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The Special Counsel

May 4, 2020

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

Re: OSC File No. DI-18-2282

Dear Mr. President:

I am forwarding to you a report from the U.S. Department of Veterans Affairs based on disclosures of wrongdoing at the Tennessee Valley Healthcare System, Social Work Services (SWS), Murfreesboro, Tennessee. The whistleblower, Licensed Clinical Social Worker [redacted] who consented to the release of her name, disclosed that SWS employees engaged in conduct that may constitute a substantial and specific danger to public health. I have reviewed the agency reports and, in accordance with 5 U.S.C. § 1213(e), provide the following summary of the reports, the whistleblower's comments, and my findings.[1]

[redacted] disclosed that SWS leadership improperly denied eligible patients access to non-skilled, in-home programs by enacting a blanket policy to deny all electronic waitlist (EWL) requests for non-skilled, in-home patients. She alleged that this policy was in direct contradiction to the proper use of EWLs, as it denies patients access to home and community-based service programs regardless of clinical recommendations or medical needs.

The agency substantiated [redacted] allegations. The investigation found that SWS staff failed to adhere to national guidance and that the decision to deny all EWL requests was made without a standard replacement. The report further concluded that there was poor communication within the SWS and insufficient training on the referral and clinical processes.

As a result of the investigation, the agency implemented several corrective measures, including instructing the facility to ensure that all involved staff members are educated and trained in the EWL services. The agency further directed SWS personnel to review consults and the computerized patient record system to determine whether veterans received appropriate and timely services and to develop an action plan to ensure the completion of these corrective actions.

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

In her comments, [redacted] noted that after OMI's site visit to the facility, the EWL was rapidly cleared. She asserted that patients were eliminated from the EWL without proper face-to-face clinical evaluation and reported that patients were not provided proper notice of cessation of their in-care services and counseled on alternative resources.

Given the concerns raised by [redacted] OSC requested a supplemental report. The agency advised that after the site visit, 12 social workers who were trained to perform EWL evaluations contacted patients from the EWL in accordance with Veterans Health Administration Handbook procedures. At that time, there were 73 patients on the EWL, 29 of whom were already approved for services, 23 were contacted by the social workers, 8 were deceased, and 13 were not yet contacted at the time of the investigation but have since been contacted. Additionally, the agency indicated that all patients who express interest in a clinical appeal, or their clinical appeal rights, are notified in a letter that describes the process along with relevant contact information. Currently, all patients are notified of their clinical appeal rights when the VA determines that they do not meet clinical eligibility criteria for receipt of in-home services.

In response to the supplemental report, [redacted] expressed great concern that eight patients had died while on the EWL for in-home services. While the lack of access to these services was not the reason for their deaths, it seems reasonable to assume that having such services would have impacted their quality of life. Although it is disappointing that such a problem ever occurred in the first place, I am gratified that the agency is now making necessary efforts to ensure that patients who qualify for in-home services receive the care that they deserve.

I have reviewed the original disclosure, the agency reports, and the whistleblower's comments. For these reasons, I have determined that the report meets the statutory requirements, and the findings appear reasonable. As required by 5 U.S.C § 1213(e)(3), I have sent copies of this letter and the agency reports to the Chairmen and Ranking Members of the Senate and House Committees on Veterans' Affairs. I have also filed redacted copies of these documents and a redacted copy of the referral letter in our public file, which is available online at www.osc.ogv. This matter is now closed.

Respectfully,

Henry J. Kerner
Special Counsel

Enclosures