to Veteran complaints, electronic patient incident reports, emails, and numerous other documents to determine whether there had been clinically significant delays or harm to any Veteran. The lack of coordinated care from the inpatient to outpatient setting poses a risk to public health and safety at Indianapolis.

The Referral Nurses reported that they had to frequently send consults back to the provider or PACT because they had not been entered correctly. An incorrect consult is discontinued and a new one must be entered in its place, and this causes a delay ranging from hours to 2 days, depending on the availability of the provider who wrote the order. Delays also occurred because they prioritize the consults according to their importance, i.e., a consult for skilled wound care would supersede a consult for bathing assistance. They also reported that the delay in processing the home care consults preceded the change in the consultation process.

Conclusions for Allegation 2

- We **substantiate** that the lack of adequate planning, training, and communication resulted in a significant delay in at least one Veteran's case with potential harm for others.

- In the above Veteran's case, we could not find evidence that a clinical or institutional disclosure was completed.

- Indianapolis staff members did not follow up with the Veteran to ensure that the consult order for in-home wound care was completed.

- There was a reported delay in processing the home care consults, which preceded the change in the consultation process.

- Two Referral Nurses may not be sufficient to handle all Indianapolis referrals, especially if one nurse is absent. There is currently no contingency plan for Referral Nurse coverage when both nurses are absent.

Recommendations to Indianapolis

6. Ensure that Veterans who are identified as having experienced delays in the consult process receive appropriate care; address as indicated.

7. Conduct an outside peer review on the identified Veteran who was readmitted to Indianapolis; specifically, review the home health consult and the timeliness of the follow up. Conduct a clinical or institutional disclosure if warranted.

8. Take appropriate administrative, educational, or disciplinary action regarding the delay in care for the identified Veteran.

9. Ensure sufficient staffing to enable consults to be processed in a timely manner, specifically addressing the current process of two Referral Nurses managing all Indianapolis NVCC consults.

10. Revisit the practice of simply discontinuing incomplete consults and improve communication to expedite the completion process for Veterans with clinical needs.

11. Develop a monitoring process to track NVCC consults, ensuring that Veterans are not lost during the processing of consults to ensure that they receive timely care.

12. Review the process for nurse post-discharge follow up with Veterans to ensure that calls are repeated and follow-up actions are implemented until the plan for home care is effected, e.g., wound care nurse is assured.

13. Review and revise the discharge documentation as needed to instruct Veterans to contact Indianapolis if a scheduled home health staff member does not come to the Veteran's home or if any element of the discharge plan is unfulfilled

VI. Additional Findings

In the course of our investigation, we discovered issues that warranted a more detailed review. Specifically, we found considerable employee dissatisfaction with the Chief, SWS, including his management of social workers' annual performance evaluations,

and we found a concerning downward trend in SWS's All Employee Survey (AES) scores, an annual VA survey of employee satisfaction.

SWS Management

During the course of the site visit, we received numerous complaints regarding the Chief, SWS. Multiple interviewees both within the SWS and in other departments expressed fears of retaliation, favoritism, and a hostile work environment due to negative interactions they had with him. Many were concerned about a lack of psychological safety and lack of support, and some were in tears when describing incidents in which he had allegedly berated and publicly humiliated them in staff meetings. Others stated that they were afraid to ask questions in these meetings for fear of being cut off or yelled at in front of their peers. SWS has been experiencing a high staff turnover rate and management was cited as one of the reasons for staff leaving in such large numbers.

Performance Evaluations

In addition to the above complaints, staff expressed concerns about the manner in which the Chief, SWS, evaluates their performance and issues ratings. We found one formal union grievance against him on this issue. VHA Handbook 1110.01, 5 c states, "Responsibilities of the Social Work Executive is participation in the development of functional statements and performance standards for social workers that ensure facilities meet or exceed current VHA performance measures." The VHA Social Work Program Office does not mandate that any specific functional statement or standard(s) be used. Its expectation is that social workers will contribute to VHA's overall performance and the performance contracts of VISN and Indianapolis Directors. In contrast, the Chief, SWS, imposed performance standards based upon relative value units (RVU).

We reviewed the Performance Plans of a sample of social work staff, both supervisory and front-line clinical, and found that only clinical staff had metrics included in their Plans. The RVU measure is derived from data pulled by a Decision Support System Informatics staff member for the overall average RVU for social workers at 1A facilities. This RVU performance measure was neither pilot tested nor reviewed and approved by Indianapolis leadership prior to its implementation. For a VA employee to receive a fully successful rating on a performance evaluation, all measures, critical and noncritical, must be rated as fully successful. If productivity on any measure is below fully successful, the overall rating falls below fully successful. Due to the introduction of this performance measure, SWS staff experienced a drop in its overall performance rating, which we confirmed by our review of the performance records of the individual SWS clinical staffers.

Declining AES SWS Survey Results

We reviewed the AES scores and turnover data for SWS and found them disturbing. Fiscal year (FY) 2017 scores appear to be worse than those of the previous year, and FY 2016's would not be considered positive. AES summarizes the SWS results by its four workgroups: Homeless, Inpatient Medicine/Transition and Care Management

(TCM), Veteran House (VH)/GEC, and Outpatient Medicine and Vocational Rehabilitation.

- Overall, workload and staffing experiences have unfavorably declined, and "physical" exhaustion and overall burnout have unfavorably increased; multiple factors appear to have significant negative outliers.
- Inpatient Medicine/TCM and VH/GEC scores have unfavorably declined on most factors, particularly on supervisory relationships, but also on psychological safety and diversity acceptance.
- Vocational Rehabilitation scores have favorably increased on most factors, including supervision and workgroup civility (respect, cooperation, conflict resolution); the Chief, SWS, does not directly supervise this workgroup.

At the completion of our site visit, Indianapolis leadership informed us that they had detailed the Chief, SWS, to another area in the facility, while they evaluated the downward AES scores and the complaints leveled against him by SWS staff.

Conclusions for Additional Findings

- Social workers and staff in SWS and other departments described the Chief, SWS, as lacking in communication skills and expressed fear of retaliation, favoritism, and a hostile work environment.

- AES scores and turnover rate are concerning and reinforce the troubling statements made by interviewees.

- RVUs are currently being used to evaluate social workers on their annual Performance Plans and these metrics were neither pilot tested nor reviewed and approved by Indianapolis leadership. It is unclear whether the use of RVUs for employee evaluation is accurate or based on sound methodology and may be producing results contrary to its intended aims.

Recommendations to Indianapolis

14. Review concerns regarding the Chief, SWS, and address as appropriate.

15. Review the results of the AES survey and develop and implement a corrective action plan to address problem areas if one has not already been developed.

16. Work with HR to review the SWS staff turnover rate and their reasons for leaving at such a high rate; develop a plan to reduce turnover.

17. SWS leadership should review best practices from other VA medical centers on productivity performance measures for both clinical social workers and supervisors and evaluate for possible adaptation; pilot test measures and obtain approval from Indianapolis leadership prior to implementation.

Recommendation to VISN 10

2. Review Indianapolis' SWS productivity metrics and the use of RVUs as an assessment tool for social work performance; ensure the accuracy and validity of these data and their suitability for achieving the aims of SWS.

VII. Summary Statement

OMI developed this report in consultation with other VHA and VA offices to address OSC's concerns that Indianapolis employees may have engaged in conduct that constitutes gross mismanagement and a substantial and specific danger to public health. In particular, VHA HR has examined personnel issues to establish accountability, and the National Center for Ethics in Health Care has provided a health care ethics review. While we found no violations of VA or VHA policy and no gross mismanagement, we did find evidence to substantiate the allegation that a substantial and specific danger to public health exists at Indianapolis based upon the findings from Allegation 2.

Attachment A
Documents in addition to the Electronic Medical Records reviewed.

VA Handbook 5005/50 Part II, Appendix G39, *Social Worker Qualification Standard GS-185 Veterans Health Administration*, February 29, 2012.

VA Community Care, *One Consult Model Fact Sheet*, August 25, 2017.

VA Community Care, *One Consult Standard Operating Procedure*, October 2017.

VHA Directive 1232 (1), *Consult Processes and Procedures*, August 24, 2016, amended September 23, 2016.

VHA Handbook 1110.04, *Case Management Standards of Practice*, May 20, 2013.

VHA Handbook 1110.02, *Social Work Professional Practice*, January 15, 2014.

VHA Handbook 1101.10(1), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014.

Richard L. Roudebush Veterans Affairs Indianapolis, Social Work Memorandum 122-09, *Social Work Service Guidelines To Consults and Orders*, July 2017.

Richard L. Roudebush Veterans Affairs Indianapolis Memorandum Number 11-57, *Consultation/Specialty Care Referral Policy*, May 18, 2017.

Richard L. Roudebush Veterans Affairs Indianapolis Memorandum Number SW-02, *Social Work Scope of Practice,* July 2, 2015.

Richard L. Roudebush Veterans Affairs Indianapolis Medical Staff Bylaws, April 2017.

All Employee Survey results 2016 and 2017.

Emails from numerous interviewees.

HPBC Consult template.

Electronic Patient Incident Reports (ePIRs) on Veterans related to consults 2016 –18.

Functional Chart with names and positions of all social workers.

Richard L. Roudebush Veterans Affairs Indianapolis Organization Chart, October 2016.

Issue Briefs re. Medical Foster Home, 2017.

Indianapolis Trip Pack, October 2017.

Patient Advocate Tracking System patient complaints, 2016 – 2018.

Social Work Competencies, 2016 and 2017.

Social Work Functional Statements on social work interviewees.

Social Work Orientation Checklist, October 2016.

Social Work Productivity Report, 2017.

Social Work Professional Practice Council Minutes, 2017.

Social Work Scope of Practice on 14 social workers.

Social Work Staffing Chart with names and positions of all social workers.

Social Work Staff Meeting minutes, 2016 and 2017.