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Shortcomings in Veterans Crisis Line and Nationwide VA Drug-Testing Protocols

FOR IMMEDIATE RELEASE
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WASHINGTON, D.C./June 12, 2017 –

In letters to the White House and Congress today, the U.S. Office of Special Counsel (OSC) reported on deficiencies in Department of Veterans Affairs (VA) programs serving veterans in crisis, and patients treated with opioids in VA facilities nationwide. (The documents associated with the cases can be found in our public file.)

The VA substantiated allegations by two anonymous whistleblowers that 35 unqualified employees held positions with the Veterans Crisis Line (VCL) in violation of agency regulations, and newly hired employees were not properly trained before conducting unsupervised crisis interventions. The VA's report to OSC found that employees lacked required education, conducted clinical duties in violation of agency rules, and were not adequately trained before they took calls from veterans. Nevertheless, the VA asserted that due to a robust quality assurance program, there was no danger to public health and safety.

The VA's conclusions were disputed by a recent VA Office of Inspector General review, which found significant deficiencies in the quality assurance program relied upon by the agency in asserting that no danger existed.

Special Counsel Carolyn Lerner found the VA's report unreasonable. In her letter, she noted that employees responsible for providing services to vulnerable veterans experiencing acute mental health crises should be held to the highest professional standards, and urged further review of VCL management and improvements to training and quality assurance.

In a separate matter, the VA substantiated a nationwide failure to comply with VA guidelines for random drug testing of patients. Based on disclosures from an anonymous whistleblower, the VA reviewed data from 16 locations and found that less than 55 percent of long-term, opioid-treated patients received routine, random urine drug tests, falling well short of VA guidelines.

The report also substantiated that providers frequently incorrectly copy and paste information in patient charts in multiple VA facilities reviewed. The VA report also found that the Community-Based Outpatient Clinic in Dover, Delaware, did not properly assign patients to a new provider after a nurse practitioner left. While no adverse events occurred, there were delays in care. The VA took action to correct the problems, and the Chief of Primary Care for the Dover CBOC stepped down in 2014.

Special Counsel Lerner noted in her letter that the VA has taken positive actions toward correcting identified problems. However, given the seriousness and nationwide scope of the allegations the Special Counsel urged the VA to "continue to vigilantly oversee and enforce its policies regarding opioid prescriptions and pain management."

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