DEPARTMENT OF VETERANS AFFAIRS
Washington DC 20420

December 23, 2013

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 letter regarding complaints lodged with the Office of Special Counsel 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. The Secretary has delegated to me the authority to sign the enclosed report and take any actions deemed necessary under 5 United States Code § 1213(d)(5).

The Secretary asked the Under Secretary for Health to review this matter and to take any actions deemed necessary under the above code. He, in turn, directed the Office of the Medical Inspector (OMI) to conduct an investigation, which included a site visit on October 8–9, 2013. In its investigation, OMI substantiated two of the three allegations made by the whistleblower but did not substantiate the remaining one. OMI substantiates the allegation that Veterans eligible for referrals for placement in the CRC Program facilities were excluded from the program in violation of VHA Handbook 1140.01 and 38 CFR §§17.61-17.71, and also the allegation that facilities were removed from the CRC Program without due process as required by policy. OMI's investigation found noncompliance with 38 CFR §§ 17.61-17.71 and VHA Handbook 1140.01, *Community Residential Care Program*. OMI made three recommendations for the Medical Center to improve its CRC Program. Findings from the investigation are contained in the report, which I am submitting for your review.

Thank you for the opportunity to respond to this issue.

Sincerely,

Jose D. Riojas
Chief of Staff

Enclosure

OFFICE OF THE MEDICAL INSPECTOR

Report to the

Office of Special Counsel

OSC File Number DI-13-2224

Department of Veterans Affairs (VA)

Robley Rex VA Medical Center

Louisville, Kentucky

Veterans Health Administration (VHA)

Washington, DC

Report Date: October 31, 2013

2013-D-1117

Executive Summary

The Under Secretary for Health 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.

Summary of Allegations

The whistleblower's allegations are as follows:

1. Veterans eligible for placement in the CRC Program were excluded from the program in violation of the regulations.

2. Veterans in the CRC Program were assigned to facilities that were not approved to be part of the CRC Program in violation of the law and regulations.

3. Facilities were removed from the CRC Program without due process in violation of regulations.

Based on its investigation, OMI makes the following conclusions and recommendations.

Conclusions

- OMI substantiates the allegation that Veterans eligible for referrals for placement in the CRC Program facilities were excluded from the program in violation of VHA Handbook 1140.01 and 38 Code of Federal Regulations (CFR) §§ 17.61-17.71. The Medical Center used their CRC Program almost exclusively for the placement of mental health patients with little or no attention given to medical patients.
- OMI did not substantiate the allegation that Veterans in the CRC Program were assigned to facilities that were not approved to be part of the Program. All current CRC Veterans are in approved facilities. VHA Handbook 1140.01 does allow Veterans to choose placement in non-approved facilities and that the action is documented in their medical record. This was the situation in cases given to OMI by the whistleblower as it was documented that the Veteran wanted the unapproved facility.
- OMI substantiates the allegation that facilities were removed from the CRC Program without due process as required by policy. The Medical Center did not follow the due process procedure detailed in 38 CFR §§ 17.66-17.71 and VHA Handbook 1140.01, and failed to include the description of the due process procedure in its Memorandum 603-13-116-009 that describes the policies and procedures of the Medical Center's CRC Program.

- The Medical Center was not compliant with VHA Directive 2009-001, as it did not inform VA Central Office of the significant downsizing of the CRC Program when it no longer accepted medical patients into the Program, and removed facilities beyond a 30-mile radius of the Medical Center.

Recommendations

The Medical Center should:

1. Ensure the CRC Program complies with all applicable regulations and policies. Specifically the CRC cannot be limited to mental health patients and to facilities within 30 miles of the Medical Center.
2. Ensure the Medical Center policy does not contradict Federal regulations or VHA national policy and that it includes the due process procedures.
3. Move the CRC Program from under mental health to the Geriatrics and Extended Care Program, as recommended by the Medical Center's CRC audit completed in March 2012.

Summary Statement:

OMI's investigation found noncompliance with 38 CFR §§ 17.61-17.71 and VHA Handbook 1140.01, *Community Residential Care Program.*

I. Introduction

The Under Secretary for Health requested that the OMI investigate complaints lodged with OSC by (b) (6), a former 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 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.

II. Facility Profile

The Medical Center, part of Veterans Integrated Service Network 9, consists of the main facility in Louisville, with 108 inpatient beds for general medicine, surgery, neurology, and mental health services, and eight health care centers. Medical, surgical, and subspecialty care is provided at the main facility while primary care and mental health services are provided at all of the health care centers. These facilities provide services to approximately 166,000 Veterans living in a 35-county area of Kentucky and southern Indiana. The Medical Center also has sharing agreements with Ireland Army Community Hospital at Fort Knox and the Kentucky National Guard.

III. Allegations

The whistleblower's allegations are as follows:

1. Veterans eligible for placement in the CRC Program were excluded from the program in violation of the regulations.

2. Veterans in the CRC Program were assigned to facilities that were not approved to be part of the CRC Program in violation of the law and regulations.

3. Facilities were removed from the CRC Program without due process in violation of regulations.

IV. Conduct of Investigation

An OMI team consisting of (b) (6) M.D., the Medical Inspector; (b) (6), Ed.D., Clinical Psychologist, both from OMI; and (b) (6), Registered Nurse (RN), MSN, Chief, Home and Community Care Programs for VHA, conducted the site visit. OMI reviewed relevant policies, procedures, reports, memorandums, and other documents, a complete list of which is in Attachment A. OMI held an entrance and an exit briefing with Medical Center leadership including: (b) (6) Master of Social Work (MSW), Interim Medical Center Director; (b) (6) M.D., Chief of Staff and CRC Program Hearing Official; (b) (6), Acting Associate Director for Patient Care Services; (b) (6), Acting Associate Director for

Operations; (b) (6), Licensed Clinical Social Worker (LCSW), Chief, Mental Health and Behavioral Science Service (MHBSS); (b) (6), M.D., Deputy Chief of Staff; (b) (6), BSN, RN, DBA, Chief, Quality Management Service; and (b) (6), RN, Scribe/Accreditation Readiness Specialist for Quality Management Service.

OMI interviewed the following individuals:

(b) (6), RN, CRC Program Coordinator

(b) (6), LCSW, Supervisory Social Worker

(b) (6), LCSW, Supervisory Program Coordinator

(b) (6), LCSW, Chief, MHBSS

(b) (6), RN, CRC Program Staff Nurse

(b) (6) CRC Program Social Worker

(b) (6), M.D., Chief of Staff and CRC Program Hearing Official

OMI interviewed the whistleblower via telephone before the site visit and in person on October 8, 2013. She provided additional information regarding her experiences during the time she was the coordinator of the Medical Center's CRC Program.

The Office of General Counsel reviewed OMI's findings to determine whether there was any violation of law, rule, or regulation.

OMI ***substantiated*** allegations when the facts and findings supported that the alleged events or actions took place. OMI ***did not substantiate*** allegations when the facts showed the allegations were unfounded. OMI ***could not substantiate*** allegations when we found no conclusive evidence either to sustain or refute the allegations.

V. Findings

Title 38 CFR §§ 17.61-17.71 and VHA Handbook 1140.01, *Community Residential Care Program* provides the guidance necessary for conducting the CRC. According to VHA Handbook 1140.01 a "CRC is a form of enriched housing which provides health care supervision to eligible [V]eterans not in need of hospital or nursing home care, but who, because of medical, psychiatric and/or psychosocial limitations are not able to live independently and have no suitable significant others to provide needed supervision and supportive care....Care must consist of room, board, assistance with activities of daily living [], and supervision.... The cost of residential care is financed by the [V]eteran's own resources. Placement is made in residential settings that are inspected and approved by the [overseeing] VA facility, but chosen by the [V]eteran." (VHA Handbook 1140.01 Section 4)

The regulations implementing the CRC Program state that placement of a Veteran in a CRC facility/home is appropriate if "the [V]eteran does not need hospital or nursing home care but is unable to live independently because of medical (including psychiatric) conditions and has no suitable family resources to provide needed monitoring, supervision, and any necessary assistance in the [V]eteran's daily living activities," (38 CFR § 17.61(b)).

All CRC facilities must be inspected by a VA inspection team and be approved by VA prior to referring Veterans to a facility. Facilities that do not continue to meet VA standards for the CRC Program are notified of their infractions and are given the opportunity to discuss the infractions and solutions with the Program Hearing Officer who is usually the Director of the VA Medical Center (VAMC) or a designee. Both the regulations and the VHA Handbook are very specific about the procedures of due process and rights afforded to CRC sponsors when there is a possibility there may be a revocation of VA approval.

Nationally, the Office of Geriatrics and Extended Care (GEC) at VA Central Office is responsible for the overall program management and policies of the CRC Program. Although in the majority of VAMCs CRC Programs are managed by GEC, some are placed under mental health, as is the case in the Medical Center.

In March 2012, because of concerns over the functioning of the Program and adverse events, the Medical Center's Risk Manager conducted a CRC Program audit. At that time, the Program had 62 Veterans and 14 facilities. Findings included lack of adherence to VA directives, complaints from CRC home sponsors, and interference with other community treatment programs. One of the recommendations included moving the CRC Program out from under mental health and placing it under GEC, where it is usually found within VHA. It was felt that this move would contribute to greater compliance with the VHA Handbook that describes the operation of the CRC Program. Other recommendations were to draw down the number of Veterans in the Program by stopping the use of homes that were outside a 30-mile radius of the Medical Center.

In April 2013, the Medical Center re-issued its policies and procedures for the operation of its CRC facilities in Medical Center Memorandum No. 603-13-116-009, *Community Residential Care Program*. The policy states that the CRC Program is focused on placing Veterans whose conditions are primarily psychiatric or mental health related. A primary program goal is to provide an improved quality of life for Veterans who are not capable of independent living due to their mental health issues.

As mentioned, the Medical Center's CRC Program is managed by the MHBSS. It currently has a total of 18 patients who are assigned to four different CRC-approved facilities. The Program has a coordinator and two case managers who visit and assess the CRC patients at least once a month.

Allegation 1: Veterans eligible for placement in the CRC Program were excluded from the program in violation of regulations.

OMI interviews indicated that although the Veterans in the CRC Program have a variety of medical issues, their primary diagnosis is mental health in nature. A new CRC consultation process indicates that the majority of consultations to the CRC Program come from the psychiatric inpatient unit. Consultations also come from community-based outpatient clinics and the mental health intensive clinical management program (MHICM), but the Veterans all have mental health issues as their primary diagnosis. Interviews with program personnel support this emphasis on mental health, at the exclusion of medical patients.

Conclusion

- OMI substantiates the allegation that Veterans eligible for placement in the CRC Program were excluded from it in violation of VHA Handbook 1140.01 and 38 CFR § 17.61. The Medical Center used its CRC Program almost exclusively for the placement of mental health patients with little or no attention given to medical patients.

Recommendation

The Medical Center should:

1. Ensure that the CRC Program complies with all applicable regulations and policies. Specifically the CRC cannot be limited to mental health patients and to homes within 30 miles of the Medical Center.

Allegation 2: Veterans in the CRC Program were assigned to facilities that were not approved to be part of the CRC Program in violation of law and regulations.

The VHA Handbook allows Veterans to choose care in non-approved CRC facilities and the choice should be documented in their electronic health record (EHR). OMI reviewed the current placement of all 18 Veterans in the Medical Center's CRC Program and determined that all were living in VA-approved CRC facilities.

The whistleblower provided the names of two Veterans who were part of the CRC Program who, according to her, were placed in non-approved CRC facilities without their consent. The first Veteran, a (b) (6) year-old, several times divorced, white male, was admitted to the Eastern State Hospital in (b) (6) 2013, where he remains today. The Veteran has a primary diagnosis of schizophrenia, paranoid type. His EHR indicates 36 admissions to the Medical Center primarily for psychiatric reasons from (b) (6) 1999 to (b) (6) 2013. He is a chronically ill Veteran who was screened and accepted for MHICM in (b) (6) 2006. His initial CRC statement of needed care was completed in (b) (6) 2011, after which he chose placement in the CRC-approved Colonial Home. Since that time, the Veteran has been followed by MHICM, as well as CRC case managers on a regular basis. Some of his other CRC placements include Valley Haven Rest Home and Clark Family Care Home. There are numerous entries in the EHR indicating that the Veteran's

preferences, stability, and control were taken into consideration when he was moved from one community facility to another or from inpatient hospitalization to a community facility. He also initiated transfer from one facility to another as he felt he was not getting the "$20 per week that President Obama promised him," and he no longer wanted to stay at the facility.

The second Veteran was a (b)(6)-year-old single, African American male with a history of HIV since 1987, depression, schizophrenia, and substance abuse. His EHR has clinical notes covering (b)(6) 2004 to the present. He has had eight Medical Center inpatient admissions, with three to medicine and five to psychiatry. He entered the CRC Program in (b)(6) 2006 and went to the Oaks Personal Care Home, to be near his family. He was sent to the Mapp Board and Care Facility and then to the Drake Family Care Home, where he has been since (b)(6) 2010. There seems to be only one time, in early 2010, when the Veteran was sent to a non-VA approved facility, per his request to go there. All transfers and movement from facility to facility or ward to facility indicated that the Veteran was very much a participant of this decision-making process.

Conclusion

- OMI did not substantiate the allegation that Veterans in the CRC Program were assigned to facilities that were not approved to be part of the Program. All current CRC Veterans are in approved facilities. The VHA Handbook does allow Veterans to choose placement in non-approved facilities and that the action should be documented in their medical record. This was the situation in cases given to OMI by the whistleblower as it was documented that the Veteran wanted the unapproved facility.

Recommendation

None

Allegation 3: Facilities were removed from the CRC Program without due process in violation of regulations.

The whistleblower stated that CRC-approved facilities lost VA approval without due process. Among these facilities were: The Oaks in Lewisport, Valley Haven in Sanders, Carrollton Manor in Carrollton, Colonial Hall Manor in Shelbyville, all in Kentucky, and Clark Board and Care Home in Clarksville, Indiana. The reasons given for the loss of VA approval were Veteran abuse, financial mismanagement of Veteran funds, and location outside of a 30-mile radius of the Medical Center. This distance, imposed arbitrarily, was designated by the CRC Program, under its revised policy to serve as a new criterion for CRC approval.

OMI found that several CRC facilities beyond the 30-mile radius had lost their VA approval. Before revoking their CRC status, the Medical Center did not afford the above-named facilities an opportunity for a hearing to defend themselves against the

charges. Furthermore, as required by the Handbook, there was no Hearing Officer at the Medical Center until one was appointed a week before OMI's site visit.

The Medical Center could not provide OMI with any of the documentation required by the Handbook for due process. The Medical Center failed to include a description of due process in its April 30, 2013, Memorandum 603-13-116-009.

When questioned by OMI, Medical Center staff said that they did not seek VACO guidance/approval to restructure their CRC Program as required by VHA Directive 2009-001, *Restructuring of VHA Clinical Programs*.

Conclusions

- OMI substantiates the allegation that facilities were removed from the CRC Program without due process as required by policy. The Medical Center did not follow due process procedures detailed in the VHA Handbook, and failed to include a description of due process procedures in its Memorandum 603-13-116-009, which describes the policies and procedures of the Medical Center's CRC Program.

- The Medical Center was not compliant with VHA Directive 2009-001, as it did not inform VA Central Office of the significant downsizing of the CRC Program when it no longer accepted medical patients into the Program and removed facilities beyond a 30-mile radius of the Medical Center.

Recommendations:

The Medical Center should:

2. Ensure that its policy does not contradict Federal regulations or VHA national policy and includes due process procedures.

3. Move the CRC Program from under Mental Health to GEC, as recommended by its CRC Program audit of March 2012.

Attachment A

Documents Reviewed by OMI

1. VHA Handbook 1140.01, *Community Residential Care Program,* March 29, 2007

2. VA Medical Center, Louisville, Kentucky, *Community Residential Care Program (CRC)*, Medical Center Memorandum No. 603-13-116-009, April 30, 2013

3. VHA Directive 2009-001, *Restructuring of VHA Clinical Programs*, March 9, 2009, (Corrected Copy)

4. VA Medical Center, Louisville, Kentucky, *Community Residential Care Program Audit*, March 2012