VA | U.S. Department of Veterans Affairs

Office of the General Counsel
Washington DC 20420

MAY 2 7 2014

In Reply Refer To:

The Honorable Carolyn Lerner
Special Counsel
U.S. Office of Special Counsel
1730 M. Street, NW, Suite 300
Washington, DC 20036-4505

RE: OSC File No. DI-13-4505

Dear Ms. Lerner:

Enclosed is the unredacted supplemental report for OSC File No. DI-13-4505. The redacted version will be sent separately via email. We hereby request that your office publish the redacted version.

If you have any questions about this request, please contact Jennifer Gray in the Office of General Counsel at 202-461-7634.

Sincerely,

Renée L. Szybala
Acting Assistant General Counsel

Enclosure

Office of the Medical Inspector
Supplemental Report
to the
Office of Special Counsel
VA Boston Healthcare System, VA Medical Center, Brockton, Massachusetts
OSC File No. DI-13- 4505
May 1, 2014

TRIM 2014-D-503

BACKGROUND

The Department of Veterans Affairs (VA) Under Secretary for Health (USH) requested that the Office of the Medical Inspector (OMI) investigate complaints lodged with the Office of Special Counsel (OSC) by Mohit Chopra, M.D., a former Department of Veterans Affairs employee (hereafter, the whistleblower) from the Brockton Campus of the VA Boston Healthcare System (VABHS), Brockton, Massachusetts (hereafter, the Medical Center). The whistleblower alleged that the Community Living Center (CLC) failed to provide appropriate medical and mental health care for specific individuals residing there and is not operating in accordance with agency-wide policies. The whistleblower alleged that the CLC may have violated laws, rules, or regulations, engaged in gross mismanagement, and was a specific danger to public health and safety. As part of its investigation, OMI conducted a site visit to the Medical Center on December 12–13, 2013. OMI's report was transmitted to OSC on March 12, 2014.

Based on its investigation, OMI made three recommendations for the Medical Center. These recommendations were endorsed by the Secretary of Veterans Affairs and the USH. OMI and the Veterans Health Administration's (VHA) Office of the Deputy Under Secretary for Operations and Management reviewed and concurred with the Medical Center's action plan in response to report recommendations.

OMI has followed the actions of the Medical Center and concludes that it has successfully completed all three of the recommendations made by OMI.

RECOMMENDATIONS AND ACTIONS

Recommendation 1: All CLC residents receiving antipsychotic/psychotropic medications should be assessed at least annually by the consultative liaison psychiatrist to ensure that the particular medication and dosage amount is consistent with the desired effects and with VA standards of care.

Resolution: All CLC residents with a stay of more than 90 days and receiving antipsychotic/psychotropic medications were identified and assessed by the

consultative liaison psychiatrist. A tracking tool was also developed to ensure that residents will be assessed at least annually by the consultative liaison psychiatrist.

Action Completed

Recommendation 2: Current residents on these drugs who have not been seen by psychiatry in the past 12 months should be seen as soon as possible.

Resolution: All CLC residents with a stay of more than 90 days receiving antipsychotic/psychotropic medications were assessed by the consultative liaison psychiatrist.

Action Completed

Recommendation 3: Develop a process to minimize or eliminate the necessity for psychotropic medications by considering other methods such as behavioral techniques, counseling, etc., to try for the desired resident outcomes.

Resolution: The clinical pharmacist compiles a medication profile for all new admissions to CLC and provides the primary care provider with recommendations. Nursing staff on the Memory Care Unit has received basic training in the management of patients with dementia, including behavioral techniques. When alternative methods have been ineffective, nursing staff will document specific behaviors that require PRN doses of prescribed psychotropics prior to medicating the resident. Nursing staff will document effectiveness in specific terms in the reassessment note following pharmacologic intervention. Data on medication effectiveness will be summarized and provided to the interdisciplinary team.

Long-term residents (stays of more than 90 days) will have a full review by the interdisciplinary team of their psychotropic medication use and effectiveness quarterly. The team will make recommendations regarding the possible reduction or elimination of medications. Nursing will document the team meeting. The primary care provider is responsible for acting on recommendations as appropriate. Staff was educated in this process.

Short-term patients (stays of 90 days or less) will have a monthly review by the interdisciplinary team of their psychotropic medication use and effectiveness. The team will make recommendations regarding the possible reduction or elimination of medications. Nursing will document the team meeting. The primary care provider is responsible for acting on recommendations as appropriate. Staff was educated in this process.

Action Completed

Subsequently OSC asked for two clarifications regarding the Conclusions and Summary Statement contained in the Executive Summary.

1. OSC felt the substantiated allegations appear to indicate that violations occurred of 38 CFR 51.120 generally, and specifically 38 CFR 51.120(m)(1) and (m)(2).

   Response: 38 CFR Part 51, entitled *Per Diem for Nursing Home Care of Veterans in State Homes,* sets forth the standards for State Veterans Homes, which are operated by the various states. As such, section 51.120 is not applicable to VA's CLCs.

2. In addition OSC felt the findings suggest that violations of 38 CFR 17.33 also occurred. However, the OMI Report notes that the "investigation did not find violation of statutory laws, rules, or regulations." We are asking for clarification on this finding.

   Response: 38 C.F.R. 17.33 is known as the "patients' rights regulation." Verbiage in the "General" section refers to "humane environment," and "prompt appropriate treatment of any physical or emotional disability." Verbiage from the "Medication" section refers to patients being "free from any unnecessary or excessive medications." The Veterans discussed in the report were in a VA long term care facility in which they were provided a safe and humane environment at the correct level of care (i.e., inpatient, outpatient, long term care, etc.) for their needs. They received daily care from nurses and were seen regularly by additional independent providers who were properly licensed and privileged during the 10 years or more that they were residents in the facility. OMI feels that in some areas their care could have been better but OMI does not feel that their patient's rights were violated.