October 4th 2024

Comments

1. Investigation was conducted for years 2022 and 2023 which were the **wrong** years. It should have been done for years 2021 and 2022. On March 7 2023 Psychiatrist AM had a Teams meeting with the Director and expressed concerns about long wait times and absence of walk in clinic at the Perry Point VAMC Mental Health Clinic. Psychiatrist AM told the Director that he was receiving informal reports from veterans that their use of street drugs including Fentanyl has increased because they have to wait long to see a prescriber. Perry Point is at high risk because it is only a 15 minute drive from the town of Elkton 'Drug capital of Maryland' and Prostitutes collaborate with Drug Dealers to sell Fentanyl laced drugs disguised as pills for anxiety and depression. Psychiatrist AM emphasized to the Director that this could lead to fatal outcomes and this could be reduced if the Psychiatric Leadership increased their time at Perry Point from one day to two days in person or remote or had one or two Psychiatrists from Baltimore who had lighter schedules assist Perry Point. This did not happen so Psychiatrist AM volunteered to work beyond tour of duty on some days and on some weekends so that we would save the lives of Veterans. So for the year 2023 PsychiatristAM helped to reduce Wait times and save veterans lives. 17 veterans die every day from suicide. Veterans have much higher rates of Fentanyl overdose than the general population Psychiatrist AM had a very high work load due to staff shortages he was responsible for3 Residential Units and was also bridging outpatients. Because of this high work load Psychiatrist AM had to

work beyond tour of duty and on some we ekends and this was all done without any request for extra compensation.

2. Investigators **did not** enquire about Walk in Mental Health services at Perry Point. They **did not** interview the Program Coordinator of the Perry Point clinic. They interviewed a front line office receptionist/Medical Assistant who may not be knowledgeable about walk in services There were **no** walk in services for veterans who had not previously registered at the Clinic The Urgent care clinic at the Main Hospital was closed. The Program Coordinator of the Perry Point Mental Health Clinic sent me an email confirming that if you have not been seen at PP in the past 12 months there is no walk in option.

3. Investigators **did not** interview the Program Coordinator of the Harm Reduction Program to obtain data on Veterans who overdosed on Fentanyl or other drugs. The Harm Reduction Program Office is aware of incidents and deaths due to street drugs overdoses. The investigators concluded that there was no harm to veterans from long wait time. This is an **incorrect** conclusion because the Harm Reduction Office data was not reviewed. It would be very critical to determine the wait times for those who overdosed on Fentanyl or others treet drugs.

4. Investigato ʁ **did not** separately examine the follow up intervals for prescribers. They looked at the interval b etweendischarge and first follow up contact by a Mental Health Provider who was

usually a social worker and in the residential program social workers do contact Veterans within one or two weeks after discharge. Thus Investigators conduded incorrectly that this met the post discharge guidelines. Investigators **did not** survey the time between discharge and appointment with a prescriber (Physician or Nurse Practitioner). On average this was about 3-4 months for the year 2021 and 2022. The guidelines require 1 month interval post discharge follow up and for those who have a suicidal flag they should be seen within 7 days of discharge Because of the Fentanyl epidemic it is very important for Veterans to get their psychiatric meds on time or they will use street drugs and die from accidental overdose.

5. Investigators state that there was **no** method to assess the time interval between date of discharge from MH RRTP to first follow up appointment. This is a wrong observation. There is a discharge note in each patients chart written by the social worker which dearly states the date of discharge and next follow up appointment by Therapist, Psychiatrist and Internist. The investigators **did not** review this note for the patients discharged from residential units. Each patient also has Patient discharge instruction note they are given. Psychiatrist AM provided the Team with a sample of veterans with data on date of discharge and date of prescriber and therapy follow up date to prove long waiting times for veterans.

6. In evaluating the productivity of the Psychiatrists assigned to the Residential Program the investigators did not obtain counts of patients discharged by each Psychiatrist in each unit. The

calculated Productivity based on notes written. Psychiatrist AM had a very high work load because he was assigned 3 Residential Units (88 beds) so this Psychiatrist AM wrote 'one line notes' when medication adjustment was done.
For e.g. "Vet is more depressed so Zoloft dose increased to 100mg Vet educated about side effects'" This note was very brief and so was not coded so no encounter was dicked and so no productivity generated so productivity was low. With a high work load it was impossible to write detailed notes and code higher level which would lead to high productivity. There was just no time because Psychiatrist A M had a lot of clinical responsibility. Productivity is therefore better assessed by number ofpatients discharged per year. Psychiatrist A M was the Attending on 88 patients every day and he discharged 484 veterans for 2022 and 2023 and Psychiatrist JK who was theAttending on thesubstance abuse residential unit (34 bed unit) discharged 236 veterans for the same years . Also important to note that there was no Unit Secretary assigned to 2 of the Residential Units at Perry Point. Psychiatrist AM had to do administrative work also for e.g arranging transportation services to bring Veterans from other hospital to be readmitted to the Residential Units. Thus in order to serve our veterans Providers have to stay beyond tour of duty on some occasions to save lives and care of our veterans.

7. Investigators report that a Psychiatrist worked on weekends violating boundary issues. They did not get details of this issue The details are that the Psychiatrist came to work on an occasional weekend to spend an hour or so filing out Medical forms for veterans to submit to get Non-VA benefits such as SSDI, Medical Assistance etc With this income Veterans will be able to live in a

HUD Vash apartment and not be homeless on the street. Veterans who are homeless are more likely to die from accidental drug overdose or suicide. Under usual circumstances all this work can be done during regular tour of duty but during 2021 and 2022 and 2023 Psychiatrist AM was assigned a large case load and so had to work beyond tour of duty to help veterans and Psychiatrist AM did not voice any complaints about this. Since members of the Psychiatrist Leadership work on weekends and earn extra money – moon lighting' Psychiatrist AM presumed that there should not be any issue if he came on some weekends and spend an hour or so to assist Veterans with completing medial paperwork to avoid homelessness. Psychiatrist AM believed that it would be extremely unethical and in violation of the Hippocratic Oath to look at the cloc kand at 4.30pm just leave on the dot when ones tour of duty ends even though there is more clinical work to do that has to be done that day

8. The Investigators did not investigate WHY there was a serious shortage of Psychiatrists at Perry Point. The reason that should have been investigated is that 4 Psychiatrists were given disciplinary letters for administrative reasons. These were seen as Whistle Blower re taliation and th ePsych atrists challenged them legally h iring th esame Maryland Employment firm th ath as represented many other staff employed at the Maryland VA. This company specialized in W hsti e Blower Retaliation against Physicians. The Psychiatrists won their case and their termination letters were withdrawn. They decided to leave to avoid any further retaliation and removal for fear of loosing their pension and other retirement. One Psychiatrist FL left for fear that she may also receive such a disciplinary letter and did want to

compromise her retirement benefit. She was the best psychiatrist in the world very caring and hardworking. The Investigator should have investigated this matter so that it does not happen for future new hires. When Prescribers leave it takes a long time to hire and wait times increases for Veterans to get their medicines and there will be adverse outcomes. Another Psychiatrist JK who was working in the Residential Program left Perry Point due to this 'Fear of Removal' October 17th was this Psychitrists last day and she was fellow ship trained at the best program in the US and she was just starting her career in the VA

It is important to note that on March 10 2023 Psychiatrist AM met with the Director of the Maryland VA System and informed him about serious concerns at Perry Point Out Patient Cinic and Residential Program that was endangering the lives of veterans

An investigation was conducted and in August 2024 the Psychiatric Leadership implemented the following changes:

1. One additional day of Outpatient coverage at Perry Point by a member of Psychiatrist Leadership
2. All veterans discharged from Residential Programs will see a Prescriber in 7days This was possible by having the Physican Assistants conduct a discharge group
3. A Physician Assistant has been assigned to reduce the work load of Psychiatrist AM so that this Psychiatrist would not have to work beyond tour of duty.