[redacted]

Subject: Whistleblower's comments on the Agency's report that is produced in response to the OSC's referral of my disclosure in the following cases: OSC File Nos. DI-21-000470 and DI-21-000503.

June 11, 2023

Please note the following:

1. The responses of the CTVHCS to the Agency are incorrect, misleading, and improper. Certainly, the Agency would do much better in the service of our Veterans if they would monitor and scrutinize their counterproductive leadership at the CTVHCS.

2. The frontline providers at the CTVHCS Pain Clinic blew the whistle on the poor performance and misconduct of senior leadership at the CTVHCS for the sake and benefit of our Veterans only. These frontline providers had nothing to gain but suffering, legal expenses, abuse, intimidation, and reprisal for their Whistleblowing Activity.

3. The Agency employs many lawyers in the Office of the General Counsel to defend a few inept and counterproductive leaders, rather than to work in the service of our Veterans and in support of the frontline providers caring for them.

4. Evidence as presented in the attached “Access of Care” document below, point to a Chief of Staff who is impairing pain management access of care to our Veterans, thus sending many referrals to community care pain management. The misconduct and poor performance of the COS is compounded with a complacent director who does not seem to care or to know how to manage. This was the main subject for the whistleblowing activities by the Chief of Pain Management at the CTVHCS in 2020-2022, that resulted in these disclosures and investigations by the OSC.

5. Instead of solving the problems and addressing the concerns that were disclosed by this whistleblower, the response of the counterproductive management at the CTVHCS to the allegations was to detail/remove the whistleblower from his position as the Chief of Pain Management on November 23, 2022, and replace him with the Chief of Anesthesia Service who is not educated, not trained, not certified, and not even credentialed to practice pain management at the CTVHCS.

6. The other responses by the Agency are untrue and misleading:

7. The “*the high rate of community referrals from the pain management clinic*,” is well explained in the “Access of Care” document and its exhibits that follow this statement. Evidence is presented that incriminates the counterproductive and unsupportive Chief of Staff (COS) in impairing access to care at the pain management clinics, and not the providers at the Pain Management Section, who are scapegoated by the COS.

8. The ”*lack of sharing the radiofrequency ablation (RFA) equipment*,” is an untrue and fake statement. Please note the following and the exhibit to follow:
    a. There are two RFA Units, one at the Temple Pain Clinic and the other one at the Austin Pain Clinic.
    b. Throughout my tenure as Chief of Pain Management and until November 23, 2022, when I was detailed from this position, sharing was always the case.

Whenever a machine broke down at one location, we transferred the other machine back and forth to the needed location on a daily basis.

c. If the machine broke down and the other machine was not called for on that day, it was because the machine was not needed, or the provider decided not to use it. I am not aware of any patient who was sent to community care because of RFA machine shortage.

d. A new RFA machine and probes were requested when our RFA machine in Temple became outdated and we could not find suitable grounding pads to fit. As efficient as the system is, it took several months to obtain this to the pain clinic in Temple. Then, the machine arrived but without the probes. We were told that the probes were lost somewhere at the VA/SPD. Following an exhaustive search, we had to wait several more months to get a new set of probes. This is a system shortcoming that is not related to the providers at the pain clinic.

e. In effect, there was never a problem in sharing the RFA machines unless the specific provider chose not to request the transfer.

f. See exhibit below: “Evidence of Sharing the RFA Machine between Temple and Austin Pain Clinics.”

9. In conclusion, the increased referral to community care pain providers was never due to the RFA machine that was always readily available whenever needed if a provider asked for it, but was because of a counterproductive COS who has persistently obstructed hiring staff to support the Pain Clinic. Please see the evidence presented below in the “Access to Care” document with exhibits.

Sincerely,

[redacted]

Evidence of Sharing the RFA Machine between Temple and Austin Pain Clinics.

[redacted]

From: [redacted]
Sent: Thursday, January 24, 2019 2:53 PM
To: [redacted].
Cc: [redacted].
Subject: RE: RFA machine 2/21/19 to Austin

Thank you all

From: [redacted].
Sent: Thursday, January 24, 2019 9:41 AM
To: [redacted]
[redacted]>
Cc: [redacted]
Subject: RE: RFA machine 2/21/19 to Austin

Much appreciated everyone!

From: [redacted]
Sent: Thursday, January 24, 2019 8:24 AM
To: [redacted]>
Cc: [redacted]
Subject: RE: RFA machine 2/21/19 to Austin

[redacted]
Thank you! I will make arrangements with SPS to have it delivered to Austin on this date.

Ms. [redacted] and Ms. [redacted]
In February, we will have RFA cases on 3 Thursdays, 2/14, 2/21, and 2/28. 2/21 will be the day we will reschedule the RFA patients from the C-arm issues today.

Thank you all for your assistance.

[redacted], RN, BSN
[redacted]

[redacted]
Sent: Thursday, January 24, 2019 8:19 AM
To: [redacted]>
Cc: [redacted]
[redacted]

Subject: RE: RFA machine 2/21/19 to Austin
Importance: High

Ms. [redacted] and Mr. [redacted]

Kindly, delver the RFA Machine to Austin on the date requested by Dr. [redacted] below.

Thanks,
[redacted]

From: [redacted]
Sent: Wednesday, January 23, 2019 3:58 PM
To: [redacted]
[redacted]>
Cc: [redacted]v>
Subject: RE: RFA machine 2/21/19 to Austin

RFA Machine has been ordered and I don't have a delivery date but should be soon. As for the transferring of the RFA Machine to Austin on 2/21/2019, you need to email [redacted] or [redacted] to schedule.

From: [redacted]
Sent: Wednesday, January 23, 2019 3:51 PM
To: [redacted]v>
Cc: [redacted]
Subject: RE: RFA machine 2/21/19 to Austin

[redacted]

From: Shehadi, Raja E.
Sent: Wednesday, January 23, 2019 3:46 PM
To: [redacted]
Cc: [redacted]>
Subject: RFA machine 2/21/19 to Austin
Importance: High

Sure Dr. [redacted] anytime you need it. I shall forward to Mr. [redacted] for action on this matter. He knows who to contact for this purpose.

Mr. [redacted] kindly send the RFA machine to Austin as requested by Dr. [redacted] Please update us as to the new machine that is promised to Austin.

Regards,
[redacted]

From: [redacted]
Sent: Wednesday, January 23, 2019 2:56 PM
[redacted]
[redacted]

Hi [redacted]

Hope you're well!

Would it be possible to request the RFA machine in Austin also on Thursday 2/21/19 for patient cases?

THANKS

20221028_LETTER TO [redacted] ACCESS TO CARE+EXHIBITS

[redacted] [redacted] M.D.
Chief Anesthesia Service
CTVHCS, Temple, Texas

October 28, 2022

Response of Dr. [redacted] [redacted] M.D., Chief of the Pain management Section, CTVHCS.
Re: Wait Times at the CTVHCS Pain Management Clinics

Dear Dr. [redacted]

1. Thank you for inquiry about the wait times for new consultations to be seen at the CVHCS Pain Clinics. Regarding your comment, "*you and your staff deciding to maintain your block schedules and appointment lengths*," please note that appointment times at the pain clinic is not driven by wait times, but rather by VHA recommendations AS PER "VHA Bookable Hours and Appointment Length Standards," and by the quality of care that we render to our Veterans.

2. Reviewing the information at the link that you referred to me on August 17, 2022, for VHA Bookable Hours and Appointment Length Standards, I responded to you by email on the same day indicating that "*I did not find any mention of "Pain" or stop code 420. The closest I found was 201) PM&RS Physician: New Patient 60 minutes; Established Patient 30-60 minutes. That is not including opioid management. Once you include opioid management, we get into the realm of OUD/dependance. Here our work is comparable to Mental Health. Here the times are 60-90 minutes. With this said, I assure you that my colleagues and I are open for any change that will improve Veteran accessibility to our clinics. We are all for the service of our Veterans. I am looking forward for your suggestions and input on the matter. Please send me more information on the matter if you have any*." (Exhibit A)

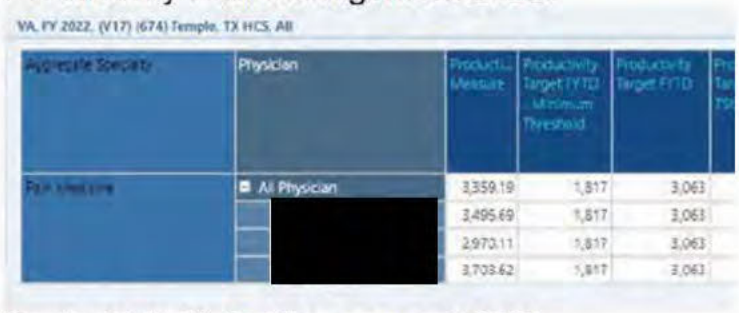
3. Therefore, the Pain Management Section and its providers are and have always been compliant with the VHA "Bookable Hours and Appointment Lengths" that is due for application by November 30, 2022. Please let me know if you see otherwise. Until to date the Pain Management Section has not rejected any changes that you have suggested that were in compliance with VHA directives and notices.

4. Additionally, we overbook our pain management clinics whenever we see fit for our Veterans and our staff, without having to stress our staff or compromise our care to our Veterans.

5. There are three interventional pain management providers in the Pain Management Section (PMS). This number of providers has not increased since about 2014 and until to date, while the number of Veterans at the CTVHCS has significantly increased and more satellite OPCs were established for the CTVHCS. The COS has consistently opposed and blocked the hiring of additional providers to the Pain Management Section to meet the growing needs of our Veterans. This has resulted in increased wait times for new consultations, decrease access to the Pain Management clinics, and increased referral to community care pain management providers.

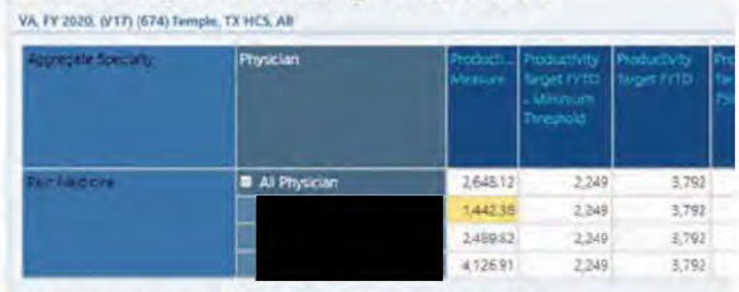
6. Increased wait times does not imply that the pain management providers are sitting, wasting their time, and doing nothing about it, so that we can increase the workload on them, squeeze more patients into their already packed clinic schedules, and solve the wait time problem. The facts point to exactly the opposite. Per the table below taken from Pyramid Analytics, the three providers at the pain management section have been and are still quite active and productive. They have exceeded the VHA set target productivity goals for the Pain Management Section for 2019, 2020, 2021, and 2022 as of September 7, 2022, with the exception of 2020, because of the enforced clinic closures due to COVID-19.

Productivity Pain Management 2022:



Productivity Pain Management 2021:

Productivity Pain Management 2020:



Productivity Pain Management 2019:

7. Consider the Specialty Productivity - Access Report and Quadrant Tool (SPARQ) data below. Please look at the plots and note that the problem is not that of productivity because the pain management section exceeded the target that was set forth by the VHA. The problem is that of Access or Wait Times for new consultations to the pain management clinics.

8. The problem of reduced access to the Pain Management Clinics at the CTVHCS is that of medical leadership, the COS, Dr. [redacted] [redacted] here are the reasons why:

    a. There have been three pain management providers at the CTVHCS since 2014 and until to date. This is despite the increase in Veteran population in Central Texas, and the fact that the CTVHCS has established additional OPCs in the area. <u>Pain Management has repeatedly submitted ERCs to hire additional providers and support staff, all of which have been repeatedly and consistently rejected by the COS</u>.

b. Dr. [redacted] rejected multiple ERC requests to hire staff to meet the growing demands of pain management in 2018 (Exhibits B & C), 2019 (Exhibit D), and 2021 (ERCs written by Dr. [redacted] and Dr. [redacted] and submitted by Dr. [redacted] to Dr. [redacted] Read the reason for hiring additional staff on page 2 of each of the attached ERCs from 2018 and 2019. As of to date the same reasons are still true. It is specifically stated that the reason is to meet the growing demands of our Veterans and to reduce referral to community care pain management by increasing access to our pain clinic services.

c. Additionally, the COS cancelled the Pain Management Nurse Practitioner's (NP) position after our NP transferred to work at the DoD in [redacted] in August 2018. Also, Dr. [redacted] obstructed us from hiring RNs and other personnel to help us out at the Pain Management Suite.

d. Even when funding for hiring a pain management provider was supplied by VISN-17 in 2022, Dr. [redacted] repeatedly refused hiring a pain management provider and advocated for sending patients to Community Care pain management providers. (Exhibits F & G)

e. Effectively the actions of the COS tied our hands at the pain management section, reduced access of our Veterans to the pain clinic services, increased community care referrals to pain management, and set us and our Veterans up for failure.

f. <u>Therefore, the decreased access to our pain clinics, the increased wait times, and the increased referrals to Community Care Pain Management is due to the failure of the COS who obstructed every effort we put to hire more personnel to meet the demand of a growing population of Veterans in the area. This is not the failure of the Chief of the Pain Management</u>

Section. The evidence presented above proves proper productivity by the pain management section providers but decreased access to the pain management clinics is due to insufficient pain management providers and that is because the COS blocked all our efforts to hire additional providers.

9. The CARA Mandated Pain Management Team (PMT) was established and chaired by Dr. [redacted] the Chief of the Pain Management Section in 2017 and conducted a successful clinic in 2018, 2019, and 2020, with 100% clinic utilization. Data reviews indicated that 50% of patients on large dose opioids were completely off opioids and the other 50% of patients on chronic opioid management were placed on safer doses of opioids. In October 2020, the COS replaced the Dr. [redacted] by Dr. [redacted] as the chair of the PMT. Under Dr. [redacted] the PMT clinic had 0% utilization in 2021 and was a total waste of resources with absolutely no productivity. Until to date the PMT at the CTVHCS is not only nonfunctional but also nonexistent. I quote the following tables from a recent "PMOP Gap Analysis Summary Report: VISN 17" from May 2022, (Exhibit E):

Pain Management Teams

	Does your facility have a PMT?	For how long?	Main service line
(504) Amarillo VA	No	-	-
(519) West Texas VA	No	-	-
(549) Dallas VA	Partially staffed	> 5 years	Anesthesiology
(671) South Texas- San Antonio	Fully staffed	2 to 5 years	PM&R
(674) Central Texas	No	-	-
(740) Texas Valley Coastal Bend	Partially staffed	1 to 5 years	Pain Medicine
(756) El Paso	Partially staffed	2 to 5 years	Surgery

PMT Staffing

	Medical Provider with Pain Expertise				Provider with Addiction Expertise				Provider with Behavioral Medicine Expertise			Provider with Rehabilitation Expertise		
	Yes/ no	Head count	Hours/ week	# X-wav	Yes/ no	Head count	Hours/ week	# X-wav	Yes/ no	Head count	Hours/ week	Yes/ no	Head count	Hours/ week
(504) Amarillo VA														
(519) West Texas VA														
(549) Dallas VA	Yes	1	1 to 4	1	No	-	-	-	Yes	1	17 to 40	Yes	1	17 to 40
(671) San Antonio	Yes	8	>160	2	Yes	6	41 to 80	2	Yes	2	41 to 80	Yes	3	41 to 80
(674) Central Texas														
(740) TX Coastal Bend	Yes	2	1 to 4	1	Yes	1	9 to 16	1	Yes	1	17 to 40	Yes	1	1 to 4
(756) El Paso	Yes	BLANK	BLANK	3	Yes	3	1 to 4	3	Yes	2	1 to 4	No	-	-

Barriers to PMT Implementation

	Staff Recruit	Staff Retain	Team Integration	Team engagement	Unfilled positions	Insufficient Resources	Primary care collaboration	Protected Time	COVID-19	Other
(504) Amarillo VA	X	X	X		X	X		X		Not implemented as a full team, tasks are divided
(519) West Texas VA	X	X	X		X			X		
(549) Dallas VA	X	X				X		X		
(671) San Antonio	X							X		
(674) Central Texas			X	X			X	X		Support of medical leadership
(740) TX Coastal Bend	X									
(756) El Paso	X	X								

a. As you can see that the CTVHCS has no Pain Management Team, has no experts working at the PMT clinic, and the reason for this as indicated in the report is the lack of "Support of Medical Leadership." Contrast this with a fully established and a fully functional PMT at the CTVHCS since 2017, under the leadership of Dr. [redacted]

10. The current hiring of support staff to the Pain Management Clinics was not an initiative by the COS at the CTVHCS but was rather a reaction by Dr. [redacted] in compliance with the report of the OMI investigation that was conducted in August 2021, upon the request of members of the Pain Management Section who called for this investigation.

11. I am hoping that my response is satisfactory to you. Please let me know if you need any further information.

Sincerely,

[redacted] MD
Email 2: [redacted]va.gov

ATTACHMENTS:

1. EXHIBIT A_20220817_TO [redacted] VHA Bookable Hours and Appointment Length Standards
2. EXHIBIT B_20180117_ERC Staffing Request-PAIN MGMT_REJECTED by COS
3. EXHIBIT C_20180607_ERC Staffing Request-PAIN MGMT_REJECTED by COS
4. EXHIBIT D_20190307_ERC Staffing Request-PAIN MGMT_REJECTED by COS
5. EXHIBIT E_MOP Gap Analysis Summary Report VISN 17
6. EXHIBIT F_20220220A_DR. [redacted] PATIENTS_Redacted
7. EXHIBIT G_20220220B_I can take OUD_Pain w_Suboxone_Redacted

++

[redacted]gmail.com

From: [redacted] E.
Sent: Wednesday, August 17, 2022 3:18 PM
To: [redacted]
Cc: [redacted] E.
Subject: RE: VHA Bookable Hours and Appointment Length Standards

Hello Dr. [redacted]

I did not see any attachments to your email, but I went to the link that is mentioned below. Twelve folders with PDF and Excel documents. I did not find any mention of "Pain" or stop code 420. The closest I found was 201) PM&RS Physician:

- New Patient 60 minutes
- Established Patient 30-60 minutes

That is not including opioid management. Once you include opioid management, we get into the realm of OUD/dependance. Here our work is comparable yp Mental Health. Here the times are 60-90 minutes. I am still reading through the documents and I shall let you know if I see otherwise.

With this said, I assure you that my colleagues and I are open for any change that will improve Veteran accessibility to our clinics. We are all for the service of our Veterans. I am looking forward for your suggestions and input on the matter. Please send me more information on the matter if you have any.

Sincerely,
[redacted] MD

From: [redacted] <[redacted]va.gov>
Sent: Wednesday, August 17, 2022 10:46 AM
To: [redacted] <[redacted]va.gov>
Subject: FW: VHA Bookable Hours and Appointment Length Standards

[redacted] **MD, MBA, D. ABA**
Chief of Anesthesia, CTVHCS
VISN 17 Chief Anesthesia Consultant
C (254)408-0516
O (254)743-1428

From: [redacted] S <[redacted]va.gov>
Sent: Wednesday, August 17, 2022 8:25 AM
To: [redacted] <[redacted]va.gov>
Subject: RE: VHA Bookable Hours and Appointment Length Standards

Always looking out for the team 😊

From: [redacted] <[redacted]va.gov>
Sent: Wednesday, August 17, 2022 8:20 AM

To: [redacted] S <[redacted]va.gov>
Subject: RE: VHA Bookable Hours and Appointment Length Standards

This will actually prove to be quite helpful with regard to what is going on in Pain.
Thanks
G

[redacted] **MD, MBA, D. ABA**
Chief of Anesthesia, CTVHCS
VISN 17 Chief Anesthesia Consultant
C (254)408-0516
O (254)743-1428

From: [redacted] S <[redacted]@va.gov>
Sent: Tuesday, August 16, 2022 10:19 AM
To: [redacted] <[redacted]va.gov>
Subject: FW: VHA Bookable Hours and Appointment Length Standards
Importance: High

Interesting that we've not been doing this

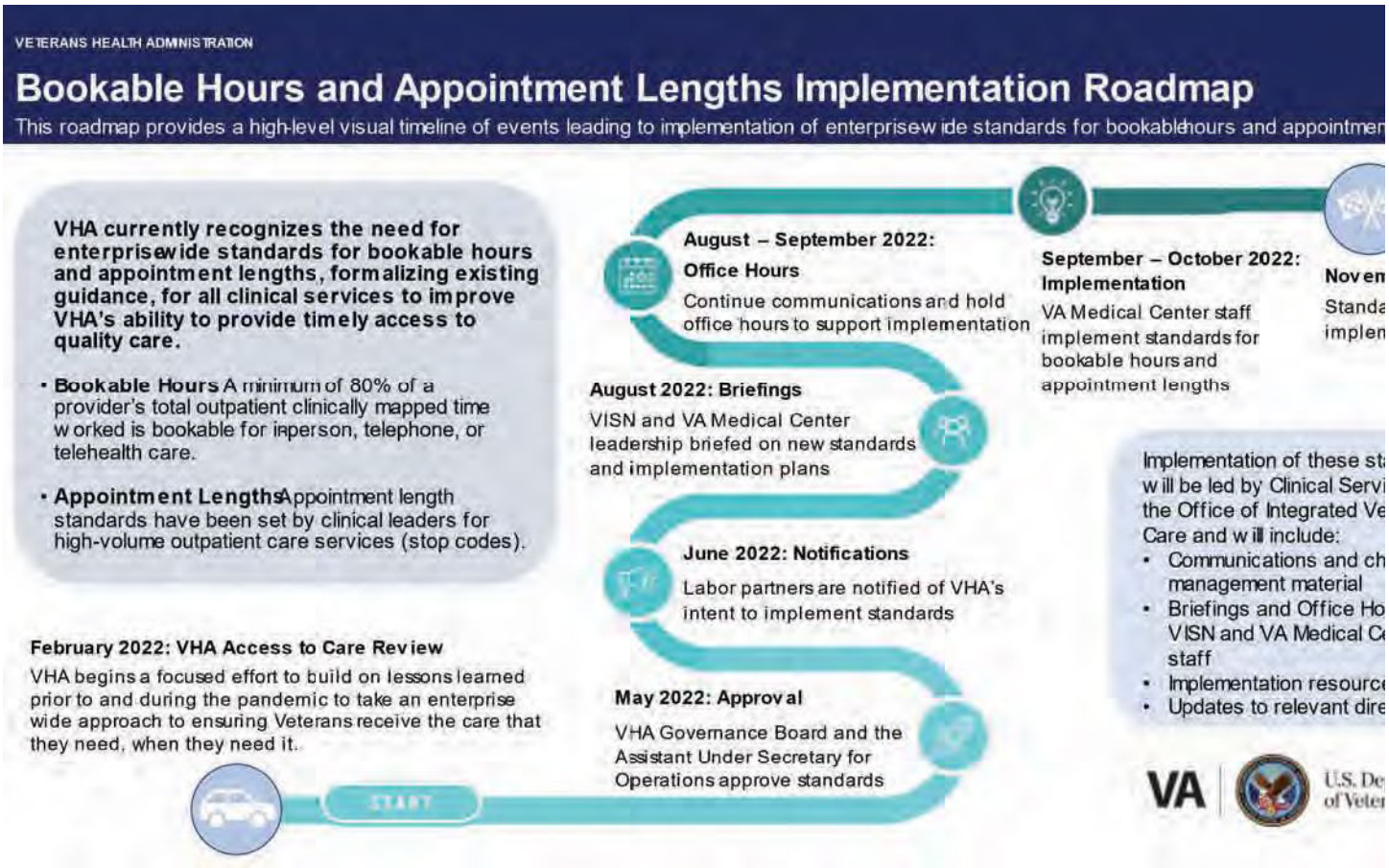
From: [redacted] K. [redacted]@va.gov>
Sent: Tuesday, August 16, 2022 9:53 AM
To: CTX Service Chiefs <CTXServiceChiefs@va.gov>; CTXAdmin Officers <CTVHCSAdministrativeOfficers@va.gov>; CTXMAS Supervisors <CTXMASSupervisors@va.gov>
Cc: [redacted] O <[redacted]va.gov>; [redacted]@va.gov>; [redacted] <[redacted]@va.gov>
Subject: VHA Bookable Hours and Appointment Length Standards
Importance: High

BLUF: VHA is implementing enterprise-wide standards for bookable hours and appointment lengths. Directives and guidebooks will be updated to reflect the new standards.

- Many services, including [redacted] Care and Mental Health, already follow policy or guidance for bookable hours and appointment lengths. Implementation of these standards across all VHA facilities and services will improve VHA's ability to provide consistent care and understand access across the system.

- The full list of Appointment Types, Lengths by Stop Code, and Exemptions can be found on [Office of Veterans Access to Care (OVAC) - Implementation Toolkit - All Documents (sharepoint.com)].

- These standards need to be fully implemented at each VA Medical Center and in all applicable clinics by **November 30, 2022.**



Very Respectfully,

[redacted]

Associate Group Practice Manager

Acting ACOS Administrative Officer- Ambulatory Care South 512-219-2340 ext 58070

Cell: 254-981-1123

Central Texas Veterans Health Care System

EXHIBIT B_20180117_ERC Staffing Request-PAIN MGMT_REJECTED by COS

Central Texas Veterans Health Care System
Executive Resources Committee (ERC)
Staffing Request

Requesting Service	Surgery	**Date of Request**	01/17/2018
Point of Contact	[redacted] M.D. [redacted] MD	**Extension**	43868/40829
Section: As identified in the Manpower Report	Pain Management	**CTVHCS Site/CBOC:**	Olin Teague
Position Requested: Title/Series/Grade	Interventional Pain Specialist, MD / AD602 / GS 15	**Is this Position Unique?** Yes or No	Yes
FTEE of Position Requested:	1.0	**If not a unique position, how many are in place?**	N/A
Type of Appointment Permanent/Temporary/Term	Permanent	**How many of those positions are vacant?**	N/A
New/Vice Identify Vice by Name / Manpower ID	New	**Date Position Vacated by Vice**	N/A
Estimated Salary Cost Including Benefits	$300,000	**Funding Source** Local/VISN/VACO	Local

Is the Position Description/Functional Statement current? ☐ Yes ☐ No **PD#**

Are you requesting an ad or journal placement? ☐ Yes ☒ No **Est. Cost** $

Are you requesting recruitment/relocation incentive?† ☒ Yes ☐ No **Est. Cost** $ 15,000

Are you requesting Permanent Change of Station expenses? ☐ Yes ☒ No **Est. Cost** $

† If an incentive is approved, requesting Service will be responsible for completion and submission of VA Form 10016.

Provide historical, current and projected workload and staffing data associated with the program for which this position is requested:

Fiscal Year	Workload † (Identify Workload Type)	Staffing ‡ Authorized	Staffing ‡ On Duty
Current Fiscal Year + 1	Procedures, Visits, Encounters		N/A
Current Fiscal Year	N/A		
Current Fiscal Year – 1	N/A		
Current Fiscal Year – 2	N/A		

† Examples include visits, encounters, procedures, etc.
‡ On board FTEE which directly support the workload

Describe the position requested and its impact on the organization. Include pertinent information regarding your request including applicable Staffing Standards, Performance Measures, VHA Directives, etc.

Currently we are losing many of our patients to community care pain management because we are unable to deliver interventional pain procedures within the specified 30-day period. Simultaneously, we are losing a lot of income to the community pain clinics because we are unable to accommodate the increased demand for pain procedures.

1. The reason for that is because our procedure slots are limited and have remained unchanged for many years while the demand for interventional pain management procedures has escalated.
2. The demand for procedures increased due to the natural increase in the number of Veterans that we serve in our area.
3. In addition, our active and a successful Opioid Safety Initiative program has redirected many patients from chronic opioid therapy to interventional pain procedures in the management of their chronic pain.

Describe how this position will improve performance, reduce backlogs, reduce budget deficits, address increased workload, etc. Include pertinent supporting data as attachments to this request, as needed.
By hiring another interventional pain management physician, we can increase the available pain procedure slots and accommodate more of our patients into our clinic rather than sending them out to community pain clinics under the 30-day rule. This will certainly allow us to save the money spent on such referrals and capture more money for our Medical Center. This will reduce waste and allow us to save at least $500,000 per month, which is the monthly average that this Medical Center lost to Community Pain Care for the last two fiscal years FY2017 and FY2016. Please see the attached Data.

Data obtained from Ms. Donna Mezzles of Patient Admin Service by email 12/28/2017.

	FY2016												
Pain Consults	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Grand Total
SVC Volume	24	28	51	73	183	193	157	204	109	82	101	142	1347
Est. Cost	$116,976.00	$136,472.00	$248,574.00	$355,802.00	$891,942.00	$940,682.00	$765,218.00	$994,296.00	$531,266.00	$399,668.00	$492,274.00	$692,108.00	$6,565,278.00

	FY2017												
PAIN	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Grand Total
SVC Vol	139	115	116	107	118	89	126	117	110	102	135	100	1374
Est. Cost	$677,486.00	$560,510.00	$565,384.00	$521,518.00	$575,132.00	$433,786.00	$614,124.00	$570,258.00	$536,140.00	$497,148.00	$657,990.00	$487,400.00	$6,696,876.00
Total SVC Vol	139	115	116	107	118	89	126	117	110	102	135	100	1374
Total Est. Cost	$677,486.00	$560,510.00	$565,384.00	$521,518.00	$575,132.00	$433,786.00	$614,124.00	$570,258.00	$536,140.00	$497,148.00	$657,990.00	$487,400.00	$6,696,876.00

How does this position support Central Texas Veterans Health Care System's Mission, Vision and Values?
As stated above, getting more of our Veterans to do their procedures at the VAMC serves the mission, vision, and values of the VA because the Veterans get superior and safer care at the VA. In addition, having all their care in one place is ideal for easy access to their medical records and bypassing incomplete notes that are sent back to us from community care pain management. Our Veterans get much safer care at the VA because we follow the Opioid Safety Initiative goals that non-VA clinics do not abide with.

How are the duties of this position being accomplished at this time?
The hired person will be requested to work at our pain clinics in Austin and Temple. We have already purchased a C-arm for that purpose and will find the proper room for it.

How would not hiring this position impact patient care or CTVHCS operations? (Why does this position need to be filled?)
The position needs to be filled for all the above-stated reasons. Not filling the position is unacceptable because it does not allow us to keep up with the increasing demand and allows a lot of wasted dollars to the community as the tables above reveal.

If this request is for a direct patient care provider (Physician, Nurse Practitioner, Physician Assistant, etc.), does your Service have sufficient clerical and nursing staff to support this position, if approved?
☐ **Yes** ☐ **No** ☐ **N/A**
NOTE: If the response to the above question is "No", the Service must identify additional staffing resources required.

Does your Service have available space and equipment to support this position, if approved?
☐ **Yes** ☐ **No**
NOTE: If the response to the above question is "No", the Service must identify additional resources required.

Will structured interviews (i.e., Performance Based Interviews) be used in the recruitment process?
☐ **Yes** ☐ **No**

If Interviews will be used, the Service *must* provide the following information:
Interview Panel Members: 3
Interview Questions:
1. Many

EXHIBIT C_20180607_ERC Staffing Request-PAIN MGMT_REJECTED by COS

Central Texas Veterans Health Care System
Executive Resources Committee (ERC)
Staffing Request

Requesting Service	Surgery	**Date of Request**	06/07/2018
Point of Contact	[redacted] M.D. [redacted] MD	**Extension**	43868/40829
Section: As identified in the Manpower Report	Pain Management	**CTVHCS Site/CBOC:**	Olin Teague
Position Requested: Title/Series/Grade	Interventional Pain Specialist, MD / AD602 / GS 15	**Is this Position Unique?** Yes or No	Yes
FTEE of Position Requested:	1.0	**If not a unique position, how many are in place?**	N/A
Type of Appointment Permanent/Temporary/Term	Permanent	**How many of those positions are vacant?**	N/A
New/Vice Identify Vice by Name / Manpower ID	New	**Date Position Vacated by Vice**	N/A
Estimated Salary Cost Including Benefits	$300,000	**Funding Source** Local/VISN/VACO	Local

Is the Position Description/Functional Statement current? ☐ Yes ☐ No **PD#**

Are you requesting an ad or journal placement? ☐ Yes ☒ No **Est. Cost** $
Are you requesting recruitment/relocation incentive?† ☒ Yes ☐ No **Est. Cost** $ 15,000
Are you requesting Permanent Change of Station expenses? ☐ Yes ☒ No **Est. Cost** $

† If an incentive is approved, requesting Service will be responsible for completion and submission of VA Form 10016.

Provide historical, current and projected workload and staffing data associated with the program for which this position is requested:

Fiscal Year	Workload † (Identify Workload Type)	Staffing ‡ Authorized	Staffing ‡ On Duty
Current Fiscal Year + 1	Procedures, Visits, Encounters		N/A
Current Fiscal Year	N/A		
Current Fiscal Year – 1	N/A		
Current Fiscal Year – 2	N/A		

† Examples include visits, encounters, procedures, etc.
‡ On board FTEE which directly support the workload

Describe the position requested and its impact on the organization. Include pertinent information regarding your request including applicable Staffing Standards, Performance Measures, VHA Directives, etc.

Currently we are losing many of our patients to community care pain management because we are unable to deliver interventional pain procedures within the specified 30-day period. Simultaneously, we are losing a lot of income to the community pain clinics because we are unable to accommodate the increased demand for pain procedures.

1. The reason for that is because our procedure slots are limited and have remained unchanged for many years while the demand for interventional pain management procedures has escalated.
2. The demand for procedures increased due to the natural increase in the number of Veterans that we serve in our area.
3. In addition, our active and a successful Opioid Safety Initiative program has redirected many patients from chronic opioid therapy to interventional pain procedures in the management of their chronic pain.

Describe how this position will improve performance, reduce backlogs, reduce budget deficits, address increased workload, etc. Include pertinent supporting data as attachments to this request, as needed.
By hiring another interventional pain management physician, we can increase the available pain procedure slots and accommodate more of our patients into our clinic rather than sending them out to community pain clinics under the 30-day rule. This will certainly allow us to save the money spent on such referrals and capture more money for our Medical Center. This will reduce waste and allow us to save at least $500,000 per month, which is the monthly average that this Medical Center lost to Community Pain Care for the last two fiscal years FY2017 and FY2016. Please see the attached Data.

Data obtained from Ms. Donna Mezzles of Patient Admin Service by email 12/28/2017.

	FY2016												
Pain Consults	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Grand Total
SVC Volume	24	28	51	73	183	193	157	204	109	82	101	142	1347
Est. Cost	$116,976.00	$136,472.00	$248,574.00	$355,802.00	$891,942.00	$940,682.00	$765,218.00	$994,296.00	$531,266.00	$399,668.00	$492,274.00	$692,108.00	$6,565,278.00

	FY2017												
PAIN	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Grand Total
SVC Vol	139	115	116	107	118	89	126	117	110	102	135	100	1374
Est. Cost	$677,486.00	$560,510.00	$565,384.00	$521,518.00	$575,132.00	$433,786.00	$614,124.00	$570,258.00	$536,140.00	$497,148.00	$657,990.00	$487,400.00	$6,696,876.00
Total SVC Vol	139	115	116	107	118	89	126	117	110	102	135	100	1374
Total Est. Cost	$677,486.00	$560,510.00	$565,384.00	$521,518.00	$575,132.00	$433,786.00	$614,124.00	$570,258.00	$536,140.00	$497,148.00	$657,990.00	$487,400.00	$6,696,876.00

How does this position support Central Texas Veterans Health Care System's Mission, Vision and Values?
As stated above, getting more of our Veterans to do their procedures at the VAMC serves the mission, vision, and values of the VA because the Veterans get superior and safer care at the VA. In addition, having all their care in one place is ideal for easy access to their medical records and bypassing incomplete notes that are sent back to us from community care pain management. Our Veterans get much safer care at the VA because we follow the Opioid Safety Initiative goals that non-VA clinics do not abide with.

How are the duties of this position being accomplished at this time?
The hired person will be requested to work at our pain clinics in Austin and Temple. We have already purchased a C-arm for that purpose and will find the proper room for it.

How would not hiring this position impact patient care or CTVHCS operations? (Why does this position need to be filled?)
The position needs to be filled for all the above-stated reasons. Not filling the position is unacceptable because it does not allow us to keep up with the increasing demand and allows a lot of wasted dollars to the community as the tables above reveal.

If this request is for a direct patient care provider (Physician, Nurse Practitioner, Physician Assistant, etc.), does your Service have sufficient clerical and nursing staff to support this position, if approved?
☐ **Yes** ☐ **No** ☐ **N/A**
NOTE: If the response to the above question is "No", the Service must identify additional staffing resources required.

Does your Service have available space and equipment to support this position, if approved?
☐ **Yes** ☐ **No**
NOTE: If the response to the above question is "No", the Service must identify additional resources required.

Will structured interviews (i.e., Performance Based Interviews) be used in the recruitment process?
☐ **Yes** ☐ **No**

If Interviews will be used, the Service *must* provide the following information:
Interview Panel Members: 3
Interview Questions:
1. Many

EXHIBIT D_20190307_ERC Staffing Request-PAIN MGMT_REJECTED by COS

Central Texas Veterans Health Care System
Executive Resources Committee (ERC)
Staffing Request

Requesting Service	Surgery	**Date of Request**	03/07/2019
Point of Contact	[redacted] M.D. [redacted] MD	**Extension**	43868/40829
Section: As identified in the Manpower Report	Pain Management	**CTVHCS Site/CBOC:**	Olin Teague
Position Requested: Title/Series/Grade	Interventional Pain Specialist, MD / AD602 / GS 15	**Is this Position Unique?** Yes or No	Yes
FTEE of Position Requested:	1.0	**If not a unique position, how many are in place?**	N/A
Type of Appointment Permanent/Temporary/Term	Permanent	**How many of those positions are vacant?**	N/A
New/Vice Identify Vice by Name / Manpower ID	New	**Date Position Vacated by Vice**	N/A
Estimated Salary Cost Including Benefits	$300,000	**Funding Source** Local/VISN/VACO	Local

Is the Position Description/Functional Statement current? ☒ Yes ☐ No **PD#**

Are you requesting an ad or journal placement? ☐ Yes ☒ No **Est. Cost** $
Are you requesting recruitment/relocation incentive?† ☒ Yes ☐ No **Est. Cost** $ 15,000
Are you requesting Permanent Change of Station expenses? ☐ Yes ☒ No **Est. Cost** $

† If an incentive is approved, requesting Service will be responsible for completion and submission of VA Form 10016.

Provide historical, current and projected workload and staffing data associated with the program for which this position is requested:

Fiscal Year	Workload † (Identify Workload Type)	Staffing ‡ Authorized	Staffing ‡ On Duty
Current Fiscal Year + 1	Procedures, Visits, Encounters		N/A
Current Fiscal Year	N/A		
Current Fiscal Year – 1	N/A		
Current Fiscal Year – 2	N/A		

† Examples include visits, encounters, procedures, etc.
‡ On board FTEE which directly support the workload

Describe the position requested and its impact on the organization. Include pertinent information regarding your request including applicable Staffing Standards, Performance Measures, VHA Directives, etc.

Currently we are losing many of our patients to community care pain management because we are unable to deliver interventional pain procedures within the specified 30-day period. Simultaneously, we are losing a lot of income to the community pain clinics because we are unable to accommodate the increased demand for pain procedures. This problem is expected to increase as VHA plans to limit the waiting times to 28 days and then to 14 days. The pain Management Section needs to grow in congruence with the growth in numbers and in demand of the population of Veterans whom we serve.

Our current shortage and need for a physician is due to:

1. The reason for that is because our procedure slots are limited and have remained unchanged for many years while the demand for interventional pain management procedures has escalated.
2. In addition, we have lost a very active Nurse Practitioner in mid-2018 who left to work at DoD.
3. Moreover, the demand for procedures increased due to the natural increase in the number of Veterans that we serve in our area, and
4. Our active and a successful Opioid Safety Initiative program has redirected many patients from chronic opioid therapy to interventional pain procedures in the management of their chronic pain.

Describe how this position will improve performance, reduce backlogs, reduce budget deficits, address increased workload, etc. Include pertinent supporting data as attachments to this request, as needed.
By hiring another interventional pain management physician, we can increase the available pain procedure slots and accommodate more of our patients into our clinic rather than sending them out to community pain clinics under the 30-day rule. This will certainly allow us to save the money spent on such referrals and capture more money for our Medical Center. This will reduce waste and allow us to save at least $500,000 per month, which is the monthly average that this Medical Center lost to Community Pain Care for the last two fiscal years FY2017 and FY2016. Please see the attached Data. This trend has continued for FY 2018.

Data obtained from Ms. Donna Mezzles of Patient Admin Service by email 12/28/2017.

	FY2016												
Pain Consults	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Grand Total
SVC Volume	24	28	51	73	183	193	157	204	109	82	101	142	1347
Est. Cost	$116,976.00	$136,472.00	$248,574.00	$355,802.00	$891,942.00	$940,682.00	$765,218.00	$994,296.00	$531,266.00	$399,668.00	$492,274.00	$692,108.00	$6,565,278.00

	FY2017												
PAIN	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Grand Total
SVC Vol	139	115	116	107	118	89	126	117	110	102	135	100	1374
Est. Cost	$677,486.00	$560,510.00	$565,384.00	$521,518.00	$575,132.00	$433,786.00	$614,124.00	$570,258.00	$536,140.00	$497,148.00	$657,990.00	$487,400.00	$6,696,876.00
Total SVC Vol	139	115	116	107	118	89	126	117	110	102	135	100	1374
Total Est. Cost	$677,486.00	$560,510.00	$565,384.00	$521,518.00	$575,132.00	$433,786.00	$614,124.00	$570,258.00	$536,140.00	$497,148.00	$657,990.00	$487,400.00	$6,696,876.00

How does this position support Central Texas Veterans Health Care System's Mission, Vision and Values?

As stated above, getting more of our Veterans to do their procedures at the VAMC serves the mission, vision, and values of the VA because our Veterans get superior and safer care at the VA. In addition, having all their care in one place is ideal for easy access to their medical records and bypassing incomplete notes that are sent back to us from community care pain management. Our Veterans get much safer care at the VA because we follow the Opioid Safety Initiative goals that non-VA clinics do not abide with.

How are the duties of this position being accomplished at this time?
The hired person will be requested to work at our pain clinics in Austin and Temple. We have an extra C-arm for that purpose and will find the proper room for it.

How would not hiring this position impact patient care or CTVHCS operations? (Why does this position need to be filled?)
The position needs to be filled for all the above-stated reasons. Not filling the position is unacceptable because it does not allow us to keep up with the increasing demand and redirects dollars to the community and away from the VA, as the tables above reveal.

If this request is for a direct patient care provider (Physician, Nurse Practitioner, Physician Assistant, etc.), does your Service have sufficient clerical and nursing staff to support this position, if approved?
☐ **Yes** ☐ **No** ☐ **N/A**
NOTE: If the response to the above question is "No", the Service must identify additional staffing resources required.

Does your Service have available space and equipment to support this position, if approved?
☐ **Yes** ☐ **No**
NOTE: If the response to the above question is "No", the Service must identify additional resources required.

Will structured interviews (i.e., Performance Based Interviews) be used in the recruitment process?
☐ **Yes** ☐ **No**

If Interviews will be used, the Service *must* provide the following information:
Interview Panel Members: 3
Interview Questions:
1. Many

PMOP Gap Analysis Summary Report: VISN 17

This report was generated based on data submitted as part of the Pain Management, Opioid Safety, and Prescription Drug Monitoring Program (PMOP) Gap Analysis, conducted in spring 2022 by the Pain Services Evaluation Program (a partnership between PMOP and the Pain Research, Informatics, Multimorbidities, and Education (PRIME) Center of Innovation at VA Connecticut). In most cases, PMOP Coordinators worked with Pain Facility Points of Contact to complete the survey. The survey covered several topics, and here we have highlighted (1) implementation of the stepped care model of pain management, (2) implementation of pain management teams (PMTs), including staffing for the four required roles, (3) barriers to PMT implementation, and (4) functions of facility PMTs.

Yellow highlighting indicates missing data or data inconsistent with other answers; in each instance we have reached out to the facility for clarification and will report facility responses as they become available.

Stepped Care Model Implementation Status

	Complexity	Foundation	Step 1	Step 2	Step 3
(504) Amarillo VA	2	Partial	Partial	Planning	Not at all
(519) West Texas VA	3	Early	Early	Planning	Not at all
(549) Dallas VA	1a	Partial	Partial	Early	Partial
(671) South Texas- San Antonio	1a	Partial	Partial	Full	Early
(674) Central Texas	1a	Full	Partial	Partial	Not at all
(740) Texas Valley Coastal Bend	3	Full	Full	Early	Planning
(756) El Paso	2	Full	Full	Partial	Partial

Note: West Texas, Dallas, and Central Texas do not have a clinic fitting the definition of an A., B., C. pain clinic. El Paso did not report whether they have a clinic fitting the definition of an A., B., C. pain clinic.

Pain Management Teams

	Does your facility have a PMT?	For how long?	Main service line
(504) Amarillo VA	No	-	-
(519) West Texas VA	No	-	-
(549) Dallas VA	Partially staffed	> 5 years	Anesthesiology
(671) South Texas- San Antonio	Fully staffed	2 to 5 years	PM&R
(674) Central Texas	No	-	-
(740) Texas Valley Coastal Bend	Partially staffed	1 to 5 years	Pain Medicine
(756) El Paso	Partially staffed	2 to 5 years	Surgery

Stop Codes

Dallas and Texas Valley Coastal Bend use 420 as the [redacted] stop code and reported no secondary stop codes. South Texas – San Antonia only used 420 for clinics with PsyD, other stop codes include 301 (MD), 160 (pharmacy), and 179 (VVC).

PMT Staffing

	Medical Provider with Pain Expertise				Provider with Addiction Expertise				Provider with Behavioral Medicine Expertise			Provider with Rehabilitation Expertise		
	Yes/ no	Head count	Hours/ week	# X-wav	Yes/ no	Head count	Hours/ week	# X-wav	Yes/ no	Head count	Hours/ week	Yes/ no	Head count	Hours/ week
(504) Amarillo VA														
(519) West Texas VA														
(549) Dallas VA	Yes	1	1 to 4	1	No	-	-	-	Yes	1	17 to 40	Yes	1	17 to 40
(671) San Antonio	Yes	8	>160	2	Yes	6	41 to 80	2	Yes	2	41 to 80	Yes	3	41 to 80
(674) Central Texas														
(740) TX Coastal Bend	Yes	2	1 to 4	1	Yes	1	9 to 16	1	Yes	1	17 to 40	Yes	1	1 to 4
(756) El Paso	Yes	BLANK	BLANK	3	Yes	3	1 to 4	3	Yes	2	1 to 4	No	-	-

Barriers to PMT Implementation

	Staff Recruit	Staff Retain	Team Integration	Team engagement	Unfilled positions	Insufficient Resources	[redacted] care collaboration	Protected Time	COVID-19	Other
(504) Amarillo VA	X	X	X		X	X		X		Not implemented as a full team, tasks are divided
(519) West Texas VA	X	X	X		X			X		
(549) Dallas VA	X	X				X		X		
(671) San Antonio	X							X		
(674) Central Texas			X	X			X	X		Support of medical leadership
(740) TX Coastal Bend	X									
(756) El Paso	X	X								

Functions performed by Facility PMTs

	(504) Amarillo VA	(519) West Texas	(549) Dallas VA	(671) San Antonio	(674) Central Texas	(740) TX Coastal Bend	(756) El Paso
Provides in-person evaluations of patients with complex pain conditions			X	X			
Provides in-person evaluations of patients with ongoing opioid prescriptions			X	X			
Provides in-person evaluations for pain medication management			X	X		X	
Issues prescriptions of pain medications for patients				X			
Provides in-person follow-up visits				X			
Provides e-consultation				X		X	X
Provides immediate consultation for assistance with prescriptions			X				
Provides telehealth evaluation for new patients			X	X			
Provides telehealth follow-up visits			X	X			
Provides case/care management			X	X			
Provides inpatient pain consultation			X				
Oversees a patient's [redacted] care							
Provides palliative care							
Other				WH, M-A-P, interventional pain, graded motor imagery, CBT/psychoTx, PT/Neuromod, family appts			

EXHIBIT F_20220220A_DR. [redacted] PATIENTS_Redacted

[redacted] E.

From: [redacted] L.
Sent: Sunday, February 20, 2022 6:07 PM
To: [redacted] (V17)
Subject: FW: Need CONFIRMATION on plan for Dr. [redacted] patients AND

With the other e-mail that I am forwarding you, this makes no sense. Would it be possible for VISN to apply pressure or a voice of reason to Dr. [redacted]

From: [redacted] <[redacted]va.gov>
Sent: Sunday, February 20, 2022 5:15 PM
To: [redacted] L. <[redacted]va.gov>
Cc: [redacted]@va.gov>; [redacted] <[redacted]va.gov>
Subject: RE: Need CONFIRMATION on plan for Dr. [redacted] patients AND

At this time that would be no.

[redacted] MD, MHSA
Chief of Staff
Central Texas Veterans Health Care System
Tele: 254-743-2323

From: [redacted] <[redacted]va.gov>
Sent: Sunday, February 20, 2022 3:38 PM
To: [redacted] O <[redacted]va.gov>
Cc: [redacted]@va.gov>; [redacted] <[redacted]va.gov>; [redacted] <[redacted]va.gov>
Subject: Re: Need CONFIRMATION on plan for Dr. [redacted] patients AND

Request for Application - basically putting our name in the hat tone considered for these 5-6 years of funding for pain med management physician extender.

Get Outlook for iOS

From: [redacted] <[redacted]va.gov>
Sent: Saturday, February 19, 2022 7:02:21 AM
To: [redacted] L. <[redacted]va.gov>
Cc [redacted]@va.gov>; [redacted] <[redacted]va.gov>; [redacted] <[redacted]va.gov>
Subject: RE: Need CONFIRMATION on plan for Dr. [redacted] patients AND

The meaning of the RFA acronym escapes me at this time.

[redacted] MD, MHSA
Chief of Staff
Central Texas Veterans Health Care System

Tele: 254-743-2323

From: [redacted] L. <[redacted]va.gov>
Sent: Friday, February 18, 2022 3:49 PM
To: [redacted] <[redacted]va.gov>
Cc: [redacted]@va.gov>; [redacted] <[redacted]va.gov>
Subject: Need CONFIRMATION on plan for Dr. [redacted] patients AND

Please let us know if we can proceed with this plan as well as submit the RFA for a NP or PA to assist with PMT in the future.

From: [redacted] L.
Sent: Thursday, February 17, 2022 12:20 PM
To: [redacted] <[redacted]va.gov>; [redacted] O <[redacted]va.gov>
Cc: [redacted]@va.gov>; [redacted] <[redacted]va.gov>; [redacted] <[redacted]va.gov>
Subject: RE: Pain Patients
Importance: High

That may very well be true, Dr. [redacted] The funding was likely requested by Dr. [redacted] and I would think would have had to been approved by executive leadership.

Nov 4 2021	**5811** Facility Pain Point of Contact (POC) and PACT Pain Champion (PR:796861) Program Manager	Pharmacy Benefits (Consolidated Unit)

With the current Dr. [redacted] situation, we need to know, who the patients and clinical pharmacists can rely on to continue suboxone therapy. The VISN PMOP clarified some things for me regarding the fact that when using suboxone for pain, an X-waiver is not even needed as long as the patients do not have OUD. Pain is considered a foundational service that is supposed to be offered by VA rather than sent to the community. The VA does a better job of providing pain services than what is done in the community. As a VISN, we are making great efforts to reduce CCN pain. VISN 17 and CTX in particular are outliers in use of CCN dollars for pain services.

We have another opportunity to request funds (through FY2026) to fortify our ability to assist both [redacted] Care and Pain Service with Medication management. The due date to request is February 28, 2022, 11:59 PM EST. Below is the description of the initiative that we would like to apply for. Based on this conversation, I don't know how we could say we don't need it.

Medication Management in Pain Management Teams (MMPMT) initiative to expand access to safe and effective pharmacological management for pain as an important component of comprehensive pain care, to optimize pain medication management strategies, and to support risk mitigation to improve patient safety and patient satisfaction. MMPMT supports the hiring of a Clinical Pharmacist Practitioner (CPP) and a Nurse Practitioner (NP) or Physician Assistant (PA) to provide care within the PMT. See Attachment B.

I am attaching the Request for Application (RFA). If we have executive support, we will communicate to the VISN to include us in the submission.

Lastly, Dr. [redacted] requested an alternate plan by today for Dr. [redacted] patients (instead of sending them to the community). I am attaching what Dr. [redacted] has come up with.

Please let us know if we can proceed with this plan as well as submit the RFA for a NP or PA to assist with PMT in the future.

From: [redacted] W. <[redacted]va.gov>
Sent: Wednesday, February 16, 2022 5:47 PM
To: [redacted] L. <[redacted]va.gov>; [redacted] O <[redacted]va.gov>
Cc: [redacted] H. <[redacted]va.gov>; [redacted] Tai A. <Tai [redacted]va.gov>; [redacted]
<[redacted]va.gov>
Subject: RE: Pain Patients

Hi Dr. [redacted]

I am 100% certain that I did not hire Dr. [redacted] with any funding from VACO. I never spoke with anyone from finance about that. He was hired as a PACT provider from a VICE position and as I stated and I never discussed this with Dr. [redacted] before he was hired nor was this part of the job description in his PD that was used to hire him. He kindly agreed to help only after he was hired. Possibly someone from some other department requested this funding but I certainly did not. I'm including Dr. [redacted] because perhaps someone from his office requested this without my knowledge. As I stated previously, Dr. [redacted] role as a PACT pain champion hasn't even been delineated yet because Dr. [redacted] never proposed anything to us. I did agree to giving him 0.2 FTE to attend all of the various meetings and in anticipation that he could serve in the role of PACT champion. For the current dilemma the pain service is in, it would not be fair for me to ask him to begin seeing patients from other clinics when he has a PACT. The literature I have reviewed basically discusses someone serving as an advisor in their own clinic so I am not comfortable asking him to see patients from Waco, Temple, etc. These sound like complex patients who will almost certainly need to be seen face to face at some point. I don't mind asking if he's comfortable seeing someone who already comes to Austin.

If Dr. [redacted] did not ask for funding, I'd like to clear this up with finance myself since he's in my service.
Thanks,
[redacted]

From: [redacted] L. <[redacted]va.gov>
Sent: Wednesday, February 16, 2022 4:33 PM
To: [redacted] W. <[redacted]va.gov>
Cc: [redacted] H. <[redacted]va.gov>; [redacted] <[redacted]va.gov>; [redacted]
[redacted]@va.gov>
Subject: RE: Pain Patients

Hi Dr. [redacted]

I double checked with finance and they confirmed that we are receiving national funding (25% of Dr. [redacted] salary). That means we really are obligated for him to be given 10 hours/week to focus on pain management initiatives. I think our biggest need is having a physician to assist with the interdisciplinary STORM reviews and participation on the CARA-mandated interdisciplinary Pain Management team. I will let Dr. [redacted] weigh in on her thoughts as to how he could be utilized. Hopefully he wasn't given the same size panel as a 1.0 FTE PCP. Let us know if it would be helpful to meet as a group/team to further discuss this.

[redacted] L [redacted] Pharm D
Associate Chief of Pharmacy, Clinical Services
Phone: 254-743-0703, Cell – 254-316-8365

"You are your last line of defense in safety. It boils down to you." – Kina Repp

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From: [redacted] W. <[redacted] va.gov>
Sent: Wednesday, February 16, 2022 10:54 AM
To: [redacted] <[redacted] va.gov>
Cc: [redacted] <[redacted] va.gov>; [redacted] <[redacted] va.gov>; [redacted] <[redacted] @va.gov>
Subject: RE: Pain Patients

Hello,

Dr. [redacted] was not hired with any funding from the VISN or VACO. This was an after the fact thing and I approached Dr. [redacted] about after he was already hired. We honestly don't even know what his role will even look like. Dr. [redacted] was supposed to make some recommendations about the PACT champion role to us. Dr. [redacted] clearly expressed to me that he did not feel comfortable making recommendations to other PACT providers, however. Unfortunately, we're now in a limbo state because of his ill-defined role. I told Dr. [redacted] that Dr. [redacted] was reassigned to ambulatory care and that he should still plan on attending committee meetings if they are still proceeding.
[redacted]

From: [redacted] L. <[redacted] va.gov>
Sent: Wednesday, February 16, 2022 9:44 AM
To: [redacted] W. <[redacted] va.gov>
Cc: [redacted] H. <[redacted] va.gov>; [redacted] Tai A. <Tai [redacted] va.gov>; [redacted] <[redacted] va.gov>
Subject: RE: Pain Patients

Providers are seeing patients virtually frequently now since the pandemic. As the PACT pain champion, we received national funding for him to commit 25% of his FTE to the efforts of pain management.

We can't afford to keep sending patients to the community just because our internal system is broken. What are your suggestions for using him in order to get more [redacted] care providers on board with prescribing new buprenorphine products with the support of pain pharmacists?

Dr. [redacted] (PMOP Coordinator) will be sending a proposed action plan for the transition of care for Dr. [redacted] patients.

From: [redacted] W. <[redacted] va.gov>
Sent: Wednesday, February 16, 2022 8:09 AM
To: [redacted] <[redacted] va.gov>; [redacted] <[redacted] @va.gov>; [redacted] @va.gov>
Cc: [redacted] <[redacted] va.gov>; [redacted] <[redacted] va.gov>; [redacted] @va.gov>
Subject: RE: Pain Patients

Hello,

I would rather not have Dr. [redacted] see patients that are not in the Austin clinic. His main job is a PACT provider and he's only serving as the PACT pain champion. Perhaps they should be sent to the community?
Thanks,
[redacted]

From: [redacted] L. <[redacted]va.gov>
Sent: Tuesday, February 15, 2022 4:37 PM
To: [redacted]@va.gov>; [redacted]@va.gov>
Cc: [redacted] <[redacted]va.gov>; [redacted] <[redacted]va.gov>; [redacted] <[redacted]va.gov>; [redacted]@va.gov>
Subject: RE: Pain Patients

Is it possible for these 5 patients to be reviewed to make sure they have been evaluated for possible mixed OUD and pain.

PATIENT	DRUG	Last RF DATE	Refills	
[redacted]				NB 2/11, Temple,
[redacted]	BUPRENORPHINE 2MG/NALOXONE 0.5	JAN 21,2022	2	Puppala?
[redacted]	BUPRENORPHINE 2MG/NALOXONE 0.5	3/16/2022	0	Wac 2/16
[redacted]	BUPRENORPHINE 2MG/NALOXONE 0.5	2/9/2022	1	GM - Cornett, Toc
[redacted]	BUPRENORPHINE 8MG/NALOXONE 2MG	2/16/2022	2	Wac 2/16
[redacted]	BUPRENORPHINE 2MG/NALOXONE 0.5	JAN 10,2022	2	NB 3/11, Waco

Tai, we may want to focus these PCPs first for getting their x-waiver. There is some time.

Dr. [redacted] & [redacted] your support will also be crucial during this time. Could follow-up be arranged with Dr. [redacted] by April for these patients?

From: [redacted] <[redacted]va.gov>
Sent: Tuesday, February 15, 2022 1:56 PM
To: [redacted] <[redacted]va.gov>; [redacted]@va.gov>; [redacted] <[redacted]@va.gov>
Cc: [redacted] Tai A. <[redacted]va.gov>; [redacted] <[redacted]va.gov>
Subject: RE: Pain Patients

Ok
Work with them and give me feedback by Thursday.

[redacted] MD, MHSA
Chief of Staff
Central Texas Veterans Health Care System
Tele: 254-743-2323

From: [redacted] L. <[redacted]va.gov>
Sent: Tuesday, February 15, 2022 1:55 PM
To: [redacted] <[redacted]va.gov>; [redacted]@va.gov>; [redacted] <[redacted]@va.gov>
Cc: [redacted] <[redacted]va.gov>; [redacted] <[redacted]va.gov>

Subject: RE: Pain Patients
Importance: High

Hello Dr. [redacted]

Before this horse gets out of the gate, can this be reconsidered? We have 91 providers within Central Texas that are x-waivered. I believe that Dr. [redacted] only had 6 or 7 patients. Surely, our Substance Use Disorder and/or Pain pharmacists can work with 1 of those 91 providers to continue the therapy they have been started on.

[redacted] *Pharm D*
Associate Chief of Pharmacy, Clinical Services
Phone: 254-743-0703, Cell – 254-316-8365

"You are your last line of defense in safety. It boils down to you." – Kina Repp

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From: [redacted] va.gov>
Sent: Tuesday, February 15, 2022 1:45 PM
To: [redacted] 2@va.gov>; [redacted] B. <[redacted] >; [redacted] @va.gov>
Cc: [redacted] va.gov>; [redacted] va.gov>
Subject: Pain Patients

We have several patients that have been receiving treatment from Dr [redacted] Due to certain circumstances, we need to find community providers for these patients.
Please work expeditiously on these referrals. Dr [redacted] will forward these patient names.

[redacted] MD, MHSA
Chief of Staff
[redacted]

EXHIBIT G_20220220B_I can take OUD_Pain w_Suboxone_Redacted

[redacted] E.

From: [redacted] L.
Sent: Sunday, February 20, 2022 6:09 PM
To: [redacted]
Subject: FW: I can take OUD/Pain w/Suboxone

From: [redacted] O <[redacted]va.gov>
Sent: Saturday, February 19, 2022 7:00 AM
To: [redacted] <[redacted]va.gov>; [redacted] <[redacted]va.gov>; [redacted] <[redacted]va.gov>
Cc: [redacted]@va.gov>; [redacted]@va.gov>; [redacted] <[redacted]@va.gov>
Subject: RE: I can take OUD/Pain w/Suboxone

Thank you Dr [redacted] But this must only be an interim measure until we transition their care fully to a provider who assumes full responsibility for their pain management.
I have read all the input over the past several days.
Trust me on this one. I have seen this type of situation (almost exact situation) go really bad at another VA, with subsequent loss of jobs at different management levels. I had access to the confidential oversight reviews at that time.

So these patients should be sent out to community care
Ms Bishop: Please ensure priority processing when these come through.

[redacted] MD, MHSA
[redacted]
[redacted] Health Care System
[redacted]

From: [redacted] <[redacted]va.gov>
Sent: Friday, February 18, 2022 10:29 AM
To: [redacted] <[redacted]va.gov>; [redacted]va.gov>
Cc: [redacted] <[redacted]va.gov>; [redacted]@va.gov>; [redacted]@va.gov>
Subject: RE: I can take OUD/Pain w/Suboxone

Thank you, Dr. [redacted] This will be extremely helpful and appreciated. Here is the list of the suboxone patients:

PATIENT	Last 4	DRUG	Last Fill Date	Refills
[redacted]	[redacted]	BUPRENORPHINE 2MG/NALOXONE 0.5	March 16, 2022	0
[redacted]	[redacted]	BUPRENORPHINE 2MG/NALOXONE 0.5	February 8, 2022	1
[redacted]	[redacted]	BUPRENORPHINE 2MG/NALOXONE 0.5	February 16, 2022	1
[redacted]	[redacted]	BUPRENORPHINE 2MG/NALOXONE 0.5	JAN 21,2022	2
[redacted]	[redacted]	BUPRENORPHINE 8MG/NALOXONE 2MG	February 16, 2022	2

Our pain pharmacists are [redacted], and [redacted]

Our SUD pharmacist is [redacted]

Let me know how I can assist further.

From: [redacted] W. <[redacted]va.gov>
Sent: Thursday, February 17, 2022 3:26 PM
To: [redacted] <[redacted]va.gov>; [redacted]va.gov>
Cc: [redacted] <[redacted]va.gov>; [redacted]@va.gov>; [redacted]va.gov>
Subject: I can take OUD/Pain w/Suboxone

Hello,

If you have veterans on suboxone for OUD that happens to have chronic pain, I can temporarily manage them until we can get someone hired in the pain service. I am not comfortable (nor do I know any PCPs who would be) managing purely pain patients with suboxone. It's off-label and too controversial. I've seen too many of our own pain specialists in VA disagreeing about its use for chronic pain. Even Dr. [redacted] himself said he does not manage pain only with suboxone. Plus, I wouldn't know how to change someone from suboxone to a full agonist because of the very long half-life of buprenorphine. If somebody can send me a list of veterans in the former category, I can arrange to see them for VVC or less preferably, telephone. I would also appreciate it if I could get support from one of our pain PharmDs to make recommendations and help manage because I don't have my own RN or LVN.

Please let me know if that would help.

Best regards,
[redacted]

[redacted]
Attorney, Disclosure Unit
U.S. Office of Special Counsel
1730 M St NW, Suite 218
[redacted] DC 20036
Phone: (202) [redacted]
Fax: (202) [redacted]
[redacted] osc.gov

September 12, 2022

Response of Dr. [redacted] M.D.
Re: OSC File Nos. DI-21-000470 and DI-21-000503

Dear Ms. [redacted]

1. Thank you for the OSC report that you sent to me on August 1, 2022. Thank you for granting extension to my response until September 15, 2022. Also, I thank all those who participated in this comprehensive investigation and preparers of this report. However, I note flaws in the response of Dr. [redacted] Director VISN-17, and in the OMI Report of Investigation.

2. I am a busy pain management clinician, I do not have the time to reiterate the voluminous amount of fact-supported material that I have already prepared and submitted over the last two years, specifically since August 2020 to the CTVHCS leadership, VISN-17 leadership, OSC, OIG, OAWP, OMI, the House and Senate committees on Veteran Affairs, our local representatives, and the EEOC. The effort, time, and money that I have spent and that my colleague Dr. [redacted] has spent in this case is enormous but was worth it as it contributed to the safety and betterment of medical care that is rendered to our Veterans at the CTVHCS.

3. **I am requesting that this response [redacted] be attached as permanent record along with your report, be sent with your report to the House and Senate Committees on Veteran Affairs and be published whenever and wherever your report is published.**

4. Please note that the report by Dr. [redacted] Director of VISN-17, is inaccurate, misleading, and biased. It is a manipulation of the facts on the matter.

5. This investigation was supposed to be against the leadership of Dr. [redacted] the Chief of Staff (COS) at the CTVHCS, and his manipulative and counterproductive decisions and actions. However, this investigation has been manipulated and redirected towards pre-determined conclusions to exonerate and protect the COS at the CTVHCS and to scapegoat Dr. [redacted] who did exactly what Dr. [redacted] had ordered him to do.

6. <u>All the allegations in this report are true and are supported by facts.</u> Please note the following:

    a. At least two allegations regarding pending actions that would have harmed our Veterans were blocked because of the vigilance and courage of the whistleblowers in reporting these pending actions to the proper authorities before they occur. This produced fear and retraction of plans by the culprits. Examples of these are plans to redact medical records and plans to replace the RN level of nursing in the Pain Procedure Room by an LVN level of nursing.

    b. The allegations were made independently by the <u>only two pain medicine specialists for the whole of the CTVHCS</u>. Please note that Dr. [redacted] and Dr. [redacted] are the only American Board-Certified Pain Medicine Specialists at the CTVHCS. None other has any Pain Medicine

accredited training or certification, even if their practice is in Pain Management.

c. Furthermore, Dr. [redacted] and Dr. [redacted] participate in a daily manner with patients and administration and are quite informed of what goes around at the CTVHCS.

d. Neither of these pain medicine specialists would risk their career by giving false allegations. Therefore, it would be to the favor of our Veterans and the VA to listen to these two pain medicine specialists to see where the problems lie and how to correct them. All to the benefit of our Veterans.

e. It appears like the majority of the submitted evidence was ignored and not addressed by the OMI investigators. A couple of claims were substantiated, not because the OMI investigators paid more attention to these claims, but because their investigative report would have appeared fake had they unsubstantiated all the allegations. To those who are well informed, the OMI report still looks deficient.

7. We need to clarify the semantics of Pain Management at the CTVHCS. Please note the following:

a. The Pain Management Section is a [redacted] section consisting of three pain management providers. This section was under the Surgical Services, but was realigned by Dr. [redacted] the COS, as a section under Whole Health Services on October 11, 2020. Dr. [redacted] leads this section and supervises two other pain management physicians in this section.

b. Pain Management at the CTVHCS that involves multiple Services and Committees that engage in the implementation of the VHA Stepped Care Model for Pain Management at the CTVHCS

i. Services that are [redacted] involved in Pain Management at the VA include, [redacted] Care, Mental Health, Whole Health, and Pharmacy. This is to be contrasted but not confused with the Pain Management Section, which is a [redacted] section of only three members that was within the Surgical Service and was then realigned under Whole Health Service on October 11, 2020, by Dr. [redacted]

ii. The Pain Oversight Committee (POC)

iii. The Comprehensive Addiction and Recovery Act Mandated Pain Management Team (PMT)

c. Dr. [redacted] Supervises and controls the Pain Management Section only, but has no control over [redacted] Care Service, Mental Health Service, Pharmacy Service, or Whole Health Service. These services fall under the authority of Dr. [redacted] [redacted] the COS. Also, both committees, the POC and the PMT, are under the authority of the COS who appoints their chairperson and dictates their members and direction.

d. The problems with pain management at the CTVHCS are, therefore, not due to the leadership of Dr. [redacted] [redacted] but due to the leadership of Dr. [redacted] [redacted] the COS, who has power over the Services and Committees mentioned above. By transferring the Chair of the POC and the PMT, these two most important pain committees, from Dr. [redacted] to Dr. [redacted] in October 2020, Dr. [redacted] has effectively removed Dr. [redacted] [redacted] from leading pain management at the CTVHCS to the favor of Dr. [redacted] [redacted] who became the de facto pain management director for the CTVHCS.

8. Engaging in the substantiating and the unsubstantiating of allegations in this report, serves as a distraction from the real problem. Most importantly here is a root-cause analysis to pinpoint the origin and the culprits of the problems and to embark upon

correcting the breaches in Pain Management at the CTVHCS and holding the culprits accountable for their actions or inactions. This is the proper way that a Highly Reliable Organization (HRO) such as ours must address such issues. All to the favor of our Veterans who suffer because of counterproductive leadership at the CTVHCS. Namely, the leadership of the Chief of Staff (COS), Dr. [redacted] and his Deputy Chief of Staff (DCOS), Dr. [redacted] who:

a. Both the COS and the DCOS failed to support the implementation of the VHA Stepped Care Model for Pain Management at the CTVHCS. The VHA Stepped Care Model for Pain Management is based in [redacted] Care Service. While Dr. [redacted] through Dr. [redacted] tried to oblige the three interventional pain management physicians to write all opioid prescriptions for the whole of CTVHCS and to treat OUD, while totally ignoring the obligation of [redacted] care to prescribe opioids as per the VHA Stepped Care Model and the obligation of Mental Health Substance Abuse Treatment Program (MH/SATP) to treat Opioid Use disorder (OUD) as they are supposed to do.

b. There are three interventional pain management providers in the Pain Management Section (PMS). This number of providers has not increased since 2014 and until to date, while the number of Veterans at the CTVHCS has significantly increased and more satellite OPCs were established for the CTVHCS. The COS has consistently opposed and blocked the hiring of additional providers to the PMS to meet the growing needs of our Veterans. This has resulted in decrease access to the Pain Management clinics and increased referral to community care pain management providers.

c. Both the COS and the DCOS failed to oblige Mental Health Substance Abuse Treatment Program (MH/SATP) at the CTVHCS to take the lead in the management of Opioid Use Disorder (OUD). The involvement of MH/SATP here is critical. The DEA X-Waiver that allows practitioners to treat OUD with Medication Assisted Therapy (MAT) such as Suboxone is issued to Addiction Specialists but is not issued to non-addiction specialist providers such as [redacted] care or pain specialists unless these work in an environment that is supported by addiction specialists. This is not the case at the CTVHCS where MH/SATP decline to treat OUD and decline consultations from other providers to this regard. This fact is obvious by the number of Suboxone prescriptions that is issued by Mental Health providers that by no means matches the number of OUD cases at the CTVHCS. In this context, The COS and the DCOS choose to do nothing about MH/SATP but try to enforce the three interventional pain management providers to treat OUD, when none of them is trained in addiction or credentialed to manage addiction at the CTVHCS. Additionally, these three providers get absolutely no support from MH/SATP who decline their consultation for OUD. **The attitude of MH/SATP at the CTVHCS is an anomaly at the VA and CTVHCS leadership chose to do nothing about it.**

d. To further exempt MH/SATP from treating OUD, they use a make-up diagnosis of Complex Persistent Opioid Dependence (CPOD) which in effect is OUD but helps in confusing providers and blurring the diagnosis of OUD that comes in mild, moderate, and severe stages. This diagnosis never made it to ICD-10 which is the list of proper medical diagnoses.

9. The following are the facts about the listed investigations into the subject matter:

a. March 21, 2021, VISN-17 Investigation by Dr. [redacted] Dr. [redacted] Director of VISN-17, suppressed the results of this investigation claiming the level of the officials involved. Dr. [redacted] kept this report as secret and never shared it with us. Perhaps because the conclusions of this report were honest and incriminated leadership at the CTVHCS. The fact is that Dr. [redacted] would be the best to investigate these claims because he is a [redacted] care physician with specific interest in pain management and an active member of VISN-17 Pain Stewardship Committee. Dr. [redacted] is aware of the VHA Stepped Care Model for Pain Management and its implementation at the VA.

b. [redacted] 20, 2021, Investigation of Dr. [redacted] The facts about this investigation are as follows:

i. This investigation was called upon to investigate the Hostile Work Environment of Threats and Harassment that was imposed by Dr. [redacted] Chief of Whole Health, and Dr. [redacted] COS, against members of the Pain Management Section. (Exhibit A)

ii. **This investigation was in violation of Policy. Specifically, VHA Directive 0700 on Administrative Investigations has been breached. Dr. [redacted] was requested by Director Mr. [redacted] to convene the investigation. Dr. [redacted] should recuse self from convening the investigation because of the following:**

1. **Dr. [redacted] being a defendant in the hostile work environment claim he ought not convene the investigation against himself. (Exhibit B)**
2. **Dr. [redacted] is aware of at least two recent [redacted] cases (protected activity) that Dr. [redacted] has filed against him, one in March 2019 and one in August 2020 plus several whistleblowing events (Prohibited Personnel Practices) against Dr. [redacted]**

iii. Additionally, Dr. [redacted] could not commit to reading and considering all the factual material that were supplied to him during his investigation. This reflects bias and pre-determined conclusions. As such Dr. [redacted] investigation is fake, unreliable, and cannot be the basis for any proper decisions or actions. (Exhibit C)

c. August 3, 2021, the OMI Investigation: Members of the investigating OMI team were given proof of all the allegations, but they seemed to have ignored most of them.

d. December 5, 2021, Dr. [redacted] investigation.

10. The following is a list of supported facts regarding the performance of Dr. [redacted] MD, Chief of the Pain Management Section at the CTVHCS as this relates to the practice of pain management in this Medical Center:

a. Dr. [redacted] was hired by the CTVHCS in June 2015. Dr. [redacted] has served our Veterans at the VA in the capacity of a pain management physician continually for more than 21 years, since June 2001.
b. Dr. [redacted] holds an active certification of the American Board of Anesthesiology, and the American Board of Anesthesiology Subspecialty is Pain Medicine.
c. Dr. [redacted] chaired the Pain Oversight Committee (POC) from September 2015 and until September 2020, when Dr. [redacted] replaced him by Dr. [redacted]
    i. Dr. [redacted] wrote an all-new Charter for the POC on December 3, 2015. and updated that every two years.
    ii. Dr. [redacted] led the monthly meetings of the POC with busy agendas and perfect minutes that have [redacted] the Opioid Safety Initiative (OSI) to the most desirable numbers among all other Medical Centers in VISN-17, in addition to [redacted] all other pain related issues.
    iii. On [redacted] 24, 2018, as the Chair of the POC, Dr. [redacted] wrote and brought into effect the all-new PAIN MANAGEMENT AND ASSESSMENT Policy for the CTVHCS (Memorandum 011-001).
    iv. On August 6, 2019, as the Chair of the POC, Dr. [redacted] wrote and brought into effect the all-new comprehensive CTVHCS OPIOID USE POLICY (Memorandum 011-013).
    v. Dr. [redacted] is not aware of any complaint against him during his tenure as the chair of the POC. Despite that, in October 2020, Dr. [redacted] the COS at the CTVHCS, appointed Dr. [redacted] to replace Dr. [redacted] as the Chair of the POC.

d. After the Comprehensive Addiction and Recovery Act (CARA) Public Law was enacted and as soon as the VHA related directive was issued,

i. Dr. [redacted] wrote the Charter for the newly formed CARA-Mandated Pain Management Team (PMT) and had it approved by the Clinical Executive Committee on July 18, 2017.

ii. Despite complete lack of help from the COS, Dr. [redacted] was able to gather a team of experts to attend the Pain Management Team Interdisciplinary Clinic that started operating in March 2018, and continued operating with 100% Clinic utilization data, successfully treating the most complex pain management patients at the CTVHCS. Boasting at least 50% of patients seen on megadose opioids were completely off opioids and the remaining were on safer opioid medication regimens.

iii. Dr. [redacted] is not aware of any complaint against him during his tenure as the chair of the PMT. Despite that, in October 2020, Dr. [redacted] the COS at the CTVHCS, appointed Dr. [redacted] to replace Dr. [redacted] as the Chair of the PMT.

e. Dr. [redacted] always updated and renewed the charters for the POC, the PMT, the Pain Management Policy, and the Opioid Use policy on time and as was required during his tenure as chair of the POC and the PMT.

f. Because of Dr. [redacted] effective and successful leadership in pain management at the CTVHCS, Dr. [redacted] was given Outstanding evaluations on all elements of the ECF for the years 2020, 2019, 2018, and 2017. Contrast these four outstanding evaluations given by three different chiefs of Surgical Services and supervisors of Dr. [redacted] namely Dr. [redacted] Dr. [redacted] and Dr. [redacted] as contrasted with the 2021 evaluation by Dr. [redacted] that reflects his retaliation against Dr. [redacted] (Exhibit D)

g. Consider the productivity of Dr. [redacted] and of the Pain Management Section for 2019, 2020, 2021, and 2022 as of September 7, 2022. Dr.

[redacted] productivity has exceeded the productivity target in each of these dates and the Pain Management Section productivity has exceeded the productivity target for all years except for 2020, because of the enforced clinic closures due to COVID-19 Pandemic and because of Dr. [redacted] Joined our team late in March 2020.

Productivity Pain Management 2022:


VA, FY 2022, (V17) (674) Temple, TX HCS, All

Aggregate Specialty	Physician	Producti... Measure	Productivity Target FYTD - Minimum Threshold	Productivity Target FYTD	Pro Tar 75
Pain Medicine	All Physician	3,359.19	1,817	3,063	
	[redacted]	3,495.69	1,817	3,063	
		2,970.11	1,817	3,063	
		3,703.62	1,817	3,063	

Productivity Pain Management 2021:


VA, FY 2021, (V17) (674) Temple, TX HCS, All

Aggregate Specialty	Physician	Producti... Measure	Productivity Target FYTD - Minimum Threshold	Productivity Target FYTD	Pro Tar 75
Pain Medicine	All Physician	4,267.76	2,249	3,792	
	[redacted]	4,190.68	2,249	3,792	
		3,647.96	2,249	3,792	
		5,385.60	2,249	3,792	

Productivity Pain Management 2020:


VA, FY 2020, (V17) (674) Temple, TX HCS, All

Aggregate Specialty	Physician	Producti... Measure	Productivity Target FYTD - Minimum Threshold	Productivity Target FYTD	Pro Tar 75
Pain Medicine	All Physician	2,648.12	2,249	3,792	
	[redacted]	1,442.38	2,249	3,792	
		2,489.82	2,249	3,792	
		4,126.91	2,249	3,792	

Productivity Pain Management 2019:


VA, FY 2019, (V17) (674) Temple, TX HCS, All

Aggregate Specialty	Physician	Producti... Measure	Productivity Target FYTD - Minimum Threshold	Productivity Target FYTD	Pro Tar 75
Pain Medicine	All Physician	4,177.05	2,249	3,792	
	[redacted]	4,020.45	2,249	3,792	
		4,201.95	2,249	3,792	
		4,379.03	2,249	3,792	

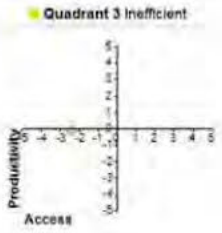
h. Now consider the Specialty Productivity - Access Report and Quadrant Tool (SPARQ) data. Please look at the plots and note the following points:

i. Please note that the Pain Management Section performance has exceeded the productivity target for all years, 2019, 2021, and 2022 as of September 7, 2022, except for 2020, because of the enforced clinic closures due to COVID-19 Pandemic and because of Dr. [redacted] Joined our team late in March 2020.

ii. Please note that the problem was not in productivity as the pain management section exceeded the target that was set forth by the VHA. The problem was Access to the pain management clinics.

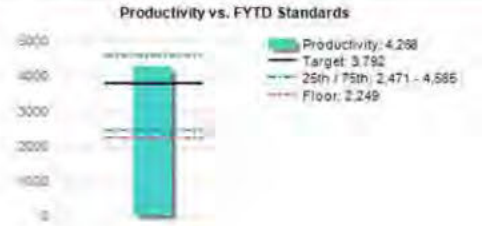
FiscalYear: FY 2022 | **Facility:** (V17) (674) Temple, TX HCS | **Specialty:** Pain Medicine

Average New Patient Wait from Create Date	**45.65** Days
Productivity	**3,359**
Productivity Target (FYTD)	**3,063**
% RVU Capacity	**0%**



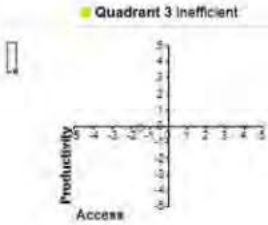
FiscalYear: FY 2021 | **Facility:** (V17) (674) Temple, TX HCS | **Specialty:** Pain Medicine

Average New Patient Wait from Create Date	**34.61** Days
Productivity	**4,268**
Productivity Target (FYTD)	**3,792**
% RVU Capacity	**0%**



FiscalYear: FY 2019 | **Facility:** (V17) (674) Temple, TX HCS | **Specialty:** Pain Medicine

Average New Patient Wait from Create Date	**41.56** Days
Productivity	**4,177**
Productivity Target (FYTD)	**3,792**
% RVU Capacity	**0%**



iii. The problem of reduced access to the Pain Management Clinics at the CTVHCS is that of the COS, Dr. [redacted] here are the reasons why:

1. There have been three pain management providers at the CTVHCS since 2014 and until to date. This is despite the increase in Veteran population in Central Texas, and the fact that the CTVHCS has established additional OPCs in the area. **Pain Management has repeatedly submitted ERCs to hire additional providers and support staff, all of which have been repeatedly and consistently rejected by the COS.**

2. Dr. [redacted] rejected multiple ERC requests to hire staff to meet the growing demands of pain management in 2018 (Exhibits E &F), 2019 (Exhibit G), and 2021 (ERCs written by Dr. [redacted] and submitted by Dr. [redacted] to Dr. [redacted] Read the reason for hiring additional staff on page 2 of each of the attached ERCs. It is specifically stated that the reason is to meet the growing demands of our Veterans and to reduce referral to community care pain management by increasing access to our pain clinic services.

3. Additionally, Dr. [redacted] cancelled the Pain Management Nurse Practitioner's (NP) position after our NP transferred to work at the DOD in [redacted] in August 2018. Also, Dr. [redacted] obstructed us from hiring RNs and other personnel to help us out at the Pain management Suite.

4. Even when funding for hiring a pain management provider was supplied by VISN-17 in 2022, Dr. [redacted] repeatedly refused hiring a pain management provider and advocated for sending patients to Community Care pain management providers. This needs to be investigated. (Exhibits P & Q)

5. Effectively the actions of the COS tied our hands at the pain management section, reduced access of our Veterans to the pain clinic services, increased community care referrals to pain management, and set us and our Veterans up for failure.

6. It is clearly documented with facts that the increased in Community Care Pain Management referrals is due to the failure of the COS who obstructed every effort we put to hire more personnel to meet the demand of a growing population of Veterans in the area. This is not the failure of the Chief of the Pain Management Section. The evidence presented above proves proper productivity by the pain management section providers but decreased access to the pain management clinics is due to insufficient pain management providers and that is because the COS blocked all our efforts to hire additional providers.

11. The following is a list of supported facts regarding the performance of Dr. [redacted] MD, Chief of Staff, as this relates to the practice of pain management at the CTVHCS:

    a. As pointed above, Dr. [redacted] has undermined Pain Management at the CTVHCS and reduced access to the Pain Management Clinics by obstructing efforts to hire needed personnel.

b. Dr. [redacted] the COS, has authority over all medical services at the CTVHCS, but failed to implement the Stepped Care Model for Pain Management. This involves [redacted] Care, Whole Health, Mental Health, and Pharmacy Services. None of these services fall under the Chief of the Pain Management Section but fall under the responsibility and authority of the COS, Dr. [redacted] and the DCOS, Dr. [redacted]

c. Mental health Substance Abuse Treatment Program (MH/SATP) at the CTVHCS has traditionally refused to treat OUD, or even help those who treat it.

   i. This fact is supported by the number of Suboxone prescriptions (MAT for OUD) that are issued by MH providers compared to the number of patients with OUD at the CTVHCS.

   ii. Also, the number of patients referred to Community Care Providers for Suboxone management is unjustifiable when we have specialized MH providers at this Medical Center who can do so.

   iii. The COS and the DCOS at the CTVHCS who are over the MH Service are aware of these facts but are complacent about it. They choose to take a passive role and to do nothing.

   iv. Instead, the COS has ordered Dr. [redacted] to force providers at the Pain management Section to [redacted] their X-Waiver and start treating OUD.

d. Providers at the Pain Management Section never denied any patient chronic opioid management when these were medically indicated. Also, I note that the providers at the Pain Management Section are pain medicine

specialists and have better, more effective, and much safer means than chronic opioids for treating chronic pain. At the Pain Management Section and through the PMT, we have been able to get many patients off mega doses of opioids and give them a better life with more effective pain management. This has been so important during the current opioid epidemic that is claiming the lives of many citizens.

e. **The sine qua non of Dr. [redacted] tenure as the COS at the CTVHCS from July 2014 and until present is securing his position and power. His actions and decisions do not appear to benefit of our Veterans.** Consider the following:

   i. Dr. [redacted] gets rid of all Associate Chiefs of Staff (ACOS) who may compete for his job. Examples Dr. [redacted] who was the ACOS over PMRS, and Dr. [redacted], who was ACOS over Internal Medicine and then became Deputy COS before Dr. [redacted] got rid of him. More cases exist.

   ii. Dr. [redacted] appoints over services ACOSs who do not constitute a threat to his position, such as putting a podiatrist (Dr. [redacted] as ACOS over the Surgical Services instead of an MD, and appointing a PhD (Dr. [redacted] as ACOS over Mental Health and not an MD. None of those constitute a threat to Dr. [redacted] position.

   iii. Dr. [redacted] discriminates against Asians and practices Ethnic Nepotism. In late 2018, he removed Dr. [redacted] (Asian) from DCOS office, and in an act of Ethnic Nepotism he assigned the position to his fellow Nigerian, Dr. [redacted] who is still his faithful DCOS until to date.

iv. During my discussion with Dr. [redacted] the chair of the VISN-17 Pain Stewardship Committee, she stated that the CTVHCS lacked a Pain Management Point of Contact (POC) who ought to be a member of that committee and carry over the duties as the POC. I nominated my colleague, Dr. [redacted] as he is best qualified for this position besides myself, as I was too busy at that time. I nominated Dr. [redacted] to Dr. [redacted] our COS who rejected the idea and falsely claimed that he has already chosen Dr. [redacted] the ACOS for Anesthesia for this position. Here I must mention that Dr. [redacted] is an Anesthesiologist who is not trained, not experienced, and not credentialed at the CTVHCS to practice as a Pain Management Physician, yet despite that Dr. [redacted] chooses her as the POC for pain management over Dr. [redacted] (Asian). This is a clear and blatant discrimination against Asians by Dr. [redacted] and he gets away with it. (Exhibits I & J)

f. In a recent "PMOP Gap Analysis [redacted] Report: VISN 17" from May 2022, I quote the following tables from (Exhibit H):

i. As you can see that the CTVHCS has no Pain Management Team, has no experts working at the PMT clinic, and the reason for this is the lack of "Support of Medical Leadership." It is Dr. [redacted] and not Dr. [redacted] who has destroyed the PMT at the CTVHCS.

ii. Contrast this with a fully established and a fully functional PMT at the CTVHCS since 2017, under the leadership of Dr. [redacted] Dr. [redacted] has destroyed the PMT at the CTVHCS by replacing Dr. [redacted] with Dr. [redacted] in October 2020, who has rendered the PMT completely unproductive and nonfunctional.

iii. For how much longer will the CTVHCS and its Veterans bear the wrath of this toxic and counterproductive medical leadership? For how much longer will VHA leadership coverup for such gross incompetence and abuse of authority?

Pain Management Teams

	Does your facility have a PMT?	For how long?	Main service line
(504) Amarillo VA	No	-	-
(519) West Texas VA	No	-	-
(549) Dallas VA	Partially staffed	> 5 years	Anesthesiology
(671) South Texas- San Antonio	Fully staffed	2 to 5 years	PM&R
(674) Central Texas	No	-	-
(740) Texas Valley Coastal Bend	Partially staffed	1 to 5 years	Pain Medicine
(756) El Paso	Partially staffed	2 to 5 years	Surgery

PMT Staffing

	Medical Provider with Pain Expertise				Provider with Addiction Expertise				Provider with Behavioral Medicine Expertise			Provider with Rehabilitation Expertise		
	Yes/ no	Head count	Hours/ week	# X-way	Yes/ no	Head count	Hours/ week	# X-way	Yes/ no	Head count	Hours/ week	Yes/ no	Head count	Hours/ week
(504) Amarillo VA														
(519) West Texas VA														
(549) Dallas VA	Yes	1	1 to 4	1	No	-	-	-	Yes	1	17 to 40	Yes	1	17 to 40
(671) San Antonio	Yes	8	>160	2	Yes	6	41 to 80	2	Yes	2	41 to 80	Yes	3	41 to 80
(674) Central Texas														
(740) TX Coastal Bend	Yes	2	1 to 4	1	Yes	1	9 to 16	1	Yes	1	17 to 40	Yes	1	1 to 4
(756) El Paso	Yes	BLANK	BLANK	3	Yes	3	1 to 4	3	Yes	2	1 to 4	No	-	-

Barriers to PMT Implementation

	Staff Recruit	Staff Retain	Team Integration	Team engagement	Unfilled positions	Insufficient Resources	Primary care collaboration	Protected Time	COVID-19	Other
(504) Amarillo VA	X	X	X		X	X		X		Not implemented as a full team, tasks are divided
(519) West Texas VA	X	X	X		X			X		
(549) Dallas VA	X	X				X		X		
(671) San Antonio	X							X		
(674) Central Texas			X	X			X	X		Support of medical leadership
(740) TX Coastal Bend	X									
(756) El Paso	X	X								

g. Dr. [redacted] [redacted] the COS, always grooms a scapegoat to sacrifice for his own blunders. The scapegoat is naïve and inapt for the chosen position so that Dr. [redacted] can control him as he pleases. Through such a naïve and inapt person, Dr. [redacted] can retaliate against staff, break the

rules, and abuse his authority. When these breaches and abuses are discovered, Dr. [redacted] sacrifices the scapegoat and [redacted] his position as the COS unaffected and unscathed to go on repeating his game over again. (Exhibits K & L)

i. This is what happened in this case. The scapegoat was Dr. [redacted] Dr. [redacted] was obsessed with power and was elevated by Dr. [redacted] to a position and to a salary that he would have never even dreamed of. Dr. [redacted] hired Dr. [redacted] as the de facto Chief of Pain Management at the CTVHCS despite the lack of expertise, experience, training, or credentials of Dr. [redacted] in Pain Management. Dr. [redacted] bestowed upon Dr. [redacted] the Chairs of the POC and the PMT and realigned the Pain Management Section under Dr. [redacted] to give him full control over Pain Management. However, effectively Dr. [redacted] was in control of Pain Management.

ii. Because Dr. [redacted] did exactly what Dr. [redacted] ordered him to do, including retaliation against members of the pain management section, abuse of authority, and breaches of multiple VHA directives. But these were all under the orders of Dr. [redacted] the COS and the direct supervisor of Dr. [redacted]

iii. Despite our repeated complaints, Dr. [redacted] never addressed any of our complaints until the OSC, the OMI, and all branches of government were involved. Then and only then, did Dr. [redacted] move to effectively fire his scapegoat, Dr. [redacted] from all clinical, all administrative, and all supervisory duties, in addition to firing him from the Chair and membership of both the POC and the PMT.

iv. How much easier it would have been had the COS at the CTVHCS heeded to the concerns of the experts in Pain Medicine? But again, this would be [redacted] that Dr. [redacted] is an effective COS without a vindictive agenda to undermine pain management at the CTVHCS. There need to be an honest investigation into the matter of Dr. [redacted] leadership at the CTVHCS. That is difficult to [redacted] under the leadership of Dr. [redacted] [redacted] VISN-17 director, who is a long-term comrade of Dr. [redacted]

h. More concerns regarding Dr. [redacted] [redacted] the COS at the CTVHCS. (Exhibits M, N, & O)

12. Please note that some exhibits below, have their own exhibits. These may be supplied upon request.

13. **If all the facts that are presented in this response and in its attached exhibits do not hold the counterproductive medical leadership at the CTVHCS accountable, then our Veterans and our Medical Center are in dire trouble. It so appears that Dr. [redacted] [redacted] is well above the law because none of these investigations and none of the well-documented facts that were presented over the last two years were able to hold him accountable for his many abuses, breaches, and blunders. I am requesting an honest investigation into the claims against Dr. [redacted] [redacted] that I have presented in this document and in the attached exhibits.**

Sincerely,

[redacted] [redacted] MD
Telephone: [redacted]
Email 1: [redacted]gmail.com
Email 2: [redacted]va.gov

ATTACHMENTS:

1. EXHIBIT A_20210703_HOSTILE WORK ENVIRONMENT & POLICY VIOLATIONS
2. EXHIBIT B_20210517_Threats and harassment
3. EXHIBIT C_20210520_[redacted] COULD NOT COMMIT
4. EXHIBIT D_ANNUAL PERFORMANCE EVALUATIONS_[redacted]X5 YEARS
5. EXHIBIT E_20180117_ERC Staffing Request-PAIN MGMT_REJECTED by COS
6. EXHIBIT F_20180607_ERC Staffing Request-PAIN MGMT_REJECTED by COS
7. EXHIBIT G_20190307_ERC Staffing Request-PAIN MGMT_REJECTED by COS
8. EXHIBIT H_PMOP Gap Analysis [redacted] Report VISN 17
9. EXHIBIT I_20220521_Central Texas Pain Point of Contact (POC)
10. EXHIBIT J_20220610B_TO [redacted]CTVHCS Point of Contact (POC)
11. EXHIBIT K_20220324_OSC_NEW INTAKE_DR. [redacted]
12. EXHIBIT L_20220110_LETTER TO PSB
13. EXHIBIT M_COS_DR. [redacted] [redacted]CONCERNS_2018-2019
14. EXHIBIT N_COS_DR. [redacted] [redacted]CONCERNS_2020-2021
15. EXHIBIT O_COS_DR. [redacted] ABUSIVE LEADERSHIP
16. EXHIBIT P_20220220A_[redacted]DR. [redacted] PATIENTS_Redacted
17. EXHIBIT Q_20220220B_[redacted]I can take OUD_Pain w_Suboxone_Redacted