



DEPARTMENT OF VETERANS AFFAIRS
Veterans Health Administration
Washington DC 20420

OCT 13 2005

In Reply Refer To:

Scott J. Bloch
U.S. Office of Special Counsel
1730 M Street, NW
Suite 300
Washington, DC 20036-4505

Dear Mr. Bloch:

Enclosed is the Department of Veterans Affairs' (VA) report in response to your request of July 14, 2005, to investigate allegations made by anonymous whistleblowers regarding the West Los Angeles Medical Center (Office of Special Counsel File Numbers DI-04-2859; DI-05-0026; DI-05-0029; and DI-05-1921). The Secretary of Veterans Affairs has delegated to me the authority to review and sign this agency report and take any actions deemed necessary under 5 U.S.C. § 1213(d)(5). Following our request for an extension, the report is now due on October 17, 2005.

I appointed an Administrative Board of Investigation (Board) to investigate the disclosures and report on their findings. The Board's conclusions are set forth in the attached report. Following their investigation at the VA Medical Center, the Board made numerous recommendations to the Medical Center Senior Management and the Network Director and Chief Medical Officer. The Board's recommendations were accepted and work on their implementation has begun. These recommendations and a number of additional recommendations are detailed in the attached report.

The Board also shared concerns that one of the psychiatrists interviewed during the investigation appeared to be impaired and recommended that appropriate actions to evaluate this situation be taken by Senior Medical Center Management.

If you have any questions about the contents of the report, please have a member of your staff contact John Barilich, MSW, MBA, Deputy Network Director, VISN 10 at (513) 247-4623.

Sincerely yours,

A handwritten signature in black ink, appearing to read "Jonathan B. Perlin", is written over a faint, larger version of the signature.

Jonathan B. Perlin, MD, PhD, MSHA, FACP
Under Secretary for Health

Enclosure

REPORT TO THE OFFICE OF SPECIAL COUNSEL

**Prepared by: John E. Barilich, MSW, MBA, Chair
 Ethan S. Rofman, MD
 Richard Harper, MD**

Department of Veterans Affairs



Report Date: September 29, 2005

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EXECUTIVE SUMMARY

The Department of Veterans Affairs (VA), Veterans Health Administration (VHA), was directed to investigate and report on disclosures made by four anonymous Whistleblowers to the Office of Special Counsel (OSC).

The information disclosed to OSC alleges that decisions regarding the allocation of psychiatric resources at the Los Angeles medical center have endangered VA patients, staff, and the public, and wasted VA resources. OSC determined that there is a substantial likelihood that the information they received discloses violations of law, rule, or regulation, gross mismanagement, a gross waste of funds, and dangers to public health and safety. Accordingly, the Special Counsel directed the VA Secretary to investigate the allegations and report on the findings within 60 days. At VA's request, the due date for VA's report was extended an additional thirty days.

Based on this information, VHA convened an Administrative Board of Investigation (Board) to investigate these allegations.

SUMMARY OF CONCLUSIONS

- The number of inpatient psychiatric beds has significantly decreased over the past ten years. This decrease is due primarily to advances in the treatment of psychiatric patients. The decrease in the number of inpatient psychiatric beds does not violate the requirement in 38 U.S.C. § 1706(b).
- Patients are transferred to other VA facilities or to private sector facilities when inpatient psychiatric beds are not available. This occurs when all inpatient beds are full or because of staffing issues. The facility has ongoing efforts to recruit additional nursing staff to address this issue. The facility has also established a multidisciplinary Work Group, co-chaired by two staff psychiatrists, to review the bed flow issue to ensure the availability of beds when needed and to diminish or alleviate such shortages in the future.
- The designation of "Ward 1 East" was created prior to the merger of the Psychiatric Emergency Service (PES) to ensure that care provided to critical care patients in need of admission would be recorded through the VA's Computerized Patient Record System and the Bar Code Medication Administration program, computer systems that are only available to inpatients. When the "Ward 1 East" designation was first used for psychiatric patients in the Emergency Department (ED), patients were kept in the ED for extended periods. Management has since mandated that patients in need of psychiatric admission must be admitted to a bed or transferred to a non-VA facility.
- The Board found that the ED was adequately staffed. ED personnel have received training regarding psychiatric patients, and additional training is planned.

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- The Board concluded that procedures are in place to medically clear psychiatric patients seen in the ED.
- The Board found that the Access Center provides comprehensive urgent care services to veterans through the Triage Center, Mental Health Clinic, and Primary Care Clinics. The staffing is adequate, and staff members have received appropriate training.
- The Board reviewed incident reports to evaluate the anecdotal stories of individual patients described by the whistleblowers. Although the Board concluded that several of these situations were appropriately handled, incident reports were not identified for all of the situations described.
- The Board found that policies and procedures are in place to manage placement in long-term care facilities, that contracts are routinely extended when determined to be medically necessary, and that the program provides appropriate and necessary information to prospective long-term care facilities.

SUMMARY OF RECOMMENDATIONS

- The multidisciplinary Work Group, co-chaired by two staff psychiatrists, should continue to monitor issues related to the availability of inpatient psychiatric beds and the care provided to psychiatric patients in the ED.
- Senior Management should ensure that mid-level supervisors receive training in strategic planning, and that front line staff are included in any future planning of this nature.
- Senior Management should request a site visit from Mental Health in VA Central Office to review the organizational structure of Psychiatry and Mental Health services.
- The facility should continue efforts to recruit nursing staff to ensure that all available inpatient beds are fully staffed.
- Facility management has mandated that rather than designate psychiatric patients as admitted to Ward 1 East, patients in need of psychiatric admission must be admitted to a bed or transferred to a non-VA facility. This requirement should be issued in a written policy.
- Staff from the ED and the Access Center should be advised of existing policies and procedures for reviewing adverse events or incidents involving substandard care in order to ensure that future allegations are fully reviewed and documented.

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SUMMARY OF ALLEGATIONS AND DISCLOSURES

The VA Secretary was directed by Special Counsel Scott J. Bloch to investigate allegations from four anonymous Whistleblowers. Information from OSC states that the Whistleblowers are VA employees. The employees allege that in the course of their employment, they have witnessed the maltreatment of psychiatry patients at the West Los Angeles Medical Center. The employees allege that management at the Medical Center has engaged in violations of law, rule, or regulation, gross mismanagement, a gross waste of funds, and substantial and specific dangers to public health and safety in connection with the provision of psychiatric services.

The Whistleblowers make numerous allegations about decisions regarding the allocation of psychiatric resources at the Medical Center. The Whistleblowers allege that these decisions have wasted VA resources and have endangered VA patients, staff, and the public. Although interrelated, the Whistleblowers' allegations fall into five broad areas of concern. These include the reduction of inpatient psychiatric beds in the VA facility; the merger of the separate PES with the general ED; the standard of medical care provided to psychiatric patients evaluated and treated in the ED; the standard of medical care provided to psychiatric patients evaluated and treated in the Access Center; and the facility's management of long-term care contracts.

I. ALLEGATIONS REGARDING THE REDUCTION OF INPATIENT PSYCHIATRIC BEDS IN THE VA FACILITY

The Whistleblowers allege that facility management has reduced the number of psychiatric beds available to its patients. They alleged that despite the fact that the medical center routinely operates at or above capacity on the psychiatric unit, the facility has, over the past 10 years, reduced the number of psychiatric beds from 366 to 84. Because of this reduction in beds, the Whistleblowers allege that the psychiatric unit at the medical center experiences a bed crisis on a monthly basis. They allege that the crisis can last from one day to two weeks. They allege that in May 2005, VA paid the cost of having mentally ill patients transported and cared for at a state hospital because beds were not available at the VA facility.

The Whistleblowers also allege that the closure of psychiatric beds violates the statutory mandate in 38 U.S.C. § 1706(b) to maintain VA's capacity to provide for the specialized treatment and rehabilitative need of certain disabled veterans including, among others, veterans with mental illness.

II. ALLEGATIONS REGARDING THE MERGER OF THE SEPARATE PSYCHIATRIC EMERGENCY SERVICE WITH THE EMERGENCY DEPARTMENT, THE CREATION OF *WARD 1 EAST*, AND CONDITIONS ON *WARD 1 EAST*

The Whistleblowers allege that VA has improperly closed the PES and routed emergency psychiatric care patients through its general ED. The Whistleblowers allege

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that during this process, VA management created a fictitious ward, "Ward 1 East," where suicidal, homicidal, and other psychiatric patients are admitted when there are no inpatient psychiatric beds available. The Whistleblowers allege that Ward 1 East was created to address the recurring bed crisis in the psychiatric unit. The Whistleblowers allege that while the patient's chart indicates that the patients has been admitted to Ward 1 East, he or she will actually remain on a gurney in the ED until a bed becomes available on a psychiatric unit. They allege that the medical center is, in effect, warehousing mentally ill veterans in the ED until space is available on a psychiatric unit.

The Whistleblowers allege that due to the bed closings and the resulting waiting periods for receiving treatment, some mentally ill patients elect to leave the ED without treatment.

The Whistleblowers also allege that the closure of the PES eliminated the distinctive elements of the emergency psychiatric care previously provided by VA. They allege that this restructuring violates the statutory mandate in 38 U.S.C. § 1706(b) to maintain VA's capacity to provide for the specialized treatment and rehabilitative need of certain disabled veterans including, among others, veterans with mental illness. They also allege that maintaining patients in the ED while ostensibly admitted to Ward 1 East violates California laws and regulations requiring that psychiatric patients admitted to a treatment facility be housed in separate psychiatric units located away from other medical patients.

The Whistleblowers make numerous allegations regarding conditions on Ward 1 East. They allege that there is inadequate staffing for Ward 1 East, and that psychiatric evaluation of and care for mentally ill patients in Ward 1 East falls to resident psychiatrists.

The Whistleblowers allege that patients technically assigned to Ward 1 East but held in the ED will rarely see the same psychiatrist twice during their hospitalization. They allege that such patients do not receive appropriate continuity of care, which impedes the ability of the psychiatric staff to develop effective treatment plans. The Whistleblowers allege that this violates VA policies requiring the development of effective treatment plans.

The Whistleblowers allege that patients admitted to Ward 1 East are actually left for up to three days on gurneys in the ED without the supervision of adequately trained nursing staff or psychiatrists. The Whistleblowers allege that during this time, they are exposed to unsafe conditions that are not therapeutic. The Whistleblowers allege that these patients may injure themselves or others. The Whistleblowers allege that while in the ED, patients have access to harmful implements such as scissors and scalpels that are ordinarily present in the ED. They allege that patients also have access to restrooms that lock from the inside and fall below ordinary standards of care for suicidal patients. Finally, they allege that mentally ill patients maintained in Ward 1 East are a danger to one another because they are not properly supervised.

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III. ALLEGATIONS REGARDING THE STANDARD OF MEDICAL CARE PROVIDED TO PSYCHIATRIC PATIENTS EVALUATED AND TREATED IN THE ED

The Whistleblowers allege that mentally ill patients routed through the ED rather than a separate PES receive substandard psychiatric medical care. They allege that personnel in the ED are not adequately trained to treat mentally ill patients who may require special care or present unpleasant cases for the medical staff to handle. They allege that there is inadequate staffing for the ED, and that psychiatric evaluation of and care for mentally ill patients in the ED falls to resident psychiatrists who rotate through the ED once per month while continuing full-time responsibilities in other parts of the VA psychiatric system. They generally allege that the ED is not properly staffed or equipped to diagnose and treat mentally ill patients.

The Whistleblowers provided an anecdotal story to demonstrate their concern regarding the psychiatric care provided to psychiatric patients who are seen in the ED. The story involved a 43-year old female patient with a history of sexual abuse who was diagnosed with Schizoaffective Disorder.

In addition to receiving inadequate psychiatric care, the Whistleblowers also allege that mentally ill patients receive inadequate medical clearance from the ED medical staff. They allege that the medical staff has failed to diagnose serious physical ailments in these psychiatric patients. They allege that mentally ill patients in the ED do not receive sufficient medical monitoring, such as periodic blood pressure measurements. One Whistleblower alleges that charts for some patients indicate that they received no medical attention whatsoever.

The Whistleblowers provided several anecdotal stories regarding situations where they allege that ED medical staff failed to provide appropriate medical treatment to psychiatric patients. One such instance involved a mentally ill patient with an amputation. According to the Whistleblowers, the ED medical staff providing care to this patient failed to diagnose gangrene. Another anecdotal incident reported by a Whistleblower involved a mentally ill patient whose lung cancer was undiagnosed by the ED medical staff.

IV. ALLEGATIONS REGARDING THE STANDARD OF MEDICAL CARE PROVIDED TO PSYCHIATRIC PATIENTS EVALUATED AND TREATED IN THE ACCESS CENTER

The Whistleblowers allege that in order to address the bed crisis and wait periods, some mentally ill patients who present to the ED for emergency care are referred to a separate outpatient facility, the Access Center. The Whistleblowers allege that acutely suicidal or homicidal patients have been referred to the Access Center and that the Access Center is poorly staffed and lacks personnel who are properly trained to deal with mentally ill patients presenting with such potentially dangerous psychiatric conditions. The Whistleblowers allege that the Access Center provides substandard care in unsafe conditions, and that it is not equipped to properly treat serious psychological conditions.

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To illustrate this point, a Whistleblower provided an anecdotal story regarding a situation where a patient referred to the Access Center subsequently attempted to commit suicide and injured a staff member who attempted to intervene.

V. ALLEGATIONS REGARDING THE FACILITY'S MANAGEMENT OF LONG-TERM CARE CONTRACTS

The Whistleblowers allege that VA Management is engaging in an ongoing waste of funds in connection with long-term care contracts arranged for mentally ill patients. They allege that the facility has poor procedures for placing and maintaining patients in long-term care. A specific incidence of mismanagement cited by a Whistleblower included the practice of contacting only one long-term facility at a time for each patient, and waiting for that facility to make an admissions decision before contacting another facility. The Whistleblowers allege that VA placement coordinators have provided unnecessary information to prospective long-term care facilities. The Whistleblowers allege that by providing this information to potential long-term care facilities, VA placement coordinators show VA patients "in a bad light" and have made it difficult to place patients in lower-cost, contracted facilities.

The Whistleblowers also allege that managers at the VA medical center are refusing to extend long-term care contracts under which private, long-term care facilities care for mentally ill veterans. The Whistleblowers allege that these patients are simply released into the public, where they pose a danger to themselves and others. The Whistleblowers allege that a high proportion of these patients ultimately require re-hospitalization. One Whistleblower indicated that the process of stabilizing a patient inappropriately discharged from a long-term care contract could take up to 180 days.

The Whistleblowers allege that these inefficient procedures for placing and maintaining patients in long-term care needlessly extend the amount of time that patients spend in high cost hospital wards, thereby wasting VA resources and increasing costs to VA. The Whistleblowers allege that these practices endanger mentally ill patients.

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METHODS FOR CONDUCTING THE INVESTIGATION

The Under Secretary for Health appointed a Board of Administrative Investigation (Board) to review the allegations contained in the OSC correspondence. The Board included the following members: John E. Barilich, MSW, MBA, Chair, Deputy Network Director, Network 10; Ethan S. Rofman, MD, Director, Mental Health Care Line, Network 1; Richard Harper, Chief of Emergency Medicine, VA Medical Center, Portland, Oregon.

The Board conducted an on-site investigation August 1 through August 4, 2005. Prior to the on-site visit, a list of witnesses to be interviewed and a list of documents needed were developed. The Board interviewed 21 witnesses under oath. Each witness was provided with a brief description of the nature of the allegations, a Notice of Rights and Responsibilities, and a designation of Representative, if the witness intended to be represented. A court reporter transcribed the testimony and each witness was given the opportunity to review his or her transcript. The members of the Board discussed the evidence and jointly wrote this report.

The initial findings and the Board's recommendations were shared with the Medical Center Director, Chief of Staff, and Nurse Executive in an exit interview conducted on August 4, 2005.

SUMMARY OF THE EVIDENCE, FINDINGS, AND RECOMMENDATIONS

I. ALLEGATIONS REGARDING THE REDUCTION OF INPATIENT PSYCHIATRIC BEDS IN THE VA FACILITY

- *Over the past ten years, facility management has improperly reduced the number of psychiatric beds from 366 to 84.*
- *The reduction of beds is responsible for a bed crisis that requires VA to pay to have patients transported and cared for at non-VA facilities.*
- *The reduction of beds violates the statutory mandate in 38 U.S.C. § 1706(b).*

A. Documentary Evidence

The number of inpatient Psychiatry beds at the Greater Los Angeles Healthcare System has been reduced over the past ten years. Documents received prior to the on-site investigation reveal there are currently four inpatient units with a bed capacity of 84. Documents reviewed also revealed that services for psychiatric patients have been maintained through partnerships, on the VA grounds, with the Salvation Army and other groups. Documents also revealed a full complement of psychiatric services and programs are available to veterans with psychiatric illnesses. (Please see important contextual information on page 23 for additional information).

B. Testimony

Several individuals testified to this issue. Although all witnesses acknowledged there were fewer beds for inpatient Psychiatry, the reasons attributed to this were varied. Only one witness, an inpatient unit Psychiatrist, alleged that this was a purposeful action by management to eliminate all services for psychiatric patients. Other witnesses attributed the decrease of inpatient beds to the success of new medications for psychiatric disorders which have resulted in shorter inpatient stays for psychiatric patients. These witnesses testified that as a result, fewer inpatient beds have been needed. Witnesses also testified that new and aggressive out patient programs such as the MHICM (Mental Health Intensive Case Management) program have also helped to treat psychiatric patients in the community, which has averted the need for inpatient hospitalizations. Many of the witnesses also testified that the nursing shortage contributes, at times, to inpatient psychiatric beds not being available for new admissions.

Witnesses testified that nursing services must adjust their staffing to ensure that the required number of nursing personnel is available to safely care for patients on inpatient units. As a result, if nursing only has enough nursing staff to safely operate and care for 20 patients, a 24-bed unit may not be able to admit any new patients to the remaining 4 beds. Although nursing recruitment is an ongoing process, there may be times when there is not sufficient nursing staff to operate

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all psychiatric beds in a safe manner. This is an issue not only for Psychiatry but also for inpatient beds in Medicine, Surgery, etc.

At times when all the beds in operation are full, patients needing an inpatient bed may be transferred to another VA or fee-based to the private sector. However, this has occurred due to a shortage of nursing personnel who would safely staff a unit. Management is continuously recruiting for nursing staff and there has been no attempt to not recruit. Senior Management has also established a Work Group to review and make recommendations on ways to improve the flow of patients on inpatient units. This Work Group is a multidisciplinary group composed of staff from all mental health disciplines and co-chaired by two staff psychiatrists.

C. Information Provided by the Office of the General Counsel on VA's Interpretation of 38 U.S.C. § 1706(b)

The Whistleblowers raise a number of concerns regarding VHA's obligation, pursuant to 38 U.S.C. § 1706(b), to maintain its capacity to provide for specialized treatment and rehabilitative needs of disabled veterans, including veterans with mental illness. The Whistleblowers seem to suggest that by eliminating the psychiatric emergency service and providing care through the general ED, VA has violated the mandate of section 1706(b). The Whistleblowers suggest that section 1706(b) obligates VA to measure the maintenance of capacity at the unit or program level within each facility and that pursuant to this statute VHA is required to maintain the same distribution of resources to the same programs and units within each facility. Their disclosures suggest that if a VA facility had a specific clinical program or unit in place in 1996, section 1706(b) prohibits the Secretary from changing, consolidating, or otherwise altering the health care delivery system in place at the facility level.

The maintenance of capacity requirement in section 1706(b) is interpreted and harmonized in conjunction with other subsections of section 1706, as well as 38 U.S.C. Chapter 17 as a whole. Pursuant to 38 U.S.C. § 1710(a), the Secretary (and the Under Secretary for Health, who has delegated responsibility regarding most matters involving the Veterans Health Administration) is authorized to determine what medical care and services are needed. Further, section 1706(a) requires that the Secretary manage the provision of hospital care and medical services in a way that promotes cost-effective delivery of health care services in the most clinically appropriate setting. In other words, the plain language of the statute anticipates that VA's delivery of health care services will be dynamic and changing over time, and charges the Secretary to ensure that the delivery of care is as cost-effective as possible.

The interpretation suggested by the Whistleblowers does not recognize the Secretary's statutory discretion to determine what type of medical care and services are needed. The interpretation would also prohibit VHA from

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undertaking new initiatives and implementing health care delivery services in new and different clinically appropriate settings, as required by section 1706(a). Nothing in the statutory history associated with section 1706(b) indicates that Congress intended such a result in passing this provision. Further, the approach suggested by the Whistleblowers disregards the well-established rules of statutory construction requiring that a section of a statute be harmonized with other sections of the statute.

VA measures the capacity requirement of section 1706(b) in the aggregate and reports their findings to Congress on a yearly basis. Copies of these reports from fiscal years 2001, 2002, and 2003 are available upon request.

C. Findings

The documentary evidence and testimony demonstrates that the number of inpatient psychiatric beds has significantly decreased over the past ten years, and that the current bed capacity is 84.

The Board members found credible the evidence indicating that advances in the treatment of psychiatric patients have resulted in a need for less inpatient treatment and fewer inpatient beds/units.

The documentary evidence and testimony establish that when the inpatient beds are full or understaffed, patients are transferred to another VA facility or to private sector facilities. The Board members found credible the evidence that this has occurred, in part, because of nursing shortages, and that the facility has ongoing efforts to recruit additional nursing staff.

Senior management at the facility has undertaken efforts to address the flow of patients on inpatient psychiatric units by establishing a multidisciplinary Work Group, co-chaired by two staff psychiatrists, to review the bed flow issue to ensure the availability of beds when needed. Based on the evidence and testimony provided, the Board believes that improvements in the flow of patients will diminish or alleviate the "bed crisis."

The decrease in the number of inpatient psychiatric beds does not violate the requirements in 38 U.S.C. § 1706(b). VA's obligations under section 1706(b), and VA's performance regarding this statutory obligation, and discussed in detail in annual reports provided to Congress.

D. Recommendations

At our Exit Briefing, we recommended that the Work Group continue to review the flow of inpatients on the units. We recommended that Senior Management implement the recommendations of this group. Senior Management concurred with our recommendation.

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We recommend that the facility continue efforts to improve staffing on existing inpatient units.

II. ALLEGATIONS REGARDING THE MERGER OF THE SEPARATE PSYCHIATRIC EMERGENCY SERVICE WITH THE ED AND THE CREATION OF WARD 1 EAST

- *VA Management created a fictitious ward to warehouse psychiatric patients when no psychiatric beds are available.*
- *Due to the bed closings and the wait periods for receiving treatment, some mental health patients have left without receiving care.*
- *Closure of the psychiatric emergency service eliminated the distinctive elements of the emergency psychiatric care previously provided by VA.*
- *Maintaining patients in the ED violates California laws and regulations requiring that psychiatric patients admitted to a treatment facility be housed in separate units located away from medical patients.¹*

A. Documentary Evidence

During the course of the investigation, the Board reviewed documents from a Work Group which is still making improvements to the ED related to the merger of PES into the ED. These improvements and recommendations covered areas such as physical improvements, education of staff, need for additional staff, security presence, etc.

B. Testimony

We obtained testimony from many individuals concerning this allegation. We interviewed Senior Management, staff psychiatrists, PES nurses, ED staff, and mid-level supervisors. Testimony obtained described a long and rocky history of attempting to merge PES with the ED. The PES had been a very active service and had on average 800 visits per month prior to 2002. Testimony revealed that in 1998, the Medical Center Director (who has since retired) decided to merge the PES into the ED. Testimony revealed the Director believed there were two different levels of care being provided and only one level of care should be provided to all veterans. This Director mandated the merger. There is no evidence to suggest that any planning went into this merger. The result was that Psychiatric Residents from the UCLA School of Medicine refused to see patients

¹ The whistleblowers allege that maintaining psychiatric patients in the ED while ostensibly admitted to "Ward 1 East" violates various California laws and regulations requiring that psychiatric patients admitted to a treatment facility be housed in separate psychiatric units located away from other medical patients. In reviewing the allegations pertaining to Ward 1 East, the Board reviewed the issue according to applicable federal laws and standards, as the referenced laws and regulations of California do not apply to VA.

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in the merged ED citing "safety" concerns. After 2-3 days of the merger, the Director reversed his mandate and the PES again became a separate entity. It is important to note that the merger left a "bad taste" for the nursing staff in PES. Testimony revealed that the majority of nursing staff in PES were long-term employees of that department.

In 2002, the VA Greater Los Angeles Healthcare System received a special grant from VA Central Office to open what is called the Access Center. This Center is staffed by VA employees in Building 206 on the Bentwood Campus. It is a program that sees psychiatric patients who need urgent care (not emergency care). The Access Center provides comprehensive services to psychiatric patients and also has primary care providers who provide medical care to psychiatric patients. The Center has been recognized by VHA as a "Best Practice." Testimony also revealed that the Center is about one mile from the ED; regular shuttle bus service is available; and special transportation can also be arranged, if needed.

Once the Access Center became operational, the workload in PES began to decline. From an average of 800 visits per month, the workload decreased to 200 visits per month or 6 visits per day. In 2003, a new Nurse Supervisor began to monitor this decrease in workload. Her testimony revealed that she began to consider how to better utilize PES staff. The staffing in the PES had remained the same even with the decline in workload. Testimony revealed that when PES staff became aware of this the Nursing Supervisor's review of workload, they became convinced that the merger of PES into the ED would again occur. Testimony revealed that no plan was in place to merge the PES into the ED at that time. However, planning did begin during the summer/fall of 2003. Testimony revealed that the planning for the merger was disjointed and not coordinated. Nursing services began working toward a merger plan separate from any other group. The nursing group consisted of Nursing Supervisors from Psychiatry and Medicine and Surgery and also included the ED Nurse Manager. Another group had also begun working on the merger of PES into ED at the same time. This group consisted of representatives from several different disciplines. Testimony revealed that both groups worked on the merger and their membership consisted of mid-level supervisors. There was no representation on the group from the "front line staff".

Several issues began developing at the time. The nursing staff in PES began to look at other positions rather than be merged into ED. Testimony revealed that the PES staff was "demoralized" and that they were being labeled as "inefficient". In addition, one of the nurses in PES testified that the plan for the merger of PES into the ED would result in the PES nurses also caring for ED patients and that the ED nurses would also care for the psychiatric patients. The PES nurses did not want to care for Medical/Surgical patients even though education would have been provided to the PES nurses. As a result, testimony revealed that some of the PES nurses retired while others obtained new positions in the Medical

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Center. The Nursing group's plan was to have the PES nursing staff spend 30 days with the ED nursing staff after the merger to mentor the ED staff on how to care for the psychiatric patients.

At some point, the two groups planning the merger did begin to meet together although testimony does not reveal when that took place. In early 2004, so many nursing staff had left PES that management determined it would be unsafe to leave it open. As a result, the merger occurred in May 2004, before all planning was completed.

Testimony revealed that the new Work Group chaired by two staff psychiatrists is looking at issues in the ED on an ongoing basis. This group is composed of front line staff. The two psychiatrists who co-chair this group testified Senior Management has approved the recommendations they have made regarding the ED space and physical layout.

The other component of this allegation concerns the fictitious "Ward 1 East". All witnesses interviewed about this acknowledged this unit designation did exist. Testimony revealed that this designation was created prior to the merger of PES into the ED. "Ward 1 East" was created to "work around" the VA's computer system. VA uses CPRS (Computerized Patient Record System) for the ordering of medications, documentation of progress notes, etc. VA also utilizes the BCMA (Bar Code Medication Administration) program to document the administration of the correct medication given to the correct patient. Unfortunately both CPRS and BCMA can only be utilized for inpatients. These two programs have not been upgraded, as of this point, for usage with outpatients, including patients who are being treated in the ED. Testimony revealed that several years ago, the ED experienced difficulties in admitting patients to the Critical Care units due to the lack of a vacant bed. Since these patients were generally not stable enough to be transferred to another hospital, the ED was confronted with the problem of how to treat these patients in the ED until a Critical Care bed became available. The ED did not want to depend on paper records and as a result the "Ward 1 East" designation was developed. By creating this designation as a unit, the patient was officially admitted to the facility as an inpatient. Physicians could enter orders into the computer system, and nursing staff could administer medications through the BCMA program. This "work around" was implemented to ensure that the patients would receive quality care in the ED while waiting for a bed to become available.

Testimony revealed that while the system was not created as a designation for psychiatric patients, it was also used for psychiatric patients waiting for a bed once PES merged with the ED. Initially some psychiatric patients were held in the ED for an extended period of time. Although testimony varied with regard to how long patients remained in the ED, this practice was recognized as being problematic since these patients also needed milieu therapy that could only be available on a psychiatric unit. As a result, management did mandate that as

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soon as a patient was identified as in need of psychiatric admission, a bed was to be found. If none were available at the Greater Los Angeles VAMC, other VA medical centers and community hospitals would be contacted to arrange admission. This is still the current practice. Witnesses did not identify a written policy addressing this issue.

C. Findings

Although all parties involved were well meaning and had good intentions in their efforts, the merger of PES into the ED was poorly planned and lacked appropriate coordination. Senior Management was informed of the progress in planning for the merger, but assumed, incorrectly, that input was being received from front line staff on this process.

Due to the past history of a previous attempt at a merger, nursing staff in PES left in significant numbers. Management had not completed the planning of the merger before the lack of nurses in PES became a crisis and required premature closure of the PES. Although we found poor planning, we did not find any evidence that the current system is putting patients at risk.

The designation of "Ward 1 East" was created prior to the merger of the PES. The Board found credible the evidence that this "work around" was created to ensure that critical care patients in need of admission would receive quality care while waiting for an inpatient bed to become available.

The Board found credible evidence that when "Ward 1 East" was first used for psychiatric patients in the ED, patients were initially kept in the ED for extended periods of time. Management has subsequently mandated that patients in need of psychiatric admission must be admitted to a bed, or transferred to a non-VA facility.

After reviewing the testimony regarding the purpose of developing the Ward 1 East designation, the Board found that this was an appropriate mechanism to improve patient safety through utilization of the facility's computerized record and medication systems. Establishing the Ward 1 East designation for this purpose does not violate any Federal laws, rules or regulations. We recommend this "work around" be used at other VA facilities that experience temporary bed shortages.

Facility management has established a Work Group to evaluate issues involving psychiatric patients in the ED.

D. Recommendations

Although management at the facility has subsequently mandated that patients in need of psychiatric admission must be admitted to a bed, or transferred to a non-VA facility, the Board found no written policy addressing this practice. The Board recommends that the facility develop a written policy on this issue. We also

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recommend that the Work Group be tasked to monitor and follow-up on this issue.

At our exit meeting with Senior Management, the Board recommended that mid-level supervisors receive training in strategic planning.

The Board recommended that front line staff always be included in the planning process to ensure comprehensive planning, and that every effort be made to improve communications with all parties involved in future program changes. We recommended that the Work Group that has already been established continue its work to evaluate issues involving psychiatric patients in the ED. Senior Management accepted our recommendations.

The Board was unable to locate any specific evidence pertaining to the anecdotal incidents where psychiatric patients left the ED because of long wait times. In order to ensure that incidents of this nature are identified and fully investigated by the facility, we recommend that ED and Access Center Staff be reminded of VHA's existing policies on reviewing and investigating allegations of improper or substandard care, and encouraged to report any incidents where the care provided to a patient appears improper or substandard.

III. ALLEGATIONS REGARDING THE STANDARD OF MEDICAL CARE PROVIDED TO PSYCHIATRIC PATIENTS EVALUATED AND TREATED IN THE ED

- *Mentally ill patients treated in the ED receive substandard psychiatric care. The ED is not properly staffed or equipped to diagnose and treat mentally ill patients. A whistleblower provided an anecdotal story to demonstrate this issue.*
- *ED personnel are not adequately trained to care for psychiatric patients. Care is provided by resident psychiatrists who rotate through the ED while continuing full-time responsibilities in other parts of the VA psychiatric system.*
- *Mentally ill patients receive inadequate medical clearance from ED medical staff. The whistleblowers provide several anecdotal stories to demonstrate this issue.*

A. Documentary Evidence

The training records of ED staff were provided to us and reviewed. Patient Incident reports pertaining to the allegations were also provided and reviewed. We also conducted a tour of the ED to see the configuration of that area. The Board also reviewed Incident Reports from the ED.

B. Testimony

Testimony revealed that plans were developed to train ED staff in the diagnosis, treatment, and management of psychiatric patients. An outside consultant was hired to provide education to nursing personnel on the psychiatric care. All ED staff were required to attend the training that was developed through this

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process, which included training on how to manage assaultive and aggressive patients. One of the planning groups also developed and produced a videotape for ED staff on common problems encountered when dealing with psychiatric patients. We also interviewed a random sample of ED staff (nurse, nursing assistant and medical clerk). All of these staff members described their training and all described appropriate intervention for working with psychiatric patients. The ED Nurse Manger testified that he is in the process of having all ED nurses complete a course that would result in the nurses becoming a Certified Emergency Nurse. This course has several modules that focus on trauma, triage, and psychiatric management. Several staff has attended this Certification and all nurses in the ED will have to attain Certification.

Some psychiatric care in the ED is provided by a psychiatrist who works half days in the department. A recent addition to the ED staff is a Nurse Practitioner who has extensive experience working in psychiatric emergency rooms. This individual was nearing completion of his VA orientation and would be assigned full-time to the ED once his orientation was complete.

Psychiatric residents provide services during off hours to the ED. The same practice is used with Medical residents and Surgery residents. Testimony also revealed that psychiatric residents provided off-hour services to the PES before the merger. One psychiatrist testified that he was developing a training experience where all psychiatric residents would have a rotation in the ED. This psychiatrist testified that his training was being developed with input from current residents and with the participation of the Medical School.

Prior to the merger of PES with the ED, medical clearances for psychiatry admissions were performed by two physician assistants. This practice has continued since the merger of PES into the ED. An attending physician reviews the work of the physician assistants.

The Board investigated the anecdotal incidents reported by the whistleblowers by reviewing incident reports from the ED. One of the anecdotal incidents cited by the Whistleblowers alleged that a lung nodule which was lung cancer was not identified by the ED staff. The Board was unable to locate any evidence pertaining to this incident.

One incident described by the whistleblowers concerned a female veteran who attempted to strangle herself after another patient made sexual advances to her in the ED. We did review this incident report and the report revealed the male patient exposed himself to the female patient. The nursing staff in the ED did intervene and separated the two patients. One nursing staff member was then assigned to observe the female patient. This observation meant the nursing staff was to remain within arms length of the patient and this was done. While the female patient was being observed, she did attempt to tie a sheet or towel around her neck. The nursing staff member immediately intervened.

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The Board also reviewed the incident report concerning a patient with gangrene. This incident was thoroughly reviewed by VA staff. The evidence indicated that a veteran presented to the ED and told the triage nurse he had a blister on his foot. The triage nurse believed a blister was not an emergency and referred the veteran to the Access Center. The veteran did go to the Access Center and when the veteran's leg was examined, it was apparent the veteran had gangrene and not just a blister. The veteran was returned to the ED and admitted to the hospital for further treatment.

In our tour of the ED, we did see that the areas for psychiatric patients and for medical patients are separate. Several physical improvements have been made over the past year to improve the area for psychiatry patients, including privacy improvements. Testimony from two psychiatrists who co-chair the Work Group to improve care in the ED revealed that all recommended physical improvements presented to Senior Management were approved. This Work Group is an ongoing group and they will continue to monitor these areas for further improvements.

C. Findings

The Board found that psychiatric residents provide services during off hours to the ED. This is not unusual. This is the same practice that is used with Medical residents and Surgery residents.

The Board found the ED to be adequately staffed. The psychiatrist who works half days in the ED is competent and qualified, and provides quality care to patients in the ED. The anticipated addition of the Nurse Practitioner will further improve staffing.

Based on the testimony and documentary evidence reviewed, the Board concluded that ED personnel have and continue to receive training in psychiatric care.

After reviewing the evidence pertaining to the female patient who attempted suicide, the Board concluded that the situation was appropriately handled. After reviewing the evidence pertaining to the patient who presented with gangrene, the Board concluded that this situation was appropriately handled. We were unable to locate the anecdotal incident pertaining to lung cancer.

Based on the testimony, the Board found that the procedure to medically clear psychiatric patients was the same process that had been in place prior to PES merging with ED. (Physician Assistants)

In our tour of the ED, we did not find any scissors or other items that a patient could harm themselves. We did note that physical improvements had been

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made and several other improvements were in the process. These improvements came about through the recommendations of the Work Group that reviews ED care to psychiatric patients.

We found no evidence to substantiate a finding that psychiatric patients treated in the ED generally receive substandard care.

D. Recommendations

In our exit interview with Senior Management, we recommended they continue to encourage and support the work group that is reviewing the care provided to psychiatric patients in the ED. Senior Management concurred with this recommendation.

The Board was unable to locate any specific evidence pertaining to the anecdotal incident where lung cancer was undiagnosed in a veteran. As noted in an earlier recommendation, ED and Access Center staff should be reminded of VHA's existing policies on reviewing and investigating allegations of improper or substandard care. We recommend that facility management encourage employees to report any incidents where the care provided to a patient appears improper or substandard in order to ensure that allegations of this nature are identified and fully investigated by the facility.

IV. ALLEGATIONS REGARDING THE STANDARD OF MEDICAL CARE PROVIDED TO PSYCHIATRIC PATIENTS EVALUATED AND TREATED IN THE ACCESS CENTER

- *Mentally ill patients are referred to the Access Center, a separate outpatient facility, to address the bed crisis and lengthy wait periods in the ED.*
- *Psychiatric patients are inappropriately referred to the Access Center .*
- *The Access Center is poorly staffed and lacks properly trained personnel.*
- *A whistleblower provided an anecdotal story regarding a patient referred to the Access Center who subsequently attempted suicide and injured a staff member who attempted to intervene.*

A. On-Site Visit

We visited the Access Center and had a tour of their intake area, mental health clinic, and primary care area.

B. Testimony

The Access Center is a VA program and staffed by VA employees. Testimony revealed that the Access Center opened in 2002 and was funded by a grant from Mental Health in VA Central Office. The purpose and mission of the Access Center is to provide urgent care to psychiatric patients and to enroll them in

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specific programs to meet their needs. Testimony revealed that the Center is very well staffed with Mental Health clinicians and Primary Care providers. Testimony also revealed that the psychiatrist in the Access Center triage area is the same psychiatrist who had worked in PES for many years. Several nurses and nursing assistants worked at the Access Center also came from PES. (NOTE: Additional testimony pertaining to the creation of the Access Center is discussed in the "Testimony" section of Paragraph II, entitled "Allegations regarding the merger of the separate psychiatric emergency service with the ED and the creation of Ward 1 East").

When the Center staff was questioned regarding the ED referring inappropriate cases to the Access Center their response was that such incidents were few and far between. In addition, the Center staff indicated that they have had no difficulty in returning inappropriate case to the ED. The Access Center staff indicated that communications with the ED are very good and are collegial in nature. The Access Center has transportation available if the need arises to return a veteran to the ED.

The Access Center has been recognized as a VA "Best Practices" at a Mental Health Conference held in Phoenix in September 2005.

C. Findings

The Board found credible the evidence showing that the Access Center provides comprehensive urgent care services to veterans through the Triage Center, Mental Health Clinic, and Primary Care Clinics. Staffing is adequate and the staff have sufficient training. This Center's staff is very clear in their mission of providing urgent care and that the ED provides emergency care.

We reviewed Incident Reports and questioned witnesses but were unable to identify a specific incident involving the anecdotal story regarding the attempted suicide and subsequent attempt to injure an employee at the Access Center.

D. Recommendations

The Board made no substantive recommendations to Senior Management concerning these allegations. We did encourage Senior Management to make aesthetic improvements (painting, new carpeting, new furniture, etc.) to the Access Center.

V. ALLEGATIONS REGARDING THE FACILITY'S MANAGEMENT OF LONG-TERM CARE CONTRACTS

- *VA wastes long-term care funds because of poor procedures for placing and maintaining mentally ill patients in long-term care facilities. Lack of adequate procedures extends the need for costly inpatient care.*

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- *VA contacts only one long-term care facility at a time when seeking placement for a patient and provides unnecessary information to long-term care facilities, making it difficult to find placement for these patients.*
- *VA fails to appropriately extend long-term care contracts, thereby inappropriately releasing patients from VA care and making it difficult to stabilize patients.*

A. Documentary Evidence

We were provided with spreadsheets of all psychiatric patients admitted to the Institute of Mental Disorders (IMD) in the past year. This document reflected when the veteran was admitted to the IMD, if the veteran was readmitted to VA, if the contract for payment was extended, and the length of the contract.

B. Testimony

Testimony revealed that IMD's are locked psychiatric nursing homes. Each IMD general has a different patient population. For example, one IMD may specialize in the treatment of fire-setters, another focuses on chronically assaultive patients, etc.

The VA staff person who had been coordinating this program testified as to the policies and procedures for placing veterans in an IMD. Once a referral is made, Social Work staff will contact the IMD and provide them with two weeks work of progress notes. The State of California mandates that IMD review two weeks' worth of progress notes to determine if a patient is stable and appropriate for placement. In some circumstances VA staff will contact more than one IMD at a time; however, depending on the type of care required, it is not always feasible to make multiple inquiries.

Testimony addressed the importance of providing accurate information to the IMD. At times when incomplete information has been sent to the IMD, it has resulted in the decision to refuse admission of the referred veteran.

A VA staff member testified that if an extension of the contract is needed, he presents this to the Associate Chief of Staff (ACOS), who makes the final determination. The ACOS testified that when he is presented with a request to extend a contract, he contacts the IMD to see what further treatment the veteran needs. He also then contacts the veteran's VA psychiatrist to see if this is appropriate. Testimony and review of the documentary evidence revealed that extensions are consistently approved. There has been no change in policy concerning the length of contracts for years.

C. Findings

The Board found credible the testimony that policies and procedures are in place to manage placement in long-term care facilities.

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The Board found credible the testimony and evidence indicating that contracts are routinely extended when determined to be medically necessary.

The Board found credible the evidence that the program provides appropriate and necessary information to prospective long-term care facilities. Providing inaccurate or incomplete information could jeopardize the safety of the VA patient, the staff, and other patients at the IMD.

None of the allegations concerning the management of long-term contracts were substantiated.

D. Recommendations

We made no recommendations to Senior Management in this area.

OTHER CONTEXTUAL INFORMATION

Over the past 20 years, significant advances have been made in the treatment of psychiatric patients. There has been development of new medications to treat the most severely mentally ill, as well as advances in community psychiatry treatment programs. As a result of these advances, more patients are recovering and needing fewer hospitalizations. Across the country, in both VA and community, psychiatric hospitals have closed or have decreased their beds. The emphasis within Psychiatry has shifted from an inpatient model to an outpatient model. The days of the asylum and the days of institutionalization are over and the mental health community is now focused on a recovery model. This is important to this investigation since the Whistleblowers allege indiscriminate closure of psychiatric beds/units. This Board did receive information that Los Angeles County has also decreased the number of psychiatric beds. In addition, many private hospitals across the country have closed their inpatient psychiatry units.

Hospitals across the country have also moved to either consolidating their psychiatric emergency rooms into the emergency department or have closed their psychiatric emergency rooms completely. This has been done due to the drop in workload for psychiatric emergency rooms which is a result of the advances in Psychiatry as described above. Unfortunately, some community hospitals have closed their psychiatric emergency room due to the low insurance reimbursement received. We believe that the drop in workload in PES is due to the advances in Psychiatry care was the reason PES was merged with the ED.

VIOLATIONS OR APPARENT VIOLATIONS OF LAW, RULE OR REGULATIONS

None

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CONCLUSIONS AND RECOMMENDATIONS

The Board found poor planning and poor communications related to the merger of PES into the ED. When the planning was taking place, many of the major positions involved in the process were vacant and occupied by staff in an "Acting" capacity, including the positions of Chief of Psychiatry and Chief of Mental Health services. In addition, the Nurse Manager of the ED was detailed/activated for service in Iraq. This Nurse Manager had extensive experience in psychiatric as well as general emergency room management. His departure created a large void in the leadership doing the planning process. These positions are now filled.

Specific recommendations were made to management at our exit interview. We recommended that Senior Management continue to have the multidisciplinary Work Group, co-chaired by two staff psychiatrists, monitor the bed flow issue to ensure the availability of inpatient psychiatric beds, and to diminish or alleviate such shortages in the future. We recommended that Senior Management continue to have the Work Group review the care provided to psychiatric patients in the ED. We recommended mid-level supervisors receive training in strategic planning, and that front line staff be included in any future planning of this nature. We also recommend that Senior Management request a site visit from Mental Health in VA Central Office to review the organizational structure of Psychiatry and Mental Health services. Senior Management has agreed to these recommendations.

We also make the following additional recommendations:

- The facility should continue efforts to recruit nursing staff to ensure that all available inpatient beds are fully staffed.
- Management has mandated that rather than designate psychiatric patients as admitted to Ward 1 East, patients in need of psychiatric admission must be admitted to a bed or transferred to a non-VA facility. The Board recommends that the facility develop a written policy on this issue. We also recommend that the Work Group monitor and follow-up on this issue.
- The Board found that the ED was adequately staffed, ED personnel have received training regarding psychiatric patients, and additional training of ED staff is planned. The Board recommends that the Work Group continue to monitor these issues to ensure that future training takes place and staffing remains adequate.
- The Board recommends that ED and Access Center staff be advised of existing policies and procedures for reviewing adverse events or incidents involving substandard care in order to ensure that future allegations are fully reviewed and documented.

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After the on-site investigation was completed, the Chair of the Board of Investigation received an Outlook (email) message from one of the witnesses who provided testimony. This psychiatrist accused the Chair of being prejudiced and that the Board had already decided the issues before the Board arrived. This witness also submitted numerous pages of Outlook messages he believed would better substantiate the allegations made by the Whistleblowers. The Chair of the Board of Investigation read all of the material submitted by this witness. There were no new issues that arose which had not been covered during the on-site investigation. The material did reflect poor communication which was identified as an issue during the investigation.

There is one final concern the Board would like to make. Our impression of one of the witnesses, who is a psychiatrist, is that he may be impaired. This individual had previously been suspended for two weeks after making a bomb threat to VA management. In our exit interview, we shared our concerns with the Senior Management and urged them to evaluate and determine if this physician is fit to practice.

U.S. OFFICE OF
SPECIAL COUNSEL
WASHINGTON, D.C.

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November 15, 2005

Mathew C. Glover, Esq.
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Re: OSC File No. DI-04-2859

Dear Mr. Glover:

I received your letter of November 9th, as well as the letter from VA Undersecretary for Health and the report of the Board of Investigation. First of all, I want to thank you for your efforts in this matter; I truly believe that OSC has helped move things at the VA West Los Angeles in a positive direction by setting up external review by the Dept. of Veterans Affairs. I do have some comments, which I would like to forward to you in response to the findings of the Board, and these comments may be made public if the comments would remain anonymous:

I agree with the Board's findings that:

- "Planning for the merger was disjointed and not coordinated."
- "The merger of PES into the ED was poorly planned and lacked appropriate coordination."
- "Senior management was informed of the progress in planning for the merger, but assumed, incorrectly, that input was being received from front line staff on this process."
- "The Board found poor planning and poor communications related to the merger of PES into the ED. When planning was taking place, many of the major positions involved in the process were vacant and occupied by staff in an 'Acting' capacity, including the positions of Chief of Psychiatry and Chief of Mental Health Services."

My question is: where is the accountability for this debacle? Yes, the situation, by the time the Board of Investigation site-visited one year and three months following the poorly planned and executed merger, was much better than the chaos, substandard care, and poor morale that immediately followed the merger. However, the distress of staff and patients, and overall waste and short-changing of the veterans seeking psychiatric services

did indeed occur for quite a long time, with inaction by mid-level supervisors and Senior Management. The "Work Group" alluded to by the Board several times, was spontaneously created by front line staff driven to take action in the face of inaction on the part of mid-level supervisors and Senior Management.

Senior management apparently gets to claim ignorance over the brewing disaster until it was hatched. The mid-level managers suffer no consequences for their lack of leadership and lack of common sense. The Chief of Mental Health Services has since retired, however the psychiatrist who served in the role of Acting Chief of Psychiatry, and who played a huge role as the point person for Psychiatry in the execution of the disaster (and who excluded the participation of front line psychiatrists), has actually been rewarded by being made Associate Chief of Psychiatry and Mental Health, a promotion which was approved by Senior Management. Mr. Brown, at FEMA, might have been rewarded following Hurricane Katrina, had he been fortunate enough to be working at the West Los Angeles VA. Thank goodness that collectively, there was enough awareness and responsibility taken by front line staff to confront and address the chaos that had been created. The site visit by the Board undoubtedly greased the wheels for Senior Management to approve necessary physical and staffing suggestions made by the Work Group. However, the findings that one year and three months later, by the grace of God, no one had died or been seriously injured and that a healthier process was already underway, greatly minimizes and downplays the damage to moral and the substandard care given to veterans following the merger of psychiatric emergency services with the ED during a rather long period of time. And apparently, there is no accountability necessary for such architects of the disaster as the Acting Chief of Psychiatry or Senior Management.

Regarding the Board's finding regarding the very significant downsizing of hospital beds for veterans with psychiatric problems: the Board seemed to miss the fact that over the period of time that the downsizing took place, there was a major reduction in spending on mental health by the Greater Los Angeles Healthcare System. Indeed, the amount of money in the overall budget spent on mental health declined from approximately 33 cents of every budget dollar to only approximately 20 cents of every budget dollar. This would seem to be an obvious reduction in spending on mental health services at the Medical Center. In my opinion, there is not a reasonable substitute for professional mental health services in the arrangements made for the Salvation Army and other non-professional organizations to take over responsibility for the complex needs of our mentally ill veterans. One example is the substantial elimination of professional treatment services for alcohol and drug problems by the VA and outsourcing to non-professional, non-medical entities.