DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON DC 20420

March 26, 2015

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

RE: OSC File No.DI-13-2224

Dear Ms. Lerner:

I am responding to your January 20, 2015, request for supplemental information on the Robley Rex Department of Veterans Affairs Medical Center in Louisville, Kentucky (hereafter, the Medical Center), in which you posed five questions. The Secretary has delegated to me the authority to sign the enclosed report and take any actions deemed necessary as referenced in 5 United States Code § 1213(d)(5).

We reviewed the cases of two Veterans placed before May 2012, and found that in neither case had there been an inappropriate placement.

Findings from the current investigation, along with responses to each of the five questions are contained in the report, which I am submitting for your review.

Thank you for the opportunity to respond.

Sincerely,

Jose D. Riojas
Chief of Staff

Enclosure

Office of the Medical Inspector
Supplemental Report
to the
Office of Special Counsel
Robley Rex VA Medical Center
Louisville, Kentucky
OSC File Number DI-13-2224
January 30, 2015

TRIM 2015-D-46

Background

The 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 (b)(6), a former Department of Veterans Affairs (VA) employee (hereafter, the whistleblower) from the Robley Rex VA Medical Center, Louisville, Kentucky (hereafter, the Medical Center). The whistleblower alleged that the current organization and management of the Community Residential Care (CRC) Program are not in accordance with agency-wide policies. The whistleblower alleged that Medical Center employees engaged in conduct that may have violated laws, rules, or regulations, gross mismanagement and an abuse of authority. OMI conducted a site visit to the Medical Center on October 8–9, 2013.

Based on its investigation, OMI made three recommendations to the Medical Center, all endorsed by the USH and the Secretary of VA. OMI and the Office of the Deputy Under Secretary for Health for Operations and Management reviewed and concurred with the Medical Center's action plan in response to report recommendations; the Medical Center completed all items of its action plan by mid-January 2014.

In a January 20, 2015, correspondence with VA, OSC has posed follow-up questions to the original report. This Supplemental Report addresses those questions. To do so, OMI interviewed both the lead physician and the lead psychologist of the investigation team by telephone; both have retired from VA. We also reviewed the original report, as well as the electronic health record (EHR) of the Veteran identified in OSC's letter. We also requested the name of the other Veteran referenced in that letter so that we can review this Veteran's case as well.

Questions Related to Allegation 2:

Veterans in the Community Residential Care (CRC) Program were assigned to facilities that were not approved to be a part of the CRC Program in violation of the law and regulations.

1. The whistleblower asserted that this allegation would have been substantiated if the agency's scope of review had been broader. In particular, she stated that the VA should have evaluated placements prior to May 2012, rather than only reviewing the placements of the 18 veterans in the CRC program at the time of OMI's investigation.

a. **Did OMI review placements prior to May 2012? If yes, how many and what were the outcomes?**

Response:

OMI attempted to review two cases provided by the whistleblower that included placements prior to May 2012. As noted in the report, in the case of the first Veteran, on one occasion he chose a non-approved facility. Per the VA directive governing the CRC Program, he had a right to do this, and his decision was documented in the EHR. In the case of the second Veteran, a February 9, 2015, email from the whistleblower stated that she was unable to recollect the Veteran's name; therefore, we are unable to substantiate the handling of his or her particular case. All other placements for the first Veteran were in approved facilities, as were the placements of 18 other Veterans whose records OMI reviewed during its investigation.

b. **Did OMI interview any employees regarding placements that occurred prior to May 2012? If yes, which employees were interviewed and what were the outcomes of those interviews?**

Response:

OMI did not specifically interview employees regarding placements that occurred prior to May 2012. As noted in the report, the CRC Program had undergone major changes since 2012, and the review focused on the practices in place at the time of the investigation.

2. The whistleblower also stated that this allegation was not substantiated because the VA inappropriately allowed veterans, who were deemed incompetent by the Veterans Benefits Administration (VBA), to choose a facility outside of the CRC Program. The whistleblower stated that the veterans were not competent to make such a choice, which was evidenced by the fact that the VBA had appointed guardians over those veterans.

a. **Did any of the placements reviewed by the OMI involve Veterans who were found incompetent? If yes, how did this finding affect placement into a facility? In particular, in the two examples provided by the whistleblower and described on pages 4-5 of the report, were either of the Veterans found incompetent by VBA?**

Response:

Neither of the investigation team members recalled that any of the Veterans in the cases reviewed had been deemed incompetent.

Upon review of the EHR of the Veteran named in the OSC letter, there is some confusion about his competency. On (b)(6) 2006, an attending neuropsychiatrist stated, "he does not meet legal criteria to pose the question within the formal judicial system as to his legal competence." On (b)(6) a social worker made a note to follow up with the

physician because of her concerns that the Veteran was not competent to handle his funds. A request was forwarded to the VA Regional Guardianship Office (VARO). An (b)(6) note in the EHR states that the Veteran's finances are currently managed by the Veteran, but paperwork has been submitted for a payee through VARO. On (b)(6) a note acknowledges that the Veteran's sister is managing his finances and a conservator appointed by VARO has been requested. On (b)(6) a note indicates that the "patient pays with assistance from family, who receive check." The whistleblower notes on (b)(6), 2010, that "although the Veteran does not have a court appointed guardian, he is considered incompetent for VA purposes and has a VA appointed fiduciary that will also need to be in agreement with his placement for payment purposes." On (b)(6) a subsequent note describes the Veteran as actively involved in picking his CRC site, but also indicates VA will notify and obtain agreement of the payee/fiduciary for the Veteran to be placed. This entry would indicate that the CRC worked with both the Veteran and the fiduciary to select an appropriate placement site.

b. With respect to veterans with guardians, were the guardians contacted regarding choosing a facility?

Response:

As noted above, the Medical Center worked with a fiduciary to obtain appropriate placement for the Veteran in question. He did not have a guardian.

3. The whistleblower also articulated another concern related to this allegation. She stated that veterans who needed placement in residential care, but were not accepted as part of the CRC program, were improperly placed in facilities that were not approved by the CRC Program. She explained that VA social workers under the direction of management were responsible for such placements. Further, many of these veterans were not given the option of choosing a facility approved by the CRC Program. The whistleblower emphasized that many of the unapproved facilities were unsafe or neglected to provide important support and follow-up, such as counseling services, transportation, clinical outreach, access to day centers and other related resources.

a. In light of this information, were veterans inappropriately placed in facilities that were not approved by the CRC Program?

Response:

Again, as noted in the report, in one of the cases reviewed, the Veteran chose to go to a nonapproved facility, as is his right; therefore, his placement is not inappropriate.