THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

July 16, 2019

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-18-4655

Dear Mr. Kerner:

I am responding to your August 7, 2018, letter regarding allegations made by an anonymous whistleblower, who alleged that employees at the Coatesville Department of Veterans Affairs (VA) Medical Center in Coatesville, Pennsylvania, engaged in conduct that may constitute a violation of law, rule, or regulation; and a substantial and specific danger to public health.

The Executive in Charge, Office of the Under Secretary for Health, directed the Office of the Medical Inspector to assemble and lead a VA team to conduct an investigation. We investigated this matter from October 2–4, 2018, and were not able to substantiate that the Associate Director, Patient Care Services and the Director, Geriatrics Extended Care, had directed social workers to discharge patients into private nursing facilities in a manner that could violate 38 United States Code § 1710A, and Veterans Health Administration Handbook 1142.02. *Admission Criteria, Service Codes, and Discharge Criteria for Department of Veterans Affairs Community Living Centers,* September 2, 2012. We make six recommendations to Coatesville.

Thank you for the opportunity to respond.

Sincerely,

Robert L. Wilkie

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
Washington, DC

Report to the
Office of Special Counsel (OSC)
OSC File Number DI-18-4655

Department of Veterans Affairs (VA)
Coatesville VA Medical Center
Coatesville, Pennsylvania

Report Date: June 10, 2019

TRIM 2018-C-48

Executive Summary

The Office of the Secretary, Department of Veterans Affairs (VA), received a referral from the Office of Special Counsel (OSC) on August 7, 2018, for a formal resolution. Subsequently, the Executive in Charge, Veterans Health Administration (VHA), directed that the Office of the Medical Inspector (OMI) assemble and lead a VA team to investigate allegations reported to OSC concerning the Coatesville VA Medical Center, located in Coatesville, Pennsylvania. The whistleblower, a social worker, who chose to remain anonymous, alleged that employees are engaging in conduct that may constitute a violation of law, rule, or regulation; and a substantial and specific danger to public health. We conducted a site visit to Coatesville on October 2–4, 2018.

Specific Allegation of the Whistleblower

[redacted] *and* [redacted] *directed social workers to discharge patients into private nursing facilities in a manner that may violate 38 U.S.C. §1710A, and Veterans Health Administration Handbook 1142.02.*

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 insufficient to support conclusions with reasonable certainty about whether the alleged event or action took place.

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

Conclusions for the Allegation

- Coatesville discharged Resident A to a personal care home, but this patient did not meet the discharge criteria of VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers,* August 13, 2008, and VHA Handbook 1142.02, *Admission Criteria, Service Codes, and Discharge Criteria for Department of Veterans Affairs Community Living Centers,* September 2, 2012, and VHA Directive 1140.11, *Uniform Geriatrics and Extended Care Services in VA Medical Centers and Clinics,* October 11, 2016. However, we are **not able to substantiate** that the [redacted] directed social workers to do this.

- Community Living Centers (CLC) clinical staff appear not to understand when the consent-to-transfer requirement in 38 United States Code (U.S.C.) Section 1710A(b)(1) applies. Some are also not adequately familiar with the clinical admission or discharge criteria set forth in VHA's CLC policies.

- Coatesville did not inform the six CLC residents who were the subjects of our record review of their right to appeal clinical decisions, including discharge decisions.

- The interactions between Nursing Service and Social Work Service regarding the appropriate disposition of patients are contentious.

Recommendations to Coatesville

1. Educate all CLC clinical staff, including the ADPCS and GEC Director, on the consent-to-transfer requirement in 38 U.S.C. 1710A(b)(1) and when it applies.

2. Educate all clinical staff on CLC admission and discharge criteria set forth in VHA Handbooks 1142.01 and 1142.02, and VHA Directive 1140.11, to ensure appropriate admissions and discharges. Monitor compliance.

3. Implement any recommendations made by VHA's GEC Program Office, which completed a site visit on December 11, 2018, recommended by the VA team issuing this report.

4. Collaborate with the National Center for Organizational Development to complete an assessment of the Coatesville and CLC leadership team to assist the staff in building a collegial team.

5. Clearly delineate the responsibility for the clinical decision to discharge patients from the CLC and ensure the process is transparent and well-documented with proper record retention.

6. Follow the clinical appeals processes described in local policy number PCS 156-17, *Appeal of Clinical Decisions,* and the Note in 1142.02, paragraph 13 c., to include training for staff, any applicable Veterans, and their families/representatives.

Summary Statement

We have developed this report in consultation with other VHA and VA offices to address OSC's concerns that Coatesville may have engaged in conduct that constitutes a violation of law, rule or regulation, or a substantial and specific danger to public health. In particular, VA's Office of Accountability and Whistleblower Protection has examined personnel issues to establish accountability, and the National Center for Ethics in Health Care has provided a health care ethics review. We found violations of VHA policy at Coatesville, but none resulting in a substantial or specific danger to public health.

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I. Introduction

The Office of the Secretary, Department of Veterans Affairs (VA), received a referral from the Office of Special Counsel (OSC) on August 7, 2018, for a formal resolution. Subsequently, the Executive in Charge, Veterans Health Administration (VHA), directed that the Office of the Medical Inspector (OMI) assemble and lead a VA team to investigate allegations reported to OSC concerning the Coatesville VA Medical Center, located in Coatesville, Pennsylvania. The whistleblower, a social worker, who chose to remain anonymous, alleged that employees are engaging in conduct that may constitute a violation of law, rule, or regulation; and a substantial and specific danger to public health. We conducted a site visit to Coatesville on October 2–4, 2018.

II. Facility Profile

Coatesville is a Joint Commission-accredited, complexity level-3 facility serving Veterans from southeastern Pennsylvania and Delaware.[1] It is located in Coatesville, Pennsylvania, with outpatient clinics in Newtown Square and Spring City. The medical center and its outpatient clinics comprise an integrated health care system dedicated to providing Veterans with care that improves their health and well-being. It offers urgent, primary, specialty, mental health, long-term care, pharmacy, and numerous supportive services to outpatients, inpatients, and residential patients. The 42-building facility is located on 128 acres. In Fiscal Year (FY) 2018, the medical center served 19,605 Veterans.

III. Specific Allegation of the Whistleblower

[redacted] *and* [redacted] *directed social workers to discharge patients into private nursing facilities in a manner that may violate 38 U.S.C. § 1710A, and Veterans Health Administration Handbook 1142.02.*

IV. Conduct of Investigation

The VA team conducting the investigation consisted of the Medical Inspector and a Clinical Program Manager, both from OMI; the National Director, Community Living Centers (CLC), Geriatrics and Extended Care (GEC); and a Human Resources (HR) Specialist/Investigator, Office of Accountability and Whistleblower Protection (OAWP). We reviewed relevant policies, procedures, professional standards, reports, memorandums, and other documents listed in Attachment A. We toured Coatesville's CLC and held entrance and exit briefings with leadership.

[1] Complexity level 3 facilities have low-volume, low-risk patients, few or no complex clinical programs, and small or no research and teaching programs.

VA initially interviewed the whistleblower via teleconference on September 10, 2018, and in person on October 3, 2018.

We also interviewed the following staff:

- Medical Center Director
- Associate Director Patient Care Services (ADPCS)
- Assistant Chief of Staff (ACoS), GEC
- Chief, Social Work Service (Chief of SW)
- Registered Nurse (RN), Director, GEC (GEC Director)
- Nurse Manager (NM), Unit 138B
- Assistant NM, Unit 138A
- CLC Staff Nurse
- CLC Certified Nursing Assistant
- Social Work Supervisor CLC (CLC Supervisor)
- Social Work Supervisor Mental Health
- Three CLC social workers
- Occupational Therapist
- Psychologist, American Federation of Government Employees (AFGE) Union President

V. Findings, Conclusions, and Recommendations

Allegation

[redacted] *and* [redacted] *directed social workers to discharge patients into private nursing facilities in a manner that may violate 38 U.S.C. § 1710A, and Veterans Health Administration Handbook 1142.02.*

Background

Section 1710A of Title 38, United States Code (U.S.C.) requires VA to provide nursing home care to any Veteran in need of such care for a service-connected disability, and to any Veteran who is in need of such care and who has a service-connected disability rated at 70 percent or more. Furthermore, 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 in the event, the Veteran cannot provide informed consent, the representative of the Veteran.[2]

VHA Directive 1140.11, *Uniform Geriatrics and Extended Care Services in VA Medical Centers and Clinics,* October 11, 2016, defines minimum clinical requirements for VHA GEC services. This Directive provides a rationale and description for the national

[2] http://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title38-section1710A&num=0&edition=prelim accessed 8-27-18.

implementation of each GEC program component, ensuring that VA medical facilities' GEC programs are suitably organized, staffed, and integrated with other services.

It notes that the Secretary must provide nursing home care for which he determines is needed (1) to any Veteran in need of such care for a service-connected disability, and (2) to any Veteran who is in need of such care and who has a service-connected disability rated at 70 percent or more (this includes Veterans who have a service-connected rating of total disability based on individual unemployability). The Directive lists the various GEC programs, along with their respective copayment amounts.

Institutional Extended Care (historically referred to as nursing home care) is also described in VHA Directive 1140.11. This type of care is supported by VA in three venues: VA-owned and operated CLCs, state-owned and operated State Veterans Homes, and care purchased by VA in community nursing homes. Nursing home services are provided for Veterans whose health care needs are so extensive that they cannot be met in Veterans' homes or in outpatient clinics, but rather require the continuous skilled nursing and personal care provided in an institutional setting. A Veteran's access to VA CLC care depends on whether they meet the eligibility criteria described in Section 1710A, the CLC's ability to provide the particular services required by the Veteran, and bed availability. VA CLC care is generally directed toward Veterans who need only short-stay services, but longer-stay services are also provided.[3] These terms are defined further below.

VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers,* August 13, 2008, provides guidance to the field for transforming the culture of VHA nursing home care and provides direction for the official change of title from Nursing Home or Nursing Home Care Unit to CLCs. The Handbook describes how the delivery of nursing home care has changed from a medical model (where the care is driven by the medical diagnosis) to a resident-centered model where the care is driven not only by the clinical needs of the individual but also by their needs as taken from a "whole person" and a "whole health" perspective. The VA CLC is a component of the spectrum of long-term care that provides a skilled nursing environment and houses specialty programs for persons needing short- and long- stay services.

The two main admission types to the CLC include:

- Short-stay: Services are those where, on admission, the Veteran's expected length of stay in the CLC is 90 days or less; and
- Long-stay: Services are those where, on admission, the Veteran's expected length of stay is greater than 90 days.

VHA Handbook 1142.02, *Admission Criteria, Service Codes, and Discharge Criteria for Department of Veterans Affairs Community Living Centers,* September 2, 2012, defines

[3] VHA Directive 1140.11, *Uniform Geriatrics and Extended Care Services in VA Medical Centers and Clinics,* October 11, 2016.

the services CLCs provide and describes the procedures for the admission and discharge process. It notes:

a. *The Veteran may be discharged from the CLC when:*
   - *The Veteran has met the treatment goals and no longer needs institutional care.*
   - *The facility can no longer accommodate the Veteran due to changes in service needs.*
   - *The Veteran shows flagrant disregard for the policies of the medical facility after being appropriately advised of such policies. If the Veteran has continuing medical needs, the facility must transfer the Veteran for appropriate alternative care.*

b. *Consistent with the requirements of Section 1710A, Veterans who meet the criteria for long-stay may not, after placement in a VA CLC, be transferred to another CLC, unless the Veteran (or the Veteran's representative), agrees to such a transfer.*

c. *Long-stay Veterans may be discharged if the Veteran no longer requires CLC or nursing home level of care. For example, a Veteran no longer requires CLC care when admission goals are met, and the condition has improved to the extent that continued services can be provided in a less restrictive, noninstitutional setting.*

Transfer refers to the movement of a resident from a bed within one certified facility to a bed in another certified facility when the resident expects to return to the original facility. Discharge refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility or other location in the community, when return to the original facility is not expected.[4]

Discharge planning begins at the time of admission, which includes ensuring all CLC admissions have documentation of an anticipated discharge date and anticipated discharge destination. This is an important factor as the expected length of stay determines short-term treatment goals and facilitates discharge planning. Planning includes setting realistic short-term goals to ensure achievement of those goals in preparation for discharge. Planning also includes setting long-term goals that describe the anticipated functional ability and state of the Veteran upon discharge. The discharge disposition will determine if staff need to begin early discharge planning and prepare the Veteran for home and community-based follow up and services.

On each CLC unit, an interdisciplinary team of professionals assesses, plans, implements, and evaluates a plan of care that is individualized and outcome-oriented. Team members include the medical provider, nurse, dietician, social worker, and therapeutic recreation member. Other staff (and disciplines) who know the resident well and who may be involved in the Veteran's care need to attend, as appropriate, including nursing assistants, environmental services, pharmacists, etc. The care plan is the road

[4] Centers for Medicare and Medicaid Services, Long Term Care State Operations Manual, 483.15(c)(8).

map for the entire team to communicate an individualized, interdisciplinary plan to meet the physical, spiritual, and psychosocial needs of the resident. Care plan goals are resident-centered and reflect the resident's preferences, needs, and habits. Active resident or surrogate involvement, and the involvement of family and friends, if the resident desires, in the team decision-making process, is central to creating a team that meets the purposes of care and treatment planning.[5]

VHA Directive 1041, *Appeal of VHA Clinical Decisions,* October 24, 2016, communicates the policy and responsibilities for handling clinical disputes. A clinical dispute is an impasse that occurs between a patient, or the patient's representative, and a VHA medical facility over the provision or denial of clinical care that potentially could result in a different and/or improved clinical outcome for the Veteran. The Directive requires the facility to have a local clinical appeals process based on this policy that establishes the procedure for handling internal appeals of clinical decisions. An attempt should be made at the patient's clinical team level to resolve clinical disputes and, if unable to be resolved, should be elevated to the medical center's Chief of Staff (CoS) who will review and attempt to resolve the dispute, and make a determination on the issue. The patient or patient's representative can appeal medical center leadership's decision to the Veterans Integrated Service Network (VISN). The VISN Director either independently reviews the documentation regarding the clinical dispute or convenes an impartial VISN clinical panel to review the documentation and make a recommendation. An independent external review may be requested to inform the VISN Director's deliberations before rendering a final decision.[6]

Findings

As a preliminary matter, we note that the whistleblower alleges CLC staff violated 1710A(b)(1) by pressuring or coercing the discharges of Veterans from the CLC without their consent. However, this legal provision applies to the transfer from a VA CLC of certain service-connected residents who continue to need nursing home care, indicating how this can be accomplished, which is to say, only with the informed consent of the resident or the resident's representative. CLC clinical staff appear not to understand when the consent-to-transfer requirement in 1710A(b)(1) applies.

In December 2017, Coatesville initiated a "difficult to discharge" (DTD) process for residents in the CLC at the direction of the ADPCS. The DTD process is separate from the Interdisciplinary Team (IDT) Conference held weekly on each CLC unit. The ADPCS led the initial DTD committee meeting, where she expressed concern regarding the number of residents who were not qualified to stay in the CLC and the need for them to be discharged. She also discussed the lack of availability of open beds for admissions. We reviewed email correspondence between CLC social workers and the CLC Supervisor regarding the new DTD process. The correspondence described the initiation of the DTD process at the request of the ADPCS, the types of residents to be included on the DTD list, and the fact that this process had become a priority.

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[5] VHA Handbook 1142.02, *Admission Criteria, Service Codes, and Discharge Criteria for Department of Veterans Affairs Community Living Centers*, September 2, 2012.
[6] VHA Directive 1041, *Appeal of VHA Clinical Decisions*, October 24, 2016.

Residents on the DTD list were supposed to include Veterans who are not eligible to stay in the CLC, Veterans under hospice treatment not eligible for CLC long-term placement, any "dischargeable" Veterans who did not have nursing needs, and any Veteran described as difficult to discharge. However, when we reviewed the DTD list, we found Veterans who were both eligible to stay in the CLC and still had inpatient skilled nursing care needs.

A DTD committee meeting was held on Mondays to review the status of residents identified as DTD. Attendees of the DTD committee meeting originally included the CoS, ADPCS, ACoS GEC, GEC Director, Director of Home-Based Primary Care, social work leadership, CLC unit NMs, CLC staff physician, physician assistants, and CLC social workers. The group reviewed the DTD residents, discussed obstacles to discharge, and identified solutions to achieve discharges. In the summer of 2018, the social workers felt the DTD committee meeting was not a collaborative environment and reached out to their local union. After they expressed their concerns to the President of the AFGE, an AFGE representative attended one DTD meeting and noted that there were many levels of management present at the meeting, and that it appeared to be an unequal representation. Briefly into the meeting, the ADPCS stated that the meeting was clinical in nature and asked AFGE to leave. She also invited the social workers to leave if they did not feel comfortable staying. The social workers left the meeting following AFGE's departure. Moving forward, social work leadership determined that the social workers no longer needed to attend the DTD meeting; rather, only the CLC Supervisor would attend and forward follow-up questions to the social workers. In response to the ADPCS' request for weekly updates on the status of the residents who were DTD, the CLC Supervisor created a DTD list that she uses to collect information from her staff to share with leadership at the weekly meetings. She instructed her staff to complete a spreadsheet by including the names of residents who did not have inpatient skilled nursing home care needs and required additional attention to arrange discharge. The social workers were to complete and/or update the spreadsheet, or DTD list, and return it to the CLC Supervisor weekly by Friday in preparation for the Monday meetings. The Supervisor also instructed them to complete at least one progress note per week for any Veteran who was on the DTD list to document their efforts toward discharge planning. The social workers raised concerns with the CLC Supervisor when her DTD list included the names of Veterans who still met CLC admission criteria and for whom discharge would be inappropriate.

We reviewed email correspondence between the GEC Director and the CLC Supervisor, which discussed social workers' concerns regarding inappropriate discharges, IDT differences of opinions regarding continued need for nursing home care, and CareTracker charting inaccuracies.[7] The [redacted] confirmed those concerns during our interview, while also acknowledging her difficulty in collaborating with the [redacted] She noted that the [redacted] would often defend nursing staff regardless of what the IDT care plan noted. She gave us an example in which she told the [redacted] that a Veteran would be discharged even though he/she still

[7] CareTracker is a software system used to collect CLC resident data and monitor resident condition. http://southpointqsm.com/pdfs/CareTracker-Brochure.pdf, accessed March 2019.

required a nursing home level of care. She was met with continued resistance, told that the CareTracker documentation could not be trusted, and that social workers should rely on the verbal report from nurses and not on the CareTracker written documentation. The CLC Supervisor also told us that in her interaction with the [redacted] she was directed to discharge Veterans from the CLC and, in some cases, to facilities other than the Veteran's first choice, if there was a waiting list at the first location. The [redacted] described the social work group as "a very paternalistic group that feels everybody should stay here because if they get discharged to the community they won't do well." She further explained that she believes the social workers' paternalistic attitude is the source of friction and disagreements about who needs a nursing home level of care and who does not, and that she "goes by what my nurse managers tell me related to what they see regarding the Veteran needs." While both the Chief of SW and the GEC Director report to the ADPCS, this line of thinking [redacted] could make social workers feel as if they are not supported or their input is invalid.

In interviews, the ADPCS and the GEC Director shared that their efforts in the CLC focused on looking at processes to determine what the CLC can do to promote Veterans functioning at their highest level, and when they reach that level, determining their most appropriate level of care. The GEC Director noted that, previously, the CLC had not thoroughly looked at whether the Veteran still required a nursing home level of care, if the Veteran qualified for care, or if appropriate care and discharge planning had occurred. As a result of these concerns, the ADPCS and the GEC Director initiated performance improvement efforts to develop more comprehensive discharge plans, setting discharge goals, and IDT reviews to make sure Veterans were meeting their goals. They told us the overall goal was to successfully attain the proper level of care and the quality of life that Veterans deserved.

The ADPCS, who supervises the Chief of SW, added a performance metric to her FY 2018 performance plan. The metric called for her to manage the DTD patients with a target of discharging 75 percent of patients on the DTD list in all areas. We found no other staff with the same or similar performance metric, including the MCD, ADPCS, or GEC Director.

We reviewed Strategic Analytics for Improvement and Learning (SAIL) CLC data for Coatesville. In FY 2017, 4th quarter (Q4), the Quality Domain of the report grades the CLC as one-star, scoring in the lowest group of CLCs across VHA nationally. Outlying metrics in the 5th quintile, or bottom 20 percent nationally in all VHA CLCs include the following: Long Stay Receipt, Short Stay Newly Received Antipsychotic Medications, Long Stay Help with Activities of Daily Living (ADL), and Long Stay Falls with Major Injury. The CLC again scored one-star in overall Quality in FY 2018 Q4 with outlying metrics in the 5th quintile including: Long Stay Receipt and Short Stay Newly Received Antipsychotic Medications, Long Stay Help with ADLs, Long Stay Falls with Major Injury, Long Stay Ability to Move Independently Worsened, and Short Stay Improvement in Function. The SAIL metrics illustrate that residents have an increased need for nursing care and assistance. This need existed in FY 2017 Q4 and increased with two additional metrics in FY 2018 Q4.

Coatesville VA Medical Center policy number PCS 127-16, *Release from Inpatient Care,* October 2016, establishes policy on granting releases from inpatient care, nursing home, and domiciliary care.[8] It states:

> *The release of an inpatient depends primarily on two basic medical decisions: The patient does not require continued services which are available only to an inpatient. All indicated outpatient medical needs, nursing, or home care are suitably arranged in advance by the Interdisciplinary Team.*

During interviews, numerous CLC social workers expressed concerns that patients had been discharged from the CLC inappropriately. They told the team that when leadership directed social workers to discharge residents for whom discharge was clinically inappropriate, social workers did not feel the environment was safe to express their concerns.

They gave us the names of six patients whom they believed Coatesville was attempting to discharge inappropriately or who had already been discharged inappropriately in violation of CLC policy. In their view, these patients had at the time of the attempted or completed discharge qualified for continued stay according to VHA Handbook 1142.02. We completed a case review of these six cases, composed of former and current residents of the Coatesville CLC, to determine if they had been handled appropriately.

Our review showed that three cases were handled appropriately. Of the remaining three cases, one was an inappropriate discharge to a personal care home in the community, but the patient subsequently returned to the Coatesville facility for urgent care and was subsequently readmitted to the Coatesville CLC where the patient remains to date. The other two cases involved inappropriate attempts to discharge patients who did not meet the discharge criteria in VHA Handbook 1142.02 but, in fact, those patients were never discharged, and to date, they remain residents in the CLC.

For example, Resident A, is 100 percent service-connected for psychosis and paranoid schizophrenia. His interdisciplinary care plan, dated [redacted] 2018, says he needs assistance with dressing and cueing for ADLs; assistance with bathing because he is unable to reach all areas of his body; assistance with toileting, as he will urinate in inappropriate places or dump his urinal in inappropriate places. The note also says that Coatesville made a referral to a Medical Foster Home (MFH), but resident A was not interested. He was subsequently offered two to three choices for discharge, and told that he needed to pick one.[9] Coatesville discharged Veteran A on [redacted] 2018, to a Personal Care Home (PCH) and, on [redacted] 2018, the PCH placed an urgent message to Coatesville requesting that the Veteran be readmitted to Coatesville because he is "failing at the personal care level, not performing daily hygiene, has been incontinent of urine and needing supervision and cueing to get bathed and dressed, dangerously opening emergency exit doors to smoke while at other times smoking in the building."

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[8] Coatesville VA Medical Center policy number PCS 127-16, *Release from Inpatient Care*, October 2016.

[9] MFH is a private home in which an MFH caregiver provides care to a Veteran resident, and the MFH caregiver lives in the MFH. Honors a Veteran's preference to reside and obtain primary health care in a home residence as an alternative to facility-based institutional long-term care. VHA Directive 1141.02(1) *Medical Foster Home Program Procedures*, August 9, 2017.

On [redacted] 2018, the CLC Supervisor noted she discussed the case with "CVAMC team" [Coatesville VA Medical Center]. Coatesville did not readmit the patient at this point; instead, the CLC Supervisor advised the PCH to contact the Community Referral Center/Community Nursing Home Coordinator. On [redacted] 2018, after he was seen in urgent care for Chronic Obstructive Pulmonary Disease exacerbation, the Veteran was readmitted to Coatesville CLC for long-term stay where he remains today.

Resident B is a 67-year-old Veteran, 100 percent service-connected, who was admitted to the CLC on [redacted] 2018, for psychosis and undifferentiated schizophrenia. On [redacted] 2018, he was evaluated by Occupational Therapy (OT), which concluded "skilled OT not likely to improve ADL or mobility status secondary to poor command following, exclusively internal motivation for behavior, and poor capacity for new learning." The DTD list shows for [redacted] 2018 that resident B "remains in nursing home level of care." We reviewed emails for the same month indicating that a CLC social worker refused the recommendation of a CLC Assistant Unit Manager to refer this resident to an MFH because that social worker felt that such a referral was unlawful and would violate Section 1710A. However, in [redacted] 2018, when another social worker assumed responsibility for this resident, this individual entered the MFH referral. There are multiple social work notes, starting in [redacted] 2018, documenting that the resident's family was told he no longer qualified for a nursing home level of care and was more appropriate for PCH or MFH. However, other notes, including the IDT Care Plan, contradict these notes and conclude that the resident continues to have skilled nursing needs. The resident and family refused discharge, and the resident remains on the CLC. The CLC Assistant Unit Manager told us that when a disagreement about a Veteran's treatment plan arises, she presents the issue to the GEC Director for guidance on what to relay to the team.

Resident C is a 78-year-old Veteran, 90 percent service-connected for multiple medical problems related to a septic hip and diabetic wound. He had several unsuccessful hip surgeries with multiple infections that resulted in the removal of the joint and the placement of a spacer. There are social work notes regarding appropriate level of care for this Veteran, documenting that he no longer needed a nursing home level of care. A social worker documented in this resident's electronic health record that they were "informed by management that treatment team should be moving Veteran towards discharge planning." Another social work note states, "Informed him that writer was informed that administration is requesting he be evaluated by the county to determine level of care." However, the IDT care plan note stated that he still required a nursing home level of care. We were told that, despite the IDT Care Plan notes and the original OT assessment, the ADPCS and the GEC Director had requested the Veteran be reassessed by a therapist from a different CLC unit. The therapist documented agreement with the initial assessments, noting that the Veteran required more care than available at a lower level of care. Upon notification of the results of the additional assessment, the ADPCS and the GEC Director instructed that the Veteran should be referred to the county Office of Aging for a level of care assessment. The Veteran declined the exam and, as a result, it was not performed. Ultimately, the Veteran was seen by a non-VA orthopedic surgeon who stated that the Veteran "should be using a Hoyer lift for all transfers and he should not be standing due to over compensation of

the opposite ankle for support." Following this appointment, the CLC Supervisor removed the resident from the DTD list, and he remains in the CLC.

Coatesville VA Medical Center policy number PCS 156-17 designates responsibilities for handling clinical disputes and ensures that patients and their representatives have access to a fair and impartial review of the disputes regarding clinical decisions. It notes that the first attempts to resolve clinical disputes will be at the patient's team level and, if not resolved, should be elevated to the CoS, or designee; this individual will review, attempt to resolve, and make a determination on the dispute. The [redacted] provides written notification to the patient or the patient's representative of the medical facility's final determination. This notification will describe the process and rationale that was used to reach a decision, as well as information on how the patient or patient's representative can appeal the medical facility decision to the VISN. It ensures that the patient or representative understands that they always have the right to accept or reject any solution offered. If the medical facility is not successful at reaching a resolution, the patient or patient's representative can appeal to the VISN. The VISN has 30 days to complete the review unless an external review is requested. The Patient Experience Advocate enters clinical dispute appeals (both for the medical facility and the VISN) into the Patient Advocate Tracking System (PATS). All details and decisions must be included in the final documentation before the case is closed.[10]

The Note to paragraph 13.c in 1142.02 states: "Veterans that wish to question a discharge decision should be referred to the local channels for dispute resolution." Both the CLC policy and the Clinical Appeals policy requires residents to be informed of their clinical appeal rights and this includes discharge decisions. We reviewed the [redacted] letters to the CLC Veterans regarding their discharges. This written notification does state that the final determination is discharge, but it does not describe the process and rationale used to reach this decision. It also does not provide any information to the Veteran or representative of their clinical appeals rights or how to appeal the Coatesville clinical decision. We reviewed email correspondence between the [redacted] in which the [redacted] noted his concerns about a CLC social worker telling a Veteran and his family that his discharge was being initiated by administrative leadership. The [redacted] said he would no longer sign letters or participate in the DTD process until staffing issues are addressed. He also said that he shredded the two letters that he had signed earlier that day. Upon review of this email correspondence, it does not appear that the intent of the written notification regarding the need for discharge was to address the clinical appeals process. The facility's [redacted] was unable to produce evidence that clinical dispute appeals were entered into the PATS system for the six cases we reviewed. Interviews with staff who participated on the DTD committee do not reference the clinical appeals process. We found no evidence that Coatesville followed its clinical appeals policy as there is no evidence it offered the appeals process to the CLC residents and/or to family members who voiced disagreement over discharge plans.

[10] Coatesville VA Medical Center policy number PCS 156-17, *Appeal of Clinical Decisions* (March 2017).

Conclusions

- Coatesville discharged Resident A to a personal care home, but this patient did not meet the discharge criteria of VHA Handbook 1142.01, 1142.02, and VHA Directive 1140.11. However, we are **not able to substantiate** that the [redacted] Director directed social workers to do this.

- CLC clinical staff appear not to understand when the consent-to-transfer requirement in 1710A(b)(1) applies. Some are also not adequately familiar with the clinical admission or discharge criteria set forth in VHA's CLC policies.

- Coatesville did not inform the six CLC residents who were the subjects of our record review of their right to appeal clinical decisions, including discharge decisions.

- The interactions between Nursing Service and Social Work Service regarding the appropriate disposition of patients are contentious.

Recommendations to Coatesville

1. Educate all CLC clinical staff, including the ADPCS and GEC Director, on the consent-to-transfer requirement in 38 U.S.C. 1710A(b)(1) and when it applies.

2. Educate all clinical staff on CLC admission and discharge criteria set forth in VHA Handbooks 1142.01 and 1142.02, and VHA Directive 1140.11, to ensure appropriate admissions and discharges. Monitor compliance.

3. Implement any recommendations made by VHA's GEC Program Office, which completed a site visit on December 11, 2018, recommended by the VA team issuing this report.

4. Collaborate with the National Center for Organizational Development to complete an assessment of the Coatesville and CLC leadership team to assist the staff in building a collegial team.

5. Clearly delineate the responsibility for the clinical decision to discharge patients from the CLC and ensure the process is transparent and well-documented with proper record retention.

6. Follow the clinical appeals processes described in local policy number PCS 156-17, *Appeal of Clinical Decisions,* and the Note in 1142.02, paragraph 13 c., to include training for staff, any applicable Veterans, and their families/representatives.

VI. Summary Statement

We have developed this report in consultation with other VHA and VA offices to address OSC's concerns that Coatesville may have engaged in conduct that constitutes a violation of law, rule, or regulation; or a substantial and specific danger to public health. In particular, VA's OAWP has examined personnel issues to establish accountability,

and the National Center for Ethics in Health Care has provided a health care ethics review. We found violations of VHA policy at Coatesville, but none resulting in a substantial or specific danger to public health.

Attachment A

The following documents in addition to the Electronic Medical Records were reviewed:

38 U.S.C. § 1710A.

VHA Handbook 1142.02, *Admission Criteria, Service Codes, and Discharge Criteria for Department of Veterans Affairs Community Living Centers,* September 2, 2012.

VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers,* August 13, 2008.

VHA Directive 1140.11, *Uniform Geriatrics and Extended Care Services in VA Medical Centers and Clinics,* October 11, 2016.

VHA Directive 1041, *Appeal of VHA Clinical Decisions,* October 24, 2016.

VHA Directive 1141.02(1) Medical Foster Home Program Procedures, August 9, 2017.

Coatesville VA Medical Center policy number PCS 127-16, *Release from Inpatient Care,* October 2016.

Coatesville VA Medical Center policy number PCS 156-17, *Appeal of Clinical Decisions,* March 2017.

Performance plans of facility staff.

Email correspondence.

http://southpointqsm.com/pdfs/CareTracker-Brochure.pdf. Accessed March 6, 2019.

Members of the Investigative Team

- [redacted], MD, FACP, FACHE, Medical Inspector, OMI
- [redacted] RN, MSN, NP, Clinical Program Manager, OMI
- [redacted] RN, MSSL, National Director, Community Living Centers, Geriatrics and Extended Care
- [redacted] HR Specialist/Investigator, Office of Accountability and Whistleblower Protection

Key to Interviewees

- [redacted] LCSW, Medical Center Director
- [redacted] MS RN NEA-BC, Associate Director Patient Care Services
- [redacted] MD, ACOS Geriatrics & Extended Care
- [redacted] LCSW, Chief of SW
- [redacted], RN, Director of Geriatrics & Extended Care
- [redacted] MSN, RN, Unit Manager 138B
- [redacted] RN, Assistant Unit Manager 138A
- [redacted] RN, Staff Nurse
- [redacted] Certified Nursing Assistant (CNA)
- [redacted] LCSW, Social Work Supervisor Mental Health
- [redacted] LCSW, CLC Social Work Supervisor
- [redacted] LCSW, CLC Social Worker
- [redacted] LCSW, Social Worker CLC
- [redacted] LCSW, Social Worker Hospice
- [redacted] OT, Occupational Therapist
- [redacted] PsyD, Psychologist (also AFGE Union President)