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The Special Counsel

April 23, 2020

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

Re: OSC File No. DI-18-4655

Dear Mr. President:

I am forwarding a report from the Department of Veterans Affairs (VA), based on disclosures of wrongdoing at the Coatesville VA Medical Center (Coatesville VAMC), Coatesville, Pennsylvania. The whistleblower, [redacted], a social worker who consented to the release of his name, alleged that facility leadership directed VA social workers to discharge patients from VA Community Living Centers (CLCs) into private nursing facilities in a manner that violates federal law and agency policy.[1] I have reviewed the disclosure, the agency report, and [redacted] comments, and in accordance with 5 U.S.C. §1213(e) provide the following summary of the agency investigation and my findings.

The agency was not able to substantiate this allegation, despite finding that patients were inappropriately discharged and not advised of their right to appeal these decisions.[2] While it appears leadership never explicitly instructed social workers to violate the law, evidence uncovered during the investigation demonstrates significant pressure was placed on social workers and their managers to discharge patients, regardless of whether discharge was clinically appropriate.

The Allegations

[redacted] alleged that [redacted], Associate Director of Patient Care Services, and [redacted], former Geriatrics and Extended Care (GEC) Chief, directed CLC social workers to discharge patients into private nursing facilities in a manner than violates 38 U.S.C. § 1710 and Veterans Health Administration Handbook (VHA) 1142.02. Section 1710 mandates that following placement in a VA nursing home, a veteran who continues to need nursing home care is not to be transferred from the nursing home without the consent of the veteran or their representative. [redacted] asserted that these managers created a list of "Difficult to Discharge" patients in Coatesville VAMC long-term care units for the express purpose of transferring these patients to non-VA assisted living facilities. [redacted] explained that managers instructed social workers to pressure reluctant

[redacted] allegations were referred to Secretary Robert L. Wilkie. The Office of the Medical Inspector (OMI) was tasked with investigating the matter pursuant to 5 U.S.C. §1213(c) and (d), and Secretary Wilkie reviewed and signed the report.

[2]OMI is "not able to substantiate" allegations when the available evidence was insufficient to support conclusions with a reasonable certainty about whether the alleged event or action took place. OMI "substantiates" allegations when the facts and findings support that alleged events or actions took place. They will "not substantiate" allegations when the facts and findings show the allegations were unfounded.

patients and family members to consent to discharge, and that these efforts to discharge patients against their wishes appeared to violate the discharge criteria established by law and VHA policy.

The Agency Report

The investigation confirmed that in December 2017, Coatesville VAMC initiated a "Difficult to Discharge" (DTD) process and established a list of designated patients for this list in the CLC at the direction of [redacted] A DTD committee comprised of senior Coatsville VMAC leadership was established and met regularly on Mondays to "identify solutions to achieve discharges." Shortly after it was established, Social workers were told verbally and via email that the DTD list and the discharge of DTD patients was "a priority." Social workers objected, noting that patients included on the DTD list were still eligible for CLC admission and were not clinically appropriate for discharge. Accordingly, when investigators reviewed the DTD list, they found patients who were eligible under the law and agency policy to stay in the CLC, and patients who had inpatient skilled nursing care needs which rendered them inappropriate for discharge.

The CLC supervisor informed investigators that [redacted] directed her to discharge patients from the CLC to facilities other than their first choice if there were waiting lists. [redacted] also added a performance metric to the Chief of Social Work's FY2018 performance plan related to the DTD list. Specifically, [redacted] included the requirement that the Chief of Social Work aim to discharge 75 percent of patients on the DTD list. Notably, no other staff, including [redacted] and [redacted] had the same or similar performance metric.

During interviews, numerous social workers expressed concerns that due to leadership directions, patients had been discharged from the CLC inappropriately. Additionally, social workers indicated that they "did not feel the environment was safe to express their concerns." They provided investigators with six patients whom they believed Coatsville VAMC was attempting to discharge inappropriately or had been discharged inappropriately.

A review of these records indicated that of six cases, three were handled inappropriately. In one case, a patient was told he needed to pick a medical foster home for discharge, over his objections and in violation of three different VHA policies. Less than 30 days after discharge, his new caregivers contacted the VA requesting that he be readmitted to the CLC due to significant personal care and behavioral issues. Despite the CLC supervisor's request, this individual was not readmitted to the VA until he was treated for complications related to a serious medical condition.

In a second case, it appears that notwithstanding clinical notes indicating a patient's significant need for nursing care, [redacted] solicited the reassessment of the patient by a therapist from a different unit, in what appeared to be an attempt to reevaluate the patient for the purpose of facilitating his discharge. When this reassessment confirmed the original determination, [redacted] then instructed that the patient be re-evaluated by the local county's Office of Aging. The patient would not consent to this exam. Eventually, the patient was evaluated by a non-VA orthopedic surgeon, who reaffirmed the original clinical determination, and the patient was removed from consideration for the DTD list.

Beyond these troubling scenarios, official discharge documentation issued to patients by the Coatsville VAMC Chief of Staff did not describe the rationale and process used to reach these decisions. Further, in violation of VHA policy, these letters did not provide any information to patients or their representatives regarding their appeal rights, or a description of the process involved in appealing clinical decisions. Investigators found no other evidence that Coatsville VAMC offered information concerning the appeal process to patients or their families.

The report made six recommendations, focused on training on legal and policy requirements associated with patient discharge. Coatsville VAMC is also in the process of implementing over 20 recommendations made by VA's GEC Program Office which visited the facility in late 2018. Additionally, efforts have been made to improve relationships within CLCs between management and staff. Local policies were also revised to delineate clinical decision-making authorities within the CLC context to ensure this process is transparent and well documented.

The Whistleblower's Comments

[redacted] disagreed with the conclusions in the report. He felt that the report's conclusions were at odds with its findings, noting that it was well established that [redacted] had a primary role in directing social work staff to discharge patients. [redacted] noted that management made demands to nursing home staff to "pressure and coerce veterans and their families into discharge without their consent." He asserted that staff were "directed, bullied, and coerced" by [redacted] to discharge veterans with continued nursing care needs. However, [redacted] noted that since the referral of this matter for investigation, there has been process improvement and discharges are now being handled more appropriately.

The Special Counsel's Analysis and Findings

In concluding that it was not able to substantiate the allegations, the VA failed to acknowledge the information revealed by the investigation that demonstrates patients and social workers were pressured to make discharge decisions that violated agency policy and were not in the interests of the patients. [redacted] claimed that their overall goal was to achieve proper levels of care and quality of life for veterans. However, it appears that their principal concern was discharging challenging patients through a sustained campaign of pressure on their employees. These efforts were exemplified by [redacted] repeated solicitations of new evaluations in a determined effort to override their employees' judgment that a patient was not ready for discharge. Notably, when a different VA therapist would not clear the patient for release, [redacted] requested patient evaluation by non-VA local officials, and eventually by a non-VA orthopedic surgeon.

With respect to pressure exerted on individual employees, I note that the DTD list was created with the imprimatur of Coatsville VAMC's Chief of Staff and other senior officials. As repeatedly noted in the report, many of these patients did not even meet clinical discharge criteria, which should have raised immediate alarm with senior clinical staff involved. CLC social workers were told by leadership to make this list a priority. When social workers registered concerns in meetings with leadership, they were prompted to leave, and subsequently excluded from subsequent

meetings. [redacted] directed the discharge of patients to facilities that were not their first choice if a waiting list existed, in what seems to be an attempt to get patients out of the CLC without regard for their needs and preferences. Finally, in an egregious violation of due process rights, when patients were discharged, they were not advised of their appeal rights afforded under agency policy. Similarly, these discharge documents, which were signed by the Coatsville VAMC Chief of Staff, did not include any details on why the patient was being discharged, or any clinical rationale for this determination.

I take significant issue with the behavior of [redacted], and while the report meets the statutory requirements, the agency findings do not appear reasonable. [redacted]. [redacted] may not have explicitly instructed social workers to discharge patients in violation of the law and VA policy, but they engaged in a sustained campaign to pressure these employees to take actions that violated both. Coatsville VAMC leadership, in particular the Chief of Staff, appear as willing participants, and I urge the VA to revisit an examination of accountability actions for all members of senior leadership who endorsed and facilitated these efforts. The behavior of management described was an appalling disservice to the vulnerable veteran population they are charged with helping. That said, I am encouraged by the corrective actions as set forth by the investigation and [redacted] statements that discharges are now handled more appropriately.

I strongly commend [redacted], his fellow CLC social workers, and their managers who resisted this inappropriate behavior. As required by 5 U.S.C. § 1213(e) (3), I have sent a copy of this letter and the agency report 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 the redacted referral letter in our public file, which is available at www.osc.gov. This matter is now closed.

Respectfully,

Henry J. Kerner
Special Counsel

Enclosures