11 September 2022

The Honorable Henry Kerner
Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW, Suite 300
Washington, DC 20036

Re: Office of Special Counsel File No. DI-21-000033, Dl-21-000470 and D1-21-000503, and Office of Medical Inspector File TRIM 2021-C-29

Dear Mr. Kerner:

I am responding to the OSC's request of me, dated August 1, 2022, regarding the investigations conducted by the Department of Veterans Affairs regarding Whistleblower Allegations that officials at the VA Central Texas Healthcare System (hereafter Temple) in Temple, Texas, engaged in conduct that may constitute Gross Mismanagement and a Substantial and Specific Danger to Public Health.

I address the body of the VA's report to the OSC, which is ostensibly based primarily on Attachment 1, included with that report. I also insert comments regarding Attachment 6 in this response pertaining to the Office of Medical Inspector report which regards the disclosures transmitted to the OMI that I had sent to the OAWP, which are identical disclosures that I had made to the OSC.

The OSC investigation was delegated to Veterans Integrated Service Network 17, to assemble and lead a VA team to conduct an investigation; it appears that two such investigations were performed, in sequence, and that only one of those investigative reports was remitted to the OSC; I have no knowledge of the status or current possession of the other report. To my knowledge, the 1st and 2nd investigations on this matter were conducted by the VA from **February 28, 2021- December 17, 2021**.

The OAWP investigation was referred to the OMI pursuant to the authority described in 38 USC §323. An investigation was commenced in regards to allegations brought forth by the Pain Management section providers. Notably, some of the investigation conducted by the OMI seem to have served as an opportunity to draw negative conclusions about the Pain Management section itself.

While only certain of the allegations were substantiated according to the VISN investigation's report (and not substantiated according to the OMI) and certain others were substantiated according to the OMI investigation's report (and not substantiated according to the VISN), **it is my belief that all of the allegations are substantiated by the evidence.**

It is noteworthy to me that the allegations I submitted were not substantially similar, but instead, they were identical; further, best I can tell, I had submitted identical evidence, including patient examples, to

[redacted]

at least the 2nd investigator assigned to the OSC investigation and to the OMI team; evidence submitted to the 1st investigator for the OSC investigation was submitted according to available evidence at the time.

The reports are characterized my numerous inaccuracies and omissions which must be clarified. I will attempt to address these inaccuracies in my response.

To start, the referral history of the case is stated within the VA's report to the OSC, although there are inaccuracies to this. The investigation on this matter is noted as having been conducted on August 17, 2021 through December 17, 2021; I continued to send correspondence to <OSC-VISN-Investigator#2> through latter January 2022. Furthermore, I was initially contacted by VISN17 HR on February 8, 2021 to initiate communication with <OSC-VISN-Investigator#1> assigned by the VA – VISN17.[1] I am not sure why the investigation dates are listed as they are in the report submitted to the OSC. To my knowledge, the investigation that was conducted on this matter by the OMI directorate of the VA-OIG started at some point following June 1, 2021, when the OMI had accepted the allegations from the OAWP.[2] I was informed that the allegations were being transmitted to the OMI on May 28, 2021.[3] I continued to send correspondence to the OMI team through latter February 2022.

The reports notes that my allegations centered on gross mismanagement, an abuse of authority, or a substantial and specific danger to public health; the referral letter to the VA was sent by the OSC on November 17, 2020. According to the report, it nearly 1 month later, on 12/14/2020, that the VA responded by stating that my initial allegations were going to be investigated by a VISN17 investigator.

According to the report, On January 14, 2021 an additional 3 allegations were referred to the VA by email. What is not reported is that I had been asked for a Letter of my current concerns on February 8, 2021, when I was contacted by the Human Resources personnel on behalf of <OSC-VISN-Investigator#1>. I responded with a Letter of Concerns that included allegations which in whole or in part had not been addressed in VISN investigation for the OSC:[4]

> "<WHS-Svc-Chief> has performed unsolicited/unrequested self-consultations on numerous patients, with whom he had not had previously established relationships and/or requests for consultation. These self-consults appear to involve patients whose names he had access to, **first**, as a member, and then, as the chairman, of the CTVHCS Pain Management Team. I do not believe these self-consults are consistent with regulation or with VA policy. **This self-consultation behavior also includes patients with whom** <WHS-Svc-Chief> **would actually only be performing administrative functions as the section Chief. It is my understanding that although his role was to be administrative, he turned these interactions into billed self-consultations.** These actions exceed <WHS-Svc-Chief>'s authority and violate law and regulation. I am unable to supply information on the extent of such consultations, as to my understanding, <WHS-Svc-Chief>'s clinic schedule has remained blocked off with no availability ever having been listed.

[1] <VISN17HR-OSC-investigationcoordinator>, emails to me, February 8-12, 2021.
[2] <OAWP-IntakeAnalyst>, email to me, June 1, 2021.
[3] <OAWP-IntakeAnalyst>, email to me, May 28, 2021.
[4] <Whistleblower#1>, email to <OSC-VISN-Investigator#1>, February 16, 2021.

"The **continued alignment of the traditional section of Pain Management under Whole Health** is a concern; Whole Health, as the home of **CIH was never intended to administrate over traditional medicine** ---certainly not a specialty service which falls under a separate ICC altogether. The alignment is inconsistent with VA policy and creates impediments to care for pain management patients. As it is done in other VA facilities, Whole Health was intended to be vertically and horizontally integrated with Mental Health and Primary Care per the VHA executive decision memo of 3/2020.[5] The concern with the **current misalignment at CTVHCS is that the appointment of a clinical director over Whole Health and subsequent/concomitant alignments of any traditional medicine specialty under its administration serves as pathway for any provider meeting criteria for hire for the Whole Health Clinical Directorship**, which has included at different facilities, physical therapist(s}, psychologist(s}, nurse practitioner(s}, and physician(s} of different specialties, **to have clinical and administrative scope beyond his/her training, expertise, and credentialing over the providers of the misaligned traditional specialties.** As such, the alignment of a traditional medical specialty under Whole Health can not only function contrary to the ICC classifications, it can also create a mechanism by which National and/or local hiring criteria and credentialing processes which are applied to providers in traditional medical specialties can be bypassed. Notably, this is exactly what has happened here at CTVHCS. As a result, the Pain management section here has become stifled and restricted from advancing its standard of care.

"Based on my understanding of the information from the CTVHCS *VISN 17 Pain Stewardship meetings*, **VISN 17** tracks New Long Term Opioid Patients as a measure; **it does not, however, track Buprenorphine as one of those opioids**. VISN 17 therefore kicks Buprenorphine products out of long term opioid tracking and yet very much tracks Buprenorphine products via the SUD16 parameter. The SUD16 parameter theoretically tracks those veterans who have been diagnosed with OUD and receive medication treatment for it, although even vague opioid diagnostic listings can suffice as the denominator of this parameter. It can appear that there are decreasing total Opioid prescriptions, decreasing co-prescribing of Opioids and Benzodiazepines, and increasing treatment of OUD ---**all by selecting whatever diagnosis is selected to match the denominator for the SUD16 parameter, even if actual OUD is not diagnosed. This is concerning because morbidity and mortality may even go up, instead of down**. It is unknown to me what the other VISNs are doing in relation to tracking the Buprenorphine via their various dashboards. Monitoring the drug in one regard, but not the other, incentivizes prescription of the drug in a more profound fashion; by the time dissemination of the drug is entrenched in prescriber habits and clinical approaches with sewn-in clinical/diagnostic ambiguity, it may be too late to reverse."

[5] VHA Executive Decision Memo – Engaging Veterans in Lifelong Health, Well-being and Resilience Integrated Project Team, March 4, 2020

It was noted in the VA's report to the OSC, that on April 13, 2021 a Fact-finding was initiated and conducted by <VISN17-HWE-Investigator>; and that a second Fact-finding was requested because the first lacked clear conclusions relative to the allegations. **I would like to clarify any confusion that this presented timeline may raise regarding the investigative course**. The report of <VISN17-HWE-Investigator> in regards to this investigation --- the OSC investigation --- lacked clear conclusions because <VISN17-HWE-Investigator>'s report had nothing to do with the OSC investigation; instead, <VISN17-HWE-Investigator> was recommended by name by the VISN17 Director to investigate allegations of a Hostile Work environment that were made by <Pain-Mgmt-Chief>.[6]

I obtained the Charge letter via FOIA request; it is dated April 7, 2021 and it includes the questions to be investigated:[7]

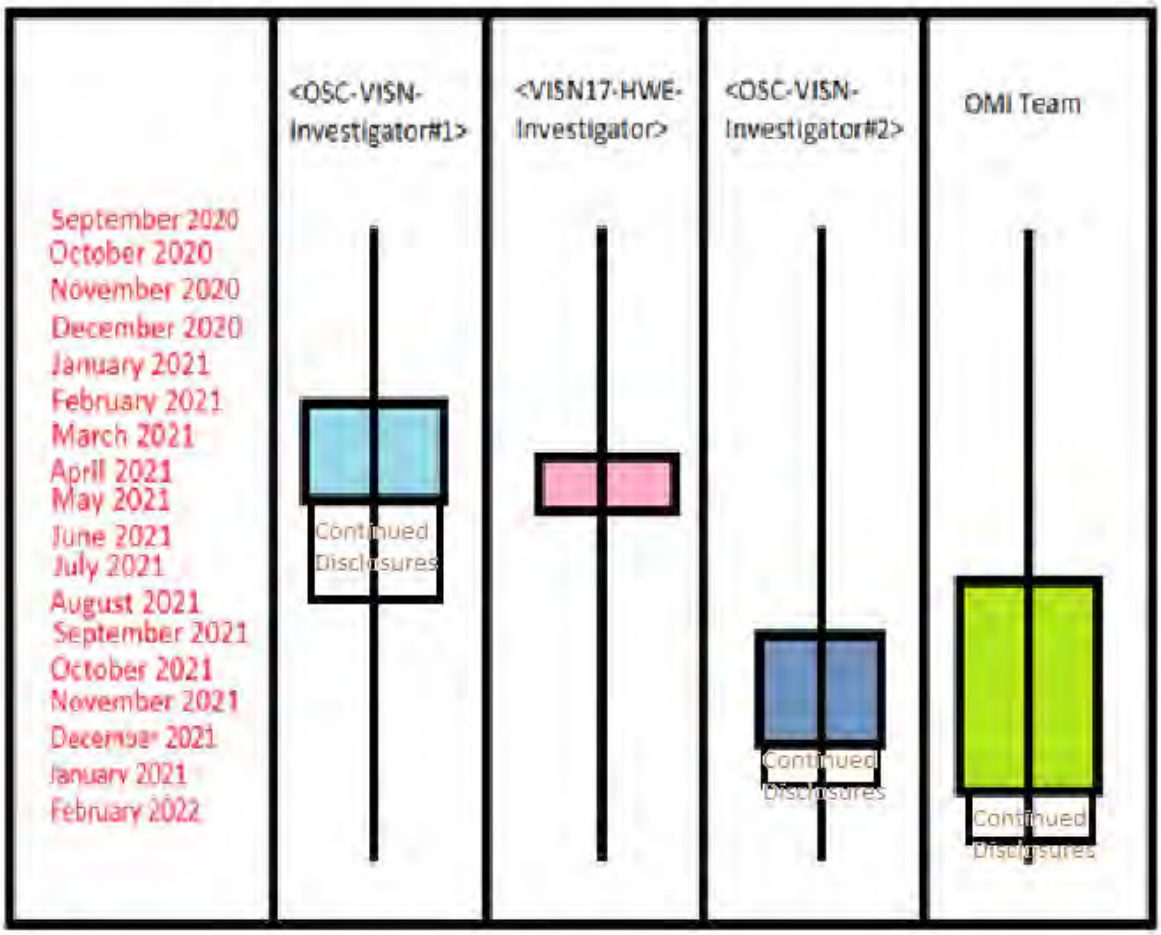
"
Has the <REDACTED> created an environment that is toxic?
What are the circumstances surrounding these allegations?
"

In his report on the question of a Hostile Work Environment, while <VISN17-HWE-Investigator> mentions the <Pain-Mgmt-Chief>'s EEO activity on more than one occasion, <VISN17-HWE-Investigator> does not appear to address much of the concerns of the Pain Management Section's providers.[8]

The OSC report goes on to mention that the OSC report is independent of OAWP, OMI, and OIG reports.

The claim is again made that the OSC investigation was taken to VISN17 with action on it only having begun on April 13, 2021. Correspondence surrounding the appointment of <VISN17-HWE-Investigator> as a Fact-finder further punctuates the task with which he was charged: to investigate the allegation of a Hostile Work Environment.[9]

[6] Emails regarding the involvement of <VISN17-HWE-Investigator>, April-September 2021.
[7] <VISN17-HWE-Investigator> Charge Letter, April 7, 2021.
[8] <VISN17-HWE-Investigator> Redacted Report, May 11, 2021. <Whistleblower#1/Me>, email to <VISN17-HWE-Investigator>, Emailed Pre-interview statement, April 13, 2021.
[9] Miscellaneous correspondence re: <VISN17-HWE-Investigator>, March 15 - May 13, 2021.



I have a hard time making sense of the supposed timeline documented in the report and the actual timeline. I had regularly sent communications to <OSC-VISN-Investigator#1> over the course of 6 months, from February 2021 to August 2021. It appears to me that the report of <OSC-VISN-Investigator#1> was entirely **excluded from the analysis**. While it may appear that there are two reports available for review to the OSC and to Congress, the report and conclusions of <OSC-VISN-Investigator#1> has been omitted, and the report of <VISN-HWE-Investigator> has been substituted in its place; my concern is that it appears that there are two investigative reports to match up to two OSC investigators' investigations; this, of course, is inaccurate, and I can only conclude that the report of <OSC-VISN-Investigator#1> was not submitted to OSC or to Congress.[10]

The Allegations / conclusions as presented by the investigation teams:

[10] <OSC-VISN-Investigator#1> Email to me, May 11, 2021.

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1) <WHS-Svc-Chief> has sought to rescind the facility's standard operating procedures (SOP) for prescribing Buprenorphine, an opioid used to treat opioid use disorder (DUD), acute pain and chronic pain.	<WHS-Svc-Chief> ordered PMS to become X-waivered by the DEA and start treating patients with OUD using Suboxone. The Central Texas Veterans Health Care System has a Mental Health / Substance Abuse Treatment Program that can professionally manage these medical problems and provider psychosocial support. <WHS-Svc-Chief> is circumventing SOP and professional standards of care for use of Buprenorphine and Suboxone.

The OSC investigation report concludes that **Allegation #1** is **not substantiated**. The OMI investigation report concludes that this Allegation is **not substantiated**.

Almost immediately, the report goes on to say: "The fact-finding did support; however, that <WHS-Svc-Chief> did seek to rescind the facility's SOP for prescribing buprenorphine. It is noted that the SOP failed to conform with the current national standards of practice and required revision. The VA Central Texas Healthcare System in Temple, Texas, will review the currently local published SOP, revising it to conform with current national standards of practice."

It is agreed that <WHS-Svc-Chief> sought to rescind the facility's SOP for Buprenorphine.

The points of contention that remain:

> "Allegation was not substantiated. *Investigation of this concern did not reveal evidence of a violation of law, rule, or regulation, gross mismanagement, a gross waste of funds, an abuse of authority, or a substantial and specific danger to public health or safety*."
>
> "*It is noted that the SOP failed to conform with the current national standards of practice and required revision*."

Regarding Point #1 –

The SOP for Buprenorphine was presented to the Clinical Executive Council at CTVHCS, voted on and passed, after having been voted for acceptance in the Pain Oversight Committee.[11] According to VHA Notice 2019-24 Mandatory-Business-Rules-for-Local-Policy-Development 11-1-19 (replaced with VHA Notice 2020-34 Mandatory-Business-Rules-for-Local-Policy-Development 10-20-20 and then VHA-Notice-2021-22-Mandatory-Business-Rules-for-Local-Policy-Development-12-13-21):[12]

[11] <Pain-Mgmt-Chief>, email to Quality, Safety, and Value, July 21, 2020.
[12] VHA Notices Mandatory Business Rules for Local Policy Development, 2019-2021.

"All VA medical facility employees must be granted access to all of their VA medical facility's SOPs in a local SOP repository, with exceptions for specific services with separate SOP sites (that is, Sterile Processing and Pathology & Laboratory Medicine), for sensitive emergency response protocols, and by specific exemption by the VA medical facility Director.

"Access to the VA medical facility's SOPs must also be granted to "VHA Publications Access" mail group to facilitate oversight. NOTE: VA medical facilities are highly encouraged to populate and utilize a voluntary SOP Library to share SOPs among services in similarly situated VA medical facilities.

"VA medical facilities should continue to use their local development and approval process for SOPs, including SOPs taken from the SOP Library. The SOP Library/"Swap" is available at: <REDACTED>. This is an internal VA Web site that is not available to the public. "

At no time during the request for the SOP was any request or designation made known by the Director regarding the access to this SOP being restricted from employees that I am aware of.

When the SOP for Buprenorphine was presented to the Clinical Executive Council at CTVHCS and voted on, it was passed. The SOP was not disseminated or made available to employees.

Therefore, I believe, as it appears the SOP was "shelved", **a violation of policy is to be substantiated for this allegation.**

Additionally, as the SOP was not made available as it was to be according to the Mandatory business rules cited above, and as the SOP pertained directly to patient care, it presents a substantial and specific danger to public health or safety and this allegation, I believe, is to be **substantiated as a substantial and specific danger to public health or safety.**

An actual patient case has come up at another facility with SOP implementation being hindered as well; at that facility, the lack of clarity regarding patient flows leading to a near-actualized patient safety event was exacerbated by the behavior surrounding a Buprenorphine SOP.[13] Briefly:

VA-OIG REPORT #**21-03195-189** --- Pharmacists' Practices Delayed Buprenorphine Refills for Patients with Opioid Use Disorder at the New Mexico VA Health Care System in Albuquerque

This investigation focuses on allegations of real or potential patient harm which highlights the following:

(1) The confusion surrounding whether or not an opioid medication is indicated for chronic pain or for Opioid Use Disorder Is real and has real, tangible effects on patient care/management decisions; the difference between those diagnoses is not merely "academic" or "moot".

(2) A point of concern is the fact that the facility had not implemented their Buprenorphine SOP; due to the facility's not having done so, the OIG could not determine

[13] VAOIG-21-03195-189 - Pharmacists' Practices Delayed Buprenorphine Refills for Patients with OUD, June 30, 2022.

the effects on access for the medication for Opioid Use Disorder (from what I see where I am at CTVHCS, our issue in Temple, TX is not a lack of already X-waivered providers… apparently in contrast to the situation in Albuquerque)

Excerpts:

> The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess allegations regarding the **policy and practices** related to the **provision of buprenorphine treatment for patients with opioid use disorder** at the **New Mexico VA Health Care System in Albuquerque** (facility).
>
> The OIG determined that pharmacy practice made no delineation between prohibition of early refills of partial opioid agonists **for opioid use disorder** and full opioid agonists **for pain**, despite the different indications for each medications' use and associated risks. **Pharmacy practice of prohibiting early refills of buprenorphine for opioid use disorder, justified under the facility policy that forbids early refills of opioids for pain**, was more restrictive than what was allowed by VHA and facility policy guidance applicable to Schedule III controlled substances, and inconsistent with guidelines for evidence-based treatment of opioid use disorder.
>
> The OIG did not substantiate that the facility's standard operating procedure (SOP) on buprenorphine treatment for patients with opioid use disorder, enacted in July 2021, was inconsistent with VHA guidance on buprenorphine treatment for patients with opioid use disorder. The OIG was **unable to determine whether implementation of the buprenorphine SOP would reduce access to buprenorphine for patients with opioid use disorder**, **as the SOP was not fully implemented at the time of the OIG's review.**

That inability to determine the magnitude of the effects on the delivery of the healthcare service in question, due to the policy violation noted above (of not making the SOP available to employees) is what I believe **substantiates a specific danger to public health or safety** as the veteran's story in Albuquerque demonstrates**.**

Regarding Point #2 –

I was unable to find any National Standard of Practice on Buprenorphine prescribing or OUD in the VHA. I searched the **National Standards of Practice** website and provide a screen capture of what I found.[14]

I did find two versions the VA/DoD CLINICAL PRACTICE GUIDELINE FOR THE MANAGEMENT OF SUBSTANCE USE DISORDERS, one from 2015 and one from 2021. From the most recent iteration of the guideline from 2021, which was published during one of the extensions to the OSC investigation (I was not allowed the opportunity to contribute), it is stated:[15]

[14] Link: Providing Feedback on Draft National Standards of Practice - VA National Standards of Practice, July 2022.
[15] VA/DoD CLINICAL PRACTICE GUIDELINE FOR THE MANAGEMENT OF SUBSTANCE USE DISORDERS, 2021.

"Variations in practice will inevitably and appropriately occur when clinicians take into account the needs of individual patients, available resources, and limitations unique to an institution or type of practice. Every healthcare professional making use of these guidelines is responsible for evaluating the appropriateness of applying them in the setting of any particular clinical situation."

"These guidelines are **not intended to represent Department of Veterans Affairs or TRICARE policy**."

In further response to the OSC and OMI report's conclusions on this matter:

I sent the OSC investigators and the OMI team documents in relation to the same. It is noteworthy that I sent the team the VA-DoD Clinical Practice Guidelines for Opioid Therapy in Chronic Pain from 2017, the VA-DoD Clinical Practice Guidelines for the Management of Substance Use Disorders from 2015, and the American Society of Addiction Medicine (ASAM) Practice Guideline Focused Update from 2020.

Noteworthy excerpts from the above:

VA/DoD CLINICAL PRACTICE GUIDELINE FOR THE MANAGEMENT OF SUBSTANCE USE DISORDERS v4.0 – 2021

"In short, patients with mild SUD **can be appropriately managed in primary care settings**. In addition, patients with more severe SUD who are not willing to follow through with a referral to specialty SUD care **due to stigma may also be treated in settings outside SUD specialty care**."

VA/DoD CLINICAL PRACTICE GUIDELINE FOR THE MANAGEMENT OF SUBSTANCE USE DISORDERS v3.0 – 2015[16]

"C. Determination of Treatment Setting Recommendation

"3. For patients with a diagnosis of a substance use disorder, we **suggest offering referral for specialty substance use disorder care** based on willingness to engage in specialty treatment. (Weak For | Not reviewed, Amended)

"Discussion

"Most patients with alcohol and other SUD do not receive adequate treatment,[21] and many patients will not accept referrals to a specialty clinic for SUD [21,44,106,107] for reasons including, but not limited to, lack of perceived need, fear of stigma, lack of readiness for treatment, lack of resources, time restrictions, etc.

"While there is evidence that selected patients with SUD can be treated in primary care or general mental healthcare, **there is value in initially offering a referral to an SUD specialty clinic** when available.

[16] VA/DoD CLINICAL PRACTICE GUIDELINE FOR THE MANAGEMENT OF SUBSTANCE USE DISORDERS, 2015.

"A referral to specialty care may **help the patient recognize that there is significant concern**, which might motivate the patient to address the issue(s) more fully. If a patient has stated that he/she does not want and will not accept a referral to the specialty clinic, then efforts should be made to **engage the patient in primary care** to include monitoring and treating substance-related problems.

"Thus, a referral to specialty SUD care should be offered if the patient has at least one of the following:

- May benefit from **additional evaluation** of his/her substance use and related problems
- Has been **diagnosed as having an SUD**
- Is willing to engage in specialty care

"Benefits of offering a referral far outweigh any associated harms, and patients vary widely in their values and preferences regarding engaging in specialty care. The offer of a referral expresses care and concern on the part of the provider and **allows an opportunity for patients to receive sufficient information for reasoned decision making**. **Referrals may have implications for resource utilization in both the primary and specialty care settings and may not be able to be based on positive screening results alone."**

VA/DoD CLINICAL PRACTICE GUIDELINE FOR OPIOID THERAPY FOR CHRONIC PAIN v3.0 – 2017[17]

"Furthermore, the presence of chronic pain does not seem to interfere with the success of MAT. The RCT by Weiss et al. (2011) and a meta-analysis by Dennis et al. (2015) reached the same conclusion that the presence of chronic pain did not influence response to opioid agonist therapy.[179,182] Given the high mortality associated with OUD and the safety and efficacy of MAT for OUD in multiple clinical trials and meta-analyses, we recommend MAT for those chronic pain patients who meet DSM-5 criteria for OUD. **Those who do not respond to minimal counseling may benefit from a comprehensive assessment and more intensive treatment of OUD and any co-occurring conditions in SUD specialty care settings.**"

The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder: 2020 Focused Update[18]

"Diagnosis Recommendations - Other clinicians may diagnose opioid use disorder, but **confirmation of the diagnosis must be obtained by the prescriber before pharmacotherapy for opioid use disorder commences**. Opioid use disorder is primarily diagnosed on the basis of the history provided by the patient and a comprehensive assessment that includes a physical examination."

Secondly, <WHS-Svc-Chief> had specifically instructed our section to utilize Buprenorphine in a fashion clinically that is opposed to professional standards of care on the use of Buprenorphine by stating which diagnosis is made does not matter. Not only was such direction contrary to the standard of care, the recent VA-OIG report cited above focuses exactly on this as a specific danger to the public health. As stated, I believe the allegation must be **substantiated as a specific danger to the public health**.

[17] VA/DoD CLINICAL PRACTICE GUIDELINE FOR OPIOID THERAPY FOR CHRONIC PAIN, 2017.

[18] The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder: 2020 Focused Update. J Addict Med. 2020 Mar/Apr;14(2S Suppl 1):1-91.

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2) <WHS-Svc-Chief> pressured providers to prescribe buprenorphine regardless of patient diagnosis and promoted incorrect guidance to providers that does not reflect the standard of care, placing patients at risk.	<WHS-Svc-Chief> ordered PMS to become X-waivered by the Drug Enforcement Agency (DEA) and start treating patients with Opioid Use Disorder (OUD) using Suboxone (Buprenorphine + Naloxone).

The OSC investigation report concludes that **Allegation #2** is **partially substantiated**. The OMI investigation report concludes that this Allegation is **fully substantiated**.

The investigators were supplied Pay for Performance documents, one of which clearly reveals "financial incentive on the prescribing of a specific medication along with incentives to apply specific diagnoses" and the OSC report states this is problematic and presents a specific and potentially substantial danger to patient safety."[19]

I have a hard time understanding why this is anything other than completely substantiated by the VISN investigation for the OSC. From the date of the issuance of the 1st Pay for Performance document in December 2020 through sometime in July 2021, this inducement was in effect. As such, I believe, this would **substantiate a violation of law, rule, or regulation**, regardless of if any such monies were paid out for the action or not and regardless of whether the recipient of the offer committed the action or not.

The OMI team report indicates: "We substantiate that the WHS Clinical Director ordered PMS providers to become X-waivered by the DEA and start treating patients with OUD with Suboxone; however, he chose not to enforce the providers' getting the X-waiver and none currently have the X-waiver."

In the OMI report, on page 19, it is stated that "Only one PMS physician has the waiver" whereas on page 23, it is stated that "he chose not to enforce the providers' getting the X-waiver and none currently have the waiver". Why there is this apparent discrepancy is not clear to me. The <WHS-Svc-Chief> initially stated that he could not force us to get the X-waiver, even writing this in a Letter to me that he had acknowledged he could not do this … then he went on to offer us the financial inducement via Performance Pay to obtain the X-waiver and treat a proposed diagnosis "Complex Persistent Opioid Dependence" with a certain dollar amount per head if a threshold of 5 patients was reached. It is true that at some point, he chose not to enforce the providers' getting the X-waiver, although he enforced our presenting him with the MOUD training certificate; one of the Pain Management section physicians then indicated that an X-waiver had been applied to his file. I have come to wonder about to the timeline of events and the discrepancy noted above, but I do not have a clear answer.

In <WHS-Svc-Chief>'s role as Whole Health Service Chief, his function over the traditional medicine section of Pain Management ought to have been administrative, as he was not credentialled as a Pain Management specialist, per the OMI report. Further, it is in <WHS-Svc-Chief>'s discretion as to which aspects of the Pay for Performance criteria are to be counted as achieved or not achieved and what he

[19] <WHS-Svc-Chief>, email to me, Performance Pay document #1, December 30, 2020.

decides to count or count against the Pain Management section provider in both the Pay for Performance criteria and the Ongoing Professional Practice Evaluation. I have previously raised my objections on the matter, but nonetheless, <WHS-Svc-Chief> forced his clinical interest and beliefs regarding an unvalidated, non-covered diagnosis into my Pay for Performance Evaluation in support of his repeated attempts at directly clinically overseeing me and my practice, which **substantiates a violation of law, rule, or regulation.**[20]

Further still, the <WHS-Svc-Chief> repeatedly cited a Number-Needed-to-Treat of 2 for patients with Buprenorphine while sparsely referencing OUD/Opioid Dependence; instead, he regularly spoke and wrote in communications to conflate diagnoses of pain and OUD, thereby confusing the relevance of the data to different subpopulations of patients, confusing further the degree to which Buprenorphine may or may not be indicated and the degree to which it is a "life-saving medication" or potentially a "life-destroying" one, as many other opioids have been over the years. The drug does appear to have an improved safety profile compared to other opioids compared in isolation or certain situations, but touting its benefits by citing an NNT of 2 to "save a life", when the Cochrane Review which gave rise to that number specifically excluded patients with comorbid chronic pain, while simultaneously attempting to induce the Pain Management providers to prescribe the opioid fully **substantiates a specific and potentially substantial danger to patient safety**.[21]

Documentation regarding an actual Veteran's case (Veteran #3, cited later in these response) was sent to <OSC-VISN-Investigator#2> and to the OMI team, showcasing the dangers of conflating an actual diagnosis of OUD/Opioid Dependence with the non-validated diagnosis of Complex Persistent Opioid Dependence, a change in prescription from Suboxone to Buprenorphine, and the Mental Health Service's behavior surrounding a consult request I placed two to three times where any meaningful discussion of current/prior diagnoses of Opioid Dependence/OUD between the MH staff and the veteran did not occur until later, at which time, the veteran denied interest in the consultation; their service opted instead to talk about pain and alcohol dependence, though neither was requested as the reason for consultation.[22] To be clear such coexisting diseases are commonly encountered in clinical practice and reasonably raise the complexity of the presenting concern of OUD/Opioid Dependence to that appropriate for a Substance Use Disorder specialist.

Notably, the veteran is charted as having gone on to attempt suicide with a combination of an opioid (not Buprenorphine) and alcohol. That veteran's story highlighted the need for the involvement of the Mental Health Service in the evaluation and treatment of OUD/Opioid Dependence and showcased that attempts to force such evaluation/treatment onto non-MH Substance Use professionals can be clinically inappropriate, dangerous, even. In the VA, a Stepped Care model for OUD is the current model touted for care, but engagement that is appropriately skilled and available in any service other than Mental Health for such presentations will be impossible or unsafe without a willing and ready Mental Health service presiding over that staircase; a veteran requiring such evaluation and treatment will simply fall off the steps without a "landing" at the top of the staircase. I believe this veteran's case affirms and **substantiates a specific and potentially substantial danger to patient safety**.

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[20] <Whistleblower#1>, email to <WHS-Svc-Chief>, I referenced my previously stated objections, December 30, 2020.

[21] Mattick RP, Breen C, Kimber J, Davoli M. Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence. Cochrane Database of Systematic Reviews 2014, Issue 2. Art. No.: CD002207.

[22] <Whistleblower#1>, Emails to <OSC-VISN-Investigator#2> and OMI team re: "Veteran #3", November 2021.

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3) <WHS-Svc-Chief> has engaged in improperly documented "self-consults" with Pain Management Team (PMT) patients, prior to their initial appointments, leading to potential billing irregularities and inequitable care.	<WHS-Svc-Chief> is performing self consults outside the VA 's clinical screening and treatment procedures. <WHS-Svc-Chief> has been performing encounters without billing or engaging physician utilization. <WHS-Svc-Chief> has implemented centralized control over consults in Whole Health and the Pain Management Team that interferes with Veteran access to Physician Care.

The OSC investigation report concludes that **Allegation #3** is **not substantiated**. The OMI investigation report concludes that this Allegation is **not substantiated**.

It is not clear to me how Allegation 3 was not substantiated. From my review of the report, it appears the OSC Report writer concedes that:

"The patient encounters were reportedly inconsistently documented within the medical record"

As such, it appears that the Report Writer agrees with my submission that <WHS-Svc-Chief> was:

Seeing some patients without being consulted, charting notes, and billing for the encounters.
Seeing some patients without being consulted, charting notes, and not billing for the encounters.
Seeing some patients without being consulted and not charting notes and not billing for the encounters.

I submitted clear examples of this to <OSC-VISN-Investigator#2>.[23]

To my knowledge, the conclusion that "When concerns were raised by members of the team about disruption of the interdisciplinary process, the consult process was modified to consist of individual appointments followed by an Interdisciplinary Team (IDT) meeting without the Veteran" is a spurious one. I had been unaware of any such record of documentation of this trajectory of events; I recall reading of some such intent, but it was not until I had seen the OMI report as an attachment to the report to the OSC, that I understand what was actually happening may have been some type of ?informal / undocumented care visits.

After 2020, the Pain Management Team stopped seeing patients altogether.[24] <WHS-Svc-Chief> indicated that he would alter the consult process; to my knowledge, this did not happen. I am aware that there had been at least a couple of consults to the PMT that were scheduled with <WHS-Svc-Chief>, only to be rescheduled and then rescheduled again, with a question as to if those consults even occurred; I do not believe I have a record of those consults, but I believe they could be found via LEAF request identifiying CARA-PMT (IDT-X) consults and reviewing the consult processing documentation of those charts.

[23] <Whistleblower#1>, email to <OSC-VISN-Investigator#1>, October – November 2021.
[24] <WHS-Svc-Chief>, email to PMT, suspending the PMT, February 24, 2021.

There does not appear to be a policy-based mechanism for a consult to the Pain Management Team to be split up into 2 or more individual consultation requests to individual providers.[25]

Instead, <WHS-Svc-Chief> broadened his consultation behavior to include:

(1) Consulting and not billing on patients based on undocumented verbal discussions with others[26]
(2) Consulting and billing on patients for whom his stated role was administrative[27]
(3) Using Pain Management section specialty consultation requests as consults to him as per his decision-making.[28]

As far as the specific discussion regarding consultation with patients prior to PMT (IDT-X) meetings, there was communication with Health Information Management Service (HIMS) wherein the matter was discussed. Correspondence from the Assistant Chief of HIMS, revealed is reviewed:[29]

"
Documentation for a Consultation needs to satisfy all three of the elements – History, Exam and Medical Decision Making. During COVID 19 the exam portion has been exempted.
In each of the 07/07/2020 cases, the patient was contacted by <WHS-Svc-Chief> prior to the Conference Meeting. Patients had no prior contact from the conference participants for the 08/04/2020 cases.
If there is no consultation process for the Whole Health Service, <WHS-Svc-Chief> would be able to see and treat patients as an active member of the PMT Conference Team.
In order to be a Team Conference, all members must have firsthand knowledge of the patient and the patient must have knowledge of each of the providers on the team.
During the PMT Team Conference the members come together for peer review, studying and discussing this case with the group and to resolve any roadblocks by utilizing each member's experience. This would **not** be a billable service but would instead be used to expedite the care of the patient.
"

It appears undisputed between the OSC Report writer and myself that <WHS-Svc-Chief> had been documenting both patient histories and medical-decision-making; in at least one case, I believe this involved ordering labs.

We can see from these responses two things:

> <WHS-Svc-Chief> would not have suggested doing his pre-visits as non-count visits *had he not been billing for them in the first place*, nor would the question even have arisen.
>
> *If* <WHS-Svc-Chief> was seeing these patients in the function of PMT Conference participant, he *should not have been billing for the pre-visits* he was performing; he was billing for them.

[25] VHA Directive 1232 - Consult Processes and Procedures
[26] Attachment 6 / OMI report TRIM 2021-C-29, pages 39-40, January 25, 2022.
[27] "Self-consultation" example; based on veteran request re: Denial of Wait Time via Mission Act
[28] "Self-consultation" example; based on veteran request re: Denial of Continuity of Care via Mission Act "epidural... cancelled... not reauthorized"
[29] Health Information Management Systems, email, September 2-10, 2020.

The suggestion on a non-count clinic *would also be inappropriate* if <WHS-Svc-Chief> was seeing these patients as his initial consultation to them in order to establish care *to make him eligible for PMT Team conference coding* (which would be a subsequent visit):

According to **VHA Directive 1230**: A telephone contact between a provider and a patient is only considered an encounter if the telephone contact is documented and that documentation include the appropriate elements of a face-to-face encounter, namely **history and clinical decision-making**. *Telephone encounters must be associated with a clinic assigned to one of the telephone stop codes and are to be designated as count clinics.*[30]

On the other hand, if <WHS-Svc-Chief> had been seeing patients in individual consultation as an Addictionologist, this represents a deviation from **VHA DIRECTIVE 1232 Consult Processes and Procedures.**

"Clinical Consult. A clinical consult is a consult document in CPRS used as two-way communication on behalf of a patient consisting of a physician or provider (sender) request seeking opinion, advice, or expertise regarding evaluation or management of a specific problem answered by a physician or other health care provider (receiver). The CPRS consult package must be used for all clinical consultations."

This further represents a deviation from §17.108:[31]

"Copayments for inpatient hospital care and outpatient medical care. A specialty care outpatient visit is an episode of care furnished in a clinic that does not provide primary care, and is only provided through a referral."

The OMI did not substantiate that <WHS-Svc-Chief> was performing self-consults outside the VA's clinical screening treatment procedures or has been performing encounters without billing and engaging physician utilization. They did substantiate that the WHS Clinical Director ceased the review of patients during the PMT meeting December 2020 and instead was utilizing this meeting for administrative purposes in violation of the Temple CARA Mandated Pain Management Charter of Team, responsible for coordinating and overseeing pain management patients experiencing acute and chronic pain (non-cancer related) as required by the CARA Act.[32]

The OMI goes on to conclude that the use of the consultative visit Current Procedural Terminology (CPT) code 99243 for the PMT meeting is inappropriate.

The OMI report comments: "The informal weekly meeting outside of the PMT implemented by the WHS Clinical Director has resulted in patient care discussions and decisions regarding patients with pain diagnoses which has not included all members of the PMT, and which have not been documented in the electronic health record (EHR). The lack of presence of the entire PMT interdisciplinary team may have resulted in a less thorough review of each patient's case. The lack of recording these discussions in the patient's EHR may impact communication related to that patient's plan of care."

[30] VHA Directive 1230 - Outpatient Scheduling Processes and Procedures, July 15, 2016, amended January 7, 2021.
[31] §17.108, Specialty care outpatient visits.
[32] CTVHCS CARA-PMT charter, dated October 17, 2019.

These two points are key:

- *"The lack of presence of the entire PMT interdisciplinary team may have resulted in a less thorough review of each patient's case."*

This is exactly the danger in <WHS-Svc-Chief> taking histories and coming up with medical-decision making on veteran on whom he is not individually consulted prior to the occurrence of any PMT meeting.

- *"The lack of recording these discussions in the patient's EHR may impact communication related to that patient's plan of care."*

It appears the OMI team is concluding that this is inappropriate / potentially dangerous. Care decisions were being made and acted upon without documentation on how or why these decisions were being made by the key decision-maker. Communication-related errors are well known to be a source for medical errors resulting morbidity, mortality, and malpractice claims; The Joint Commission (previously known as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)) issued a Sentinel Alert Event on the same topic, Issue 58, September 12, 2017.[33]

Office of Special Counsel File No. DI-21-000033, DI-21-000470 and D1-21-000503	**Office of Medical Inspector File TRIM 2021-C-29**
4) <WHS-Svc-Chief> initiated changes to the Pain Management referral process that imposed barriers to access to interventional pain care services.	Not addressed

The OSC investigation report concludes that **Allegation #4** is **not substantiated**. The OMI investigation report did not address the allegation.

This allegation appears to have been non-substantiated purely due to a misunderstanding; my emails to <OSC-VISN-Investigator#1> and to <OSC-VISN-Investigator#2> discuss two separate topics together: (1) A screening function of Whole Health personnel into the consult request process to the traditional medicine section of Pain Management and (2) A requirement for an Intro to Whole Health class to see our traditional medicine section of Pain Management.

Regarding the description in the report to the OSC, "During the fact-finding, the whistleblower indicates that the requirement for provider completion of the "Intro to Whole Health" VHA course was only implemented for consult referrals to Complimentary and Integrative Health Services and not for consult referral to interventional pain management.[34] This is reflected in the template for Pain Management consultation, as well as in the service agreement for Pain Management Services at Temple. The service agreement additionally indicates that patients may receive interventional pain concurrently with acupuncture or chiropractic care" I cannot speak to any current iteration of any policies; I have not been allowed to see them.

[33] JCAHO alert *Sentinel Event Alert,* Issue 5, September 12, 2017.

[34] <OSC-VISN-Investigator#1> and <OSC-VISN-Investigator#2> emails, March 26, 2021 and October 4, 2021.

I am that Whistleblower to whom <OSC-VISN-Investigator#2> referenced, and if I recall correctly, I verbally stated during our interview, that the Intro to Whole Health class *was* required and implemented for consults placed and meant for the Pain Management section, and stayed required as far as I knew, although by the time the matter was being discussed with <OSC-VISN-Investigator#2>, this demand was no longer being enforced and then it was removed as a prerequisite altogether, as apparently, there was a large backlog of veterans waiting for the class which had been mandatory. At first, the class had to have been taken; then it was changed to had to have been scheduled; as long as it was scheduled the pain consult could then occur.[35]

On a related topic, my disclosure regarding the fact that <WHS-Svc-Chief> was instituting a plan whereby Whole Health coaches would be screening consults to the WHS, including Pain Management was reviewed by the investigators; I came upon this information by hearing <WHS-Svc-Chief> say this directly and subsequently put this in writing in an email.[36] It is my belief that *my disclosure regarding this matter* is what stopped <WHS-Svc-Chief> from enacting the screening process by which Whole Health Coaches would screen and direct/redirect consults to the Pain Management section; to my knowledge, Whole Health coaches did not screen consults to the Pain Management section, and I believe that is fortunate.

I include here the results of a recent VA-OIG investigation in which a patient's care appeared to be determined by the screening action of a complementary care provider, although the request from the referring provider was for a Pain Management consult.[37]

> VA-OIG REPORT #**21-03525-148** --- Failure to Follow a Consult Process Resulting in Undocumented Patient Care at the Chillicothe VA Medical Center in Ohio
>
> *This investigation focuses on allegations of patient harm which seems to have stemmed from:*
>
> > *(1) The lumping together of traditional Pain Medicine with Complementary/Alternative care modalities.*
> >
> > *(2) The use of non-physician complementary care personnel to screen consults which may be intended for traditional medicine physicians/providers*
> >
> > *(3) The harms that can follow in the setting of seeing patients in consultation outside of established consult processes and without being properly consulted.*

[35] Miscellaneous, <OSC-VISN-Investigator#2> emails, March – April 2021.
[36] Miscellaneous, <OSC-VISN-Investigator#2> emails, Single Consult Channel.
[37] VAOIG-21-03525-148 - Failure to Follow a Consult Process

Excerpts:

> The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess 10 allegations related to the **quality of patient care, the management of patient care, and the availability and use of resources through the Urgent Care Center (UCC) at the Chillicothe VA Medical Center** (facility) in Ohio.
>
> Veterans Health Administration (VHA) and facility policies **require that the sending provider enters a consult**, and the **receiving provider links the visit note directly to the consult**. For a STAT (or a same-day) consult, the sending provider must also contact the receiving provider to discuss the patient's case.
>
> In addition, because the consult was not entered, chiropractor 1 and the clinical massage therapist could not link the visit note to the consult and had no process for documentation when the consult was not entered. As a result, chiropractor 1 and the clinical massage therapist **failed to document the care provided to the patient within the electronic health record (EHR)**.
>
> On August 22, 2021, the OIG received 10 allegations involving care provided through the UCC. The first allegation involved an urgent care provider sending a patient with a T12 compression fracture to have chiropractic care at the Complementary and Alternative Medicine (CAM) clinic **and a week later the patient returned to the UCC with a T12 burst fracture and fractures of the right 11th and 12th ribs.**
>
> Through interviews, the OIG was provided with the following information. **The facility's CAM clinic provides several treatment options including pain management, chiropractic care, and clinical massage therapy**. To access services, a provider enters a CAM consult. **A chiropractor reviews the consult and determines** what services would be most appropriate for the patient's need.
>
> The OIG found that the **urgent care provider did not refer the patient for chiropractic care**. Rather, the urgent care provider assessed the patient's condition on day 8 and documented the disposition care plan as **"patient has been referred to pain management**.

The trajectory of the care episode described at the Chillicothe VA demonstrates the identical concerns that I have raised, ones which I believe **substantiate a specific danger to public health or safety.**

As such, I believe this allegation is to be **substantiated.**

Office of Special Counsel File No. DI-21-000033, DI-21-000470 and D1-21-000503	**Office of Medical Inspector File TRIM 2021-C-29**
5) <CTVHCS-CoS> and <WHS-Svc-Chief> violated the MISSION Act of 2018 (MISSION Act) and jeopardized patient health and safety by prohibiting pain management physicians from approving pain management community care programs for patients on the basis of the "improved continuity of care" criterion.	The OMI did **not substantiate** the WHS Clinical Director refused to allow community care pain management. The OMI **partially substantiates** that the WHS Clinical Director violated the MISSION Act by refusing to allow community care referrals for pain management based on best medical interest (BMI) criteria. There is confusion regarding multiple interpretations of BMI criteria and instructions given by the WHS Clinical Director regarding BMI approval which are not fully in alignment with MISSION Act.

The OSC investigation report concludes that **Allegation #5** is **not substantiated**. The OMI investigation report concludes that this Allegation is **partially substantiated**.

It appears that Allegation 5 focuses on the prohibition of veterans from being seen in the community; I raised the matter up to <Pain-Mgmt-Chief> and I had sent multiple examples to <OSC-VISN-Investigator#2> and to the OMI team.[38] It is noted on a coded/billed note charted authored by <WHS-Svc-Chief> that regarding the veteran: "Received message. Patient wanted to continue to be seen in the community for pain management… He was supposed to have epidural in the community but this was cancelled because community care was not reauthorized."

Best I can tell, this is blatant evidence that veterans were not only being denied care in violation of the MISSION Act, but it brings up that the <WHS-Svc-Chief> was seeing veterans and coding/billing the interactions off of his own handling of administrative complaints that came about in the first place based on his instructions to deny such care to Veterans in the community. As such, not only were the veterans denied care in the community in apparent violation of the MISSION Act, but a key decision-maker, <WHS-Svc-Chief>, potentially increased his own RVU production numbers by then seeing those veterans who were denied Pain Management Specialty care in the community based off of his instructions.[39]

Attachment 6 / OMI report TRIM 2021-C-29 **partially substantiated** that the MISSION Act was violated, stating there is confusion regarding … instructions given by the <WHS-Svc-Chief> … not fully in alignment with MISSION Act. I am confused by that conclusion. The Pain Management sections were given instructions contrary to the MISSION Act; I raised these concerns up the supervisory chain and to those with oversight functions otherwise; there were veterans who would have qualified for Care in the Community were denied it if the reason was Best Medical Interest – Improved Continuity of Care. It seems to me that the OMI would wholly **substantiate the allegation**.

[38] Mission Act disclosures to <Pain-Mgmt-Chief> and OMI team, emails, January 8, 2021 - October 2021.
[39] "Self-consultation" example; based on veteran request re: Denial of Continuity of Care via Mission Act "epidural... cancelled... not reauthorized"SI "Cancelled because community care was not reauthorized"

To illustrate just how "contrary" these instructions and this consult processing was to the Specialty Service, I sent the OMI team as well as to <OSC-VISN-Investigator#1> and to <OSC-VISN-Investigator#2> specific patients affected.[40] I also include as an attachment to this response, documentation of just how serious this topic was taken *prior* to the Pain Management section being realigned under the complementary care service of Whole Health; I had not allowed a consult request to go through due to the wording used on "continuity"; a patient care advocate indicated his intent to escalate the issue directly to the Chief of Staff skipping the rest of my chain of command, although I did communicate with my chain of command on the topic.[41] See attached. After the Realignment under Whole Health, such a denial did not seem to trouble leadership, suggesting that Mission Act violations which were partially substantiated by the OMI would not have occurred in the first place ***but for*** the Realignment.

Importantly, consultation requests made to the community were brought up not just to <WHS-Svc-Chief>, but also through the chain of command on the handling of such consult requests. <OSC-VISN-Investigator#2> makes reference of "disclaimers" added by the Pain Management section; the "disclaimers" were not disclaimers; instead, the wording used specifically directed the requestor to address the request further with <WHS-Svc-Chief> by way of deferral to his decision-making on appeal if desired, as the decision was actually his via instruction.[42]

Per <WHS-Svc-Chief>, <CTVHCS-CoS> complained of specific wording that he wanted redacted from the charts; <OSC-VISN-Investigator#2> inaccurately attributed the generation of this wording to me. The name of <CTVHCS-CoS> was added by the <Pain-Mgmt-Chief> to the redirection wordings as the <CTVHCS-CoS> was aware and seemingly supportive of the clinical determinations being made by the administrative chain of command.[43] The discussion unfolded as <WHS-Svc-Chief> took notice that <Pain-Mgmt-Chief> had begun using the wording in question and tasked him and the Pain Management section to identify the consultation requests where such wording was utilized.[44]

List(s) of the veterans with relevant requested consultations were sent to <Pain-Mgmt-Chief> by <WHS-Svc-Chief>; by this point in time, approximately 500 consultation requests were identified with wording for redaction; these consultation requests pertain to requests being made for community care that instead of being processed for forwarding to Care in the Community (CITC) were processed for here at CTVHCS; the lists reveal the status of the consults, including many that were listed as "complete."[45]

It is very difficult to make the claim that there were no other veterans who were denied care in the community when it was being requested for Best Medical Interest – Improved Continuity of Care, as at least some of these consultations were performed here at CTVHCS instead of in the community, and these consultations contained the wording that was applied to the consult processing when the request was not being sent to the community.

A LEAF request could be submitted by the investigator(s) to identify first the charts where such wording was used, and then which of those patients were seen here at CTVHCS, and potentially also which of those consult requests mention any variation of the word "community" or "CITC" or "established." This

[40] Mission Act disclosures to investigators, emails, re: BMI denials.
[41] Miscellaneous, Pre-Realignment approach to Mission Act, emails, August – September 20, 2020.
[42] <Whistleblower#1> emails, Progression of deferring to <WHS-Svc-Chief>, 2021.
[43] <Whistleblower#1> to <CTVHCS-CoS>; email, no more processing until consults clarified, March 1, 2021.
[44] <Pain-Mgmt-Chief>, email re: wording used, February 26, 2021.
[45] Miscellaneous, re: Chart identification for redaction, emails, April 2021.

would help identify patients who were denied community care within the short time (?1-2 months) where such wording *was used* during consult request processing/disposition, although it is noteworthy that consults continued to be processed per instructions via the supervisory chain to deny veteran care in the community seemingly owed to them under the MISSION Act for several months thereafter.

As far as the OMIs characterization of the allegations and their findings:

I am unaware that anyone claimed that the <WHS-Svc-Chief> disallowed **ALL** consults to the community for Pain Management.

I do not believe that he ever disallowed consults for the community in the setting of Drive Time, except for in cases where the Intro to Whole Health Class was not performed during the stretch of time when the Intro class was required to be scheduled prior to a Pain Management Specialty appointment being scheduled, in which case, such consultation requests may have indeed been disallowed.
I sent the OMI team direct evidence with specific patient(s) of community care being requested and denied under orders.[46] I have sent blatant examples of community care being denied for the BMI-continuity of care designation under the instructions given to the Pain Management Section occurring to the OMI team; I am unsure as to how this allegation is only partially substantiated and not **wholly substantiated.**

The portion of the statement citing "confusion" is only relevant insomuch as Pain Management Section staff directly requested clarification, and instructions throughout continued to contain elements of denying community care in a manner that appears inconsistent with the MISSION Act.

If consults for community care were denied according to instructions given via the <WHS-Svc-Chief> under threat of administrative action for not adhering, with the knowledge and support of <CTVHCS CoS> and <CTVHCS Director> on escalation of the issue, and the OMI states that the instructions were not "fully in alignment with the MISSION Act", I would consider that this allegation must be **wholly substantiated.**

As to the OMI report's statement regarding a "large number of consults that are referred to the community (90% of which are new consults)": Our practice quickly became to process all consults to accept for scheduling here within the VA with limited exceptions --- in accordance with the instructions from the <WHS-Svc-Chief>. We were even eventually given the instruction to disregard our own consult template to accept the consult requests.[47] As such, the large number of consults to the community were secondary largely to Wait Time and Drive Time; this is consistent with the caution that I gave to the <CTVHCS-CoS> regarding <WHS-Svc-Chief>'s instructions on Community Care consult processing not serving to meet the presented goals in an email dated 2/8/2021 (I forwarded this email thread onwards to the to <OSC-VISN-Investigator#1>, <OSC-VISN-Investigator#2>, and the OMI team):[48]

> "
> …

[46] Investigators, emails, 2021.
[47] <Pain-Mgmt-Chief> email re: disregard consult template, March 7, 2021.
[48] <Whistleblower#1> to <CTVHCS CoS> re: what will happen due to consult processing (destabilization), February 8, 2021.

- In consult processing, veterans are having their care blocked with <WHS-Svc-Chief> using his time in reviewing consults that are declined with the intention of having patients who require opioids scheduled with us instead of their established pain doctors.
- This serves to destabilize the pain care of these patients.
- In the meantime, every patient for opioid management that is being scheduled with us is a patient not on opioids and for intervention who is not being scheduled with us for the tasks we actually perform.
- As there are only 3 of us interventional pain doctors, these patients who are not on opioids end up being sent to the community anyway due to wait times.
- <WHS-Svc-Chief>'s decisions designed to force us to take over opioid management therefore has the following end effects: (1) Veteran stable on their opioid regimens with outside care providers are getting their care destabilized (2) Veterans who are not on opioids are being sent to the Community anyway, and will likely get started on opioids (3) If these changes to Community Care Pain requests are being sold as ways to get costs down and stabilize care, it is very likely to do the opposite.
- In essence, with <WHS-Svc-Chief>'s decision-making, the veterans are actually at greater risk, and on top of that, we are at even greater risk of being constructively dismissed or terminated as <WHS-Svc-Chief> has found a way to generate even more complaints against us.

…
"

I was able to understand this and reach this conclusion even as a still relatively new probationary employee; it is my belief that a rational person would not expect the instructions of <WHS-Svc-Chief> to actually decrease consults to the community, controlling for the number of in-house clinical care staff. The only real effect of adherence to the instructions was the disruption of stable / already existing care plans for veterans who were receiving care.

The OMI report states that: "The WHS Clinical Director identified concerns regarding community care referrals for pain management lacking comprehensive provision of care as described in the referrals' associated Standardized Episodes of Care (SEOC)":

More accurately, the <WHS-Svc-Chief> himself had identified that the Stepped Care Model for Pain was not being implemented at CTVHCS, and that some requests for care in the community regarded care that could be provided at the Primary Care level with or without the assistance of Pain Management Pharmacy who are pharmacist staff which were specifically hired for the purpose.[49] Best I can gather from subsequent comments/communications, facility leadership deviated from the Stepped Care Model for Pain in not supporting such a primary care function. <Pain-Mgmt-Chief> described later that <WHS-Svc-Chief> had told him explicitly that <WHS-Svc-Chief> does not have control over Primary Care or Mental Health, and as such <WHS-Svc-Chief> could only force his action plans onto our traditional section of Pain Management.[50]

As to the OMI report's claim that "Temple Memorandum 011-001, Pain Management and Assessment dated April 24, 2018, notes the Pain Management Clinic is a resource for interventional pain management modalities, primarily pain management interventions for pain relief only; however, the

[49] <WHS-Svc-Chief>, email re: Stepped Care Model / Primary Care, February 2021.
[50] <Pain-Mgmt-Chief>, email re: <WHS-Svc-Chief> has control over us only, February 2022.

new draft of the policy (currently in the concurrence process) establishes policy for the assessment and management of Veterans' pain using the stepped-model of pain care in alignment with VHA guidelines.

As a whistleblower and a board-certified Pain Management specialist at CTVCHS, I have been excluded from any say in any such policy; I consider this approach to the policy at the facility as consistent with reprisal and contrary to HRO principles; in my view, any such agreement appears to be between and amongst services other that the Pain Management section.

The OMI report states: "The draft PMS service agreement lacks collaboration of pain medicine and palliative care teams, as described in VHA Directive 2009-053 stepped care model and includes verbiage regarding the MISSION Act for community care referrals that is not inclusive of all criteria; however, it does expand PMS services and discusses collaboration in the provision of pain management in appropriate settings, including primary care and specialty care, in alignment with VHA guidelines regarding the stepped care modal of pain care":

As per above, the collaboration on the Pain Management Service Agreement excludes significant input from the actual Pain Management section; importantly, the silencing of our scientific input and concerns was enabled by Realigning our section under the Whole Health Service and turning control of this policy/document creation to the Clinical Director of Whole Health, <WHS-Svc-Chief>, who was not credentialled or privileged here as a Pain Management specialist.

Further on in the OMI report, "Large numbers of pain management consults are referred to the community; however, the facility has not thoroughly analyzed the reasons behind the large number or implemented actions to add address all causes of the large referral numbers. Additionally, there are many discontinued consults to the community due to the inability to contact the patient."

This was addressed by me in the email previously cited to <CTVHCS-CoS> as per above; consistent with HRO principles, the first step for facility leadership would be to listen to such input from the Pain Management section providers who are the facility's experts on the front-line providing hands-on care. Interestingly, this was addressed by both the <Pain-Mgmt-Chief> and <WHS-Svc-Chief>, with their instructions to fill open slots within 24-48 hours of any clinical day.[51] I fully agreed then (and still do) with that instruction; I asked the staff a few times (I would guess between 3-12 times) in 2021 if these instructions were being followed, and I was told 'yes' … I decided to stop asking… there was not much more I could do, as I am not in the supervisory chain of the scheduling staff.[52] Interestingly, in spite of the many clinic closures and lack of staff and supply support, I managed to produce at a level above the mean, with a higher percentage of non-procedure visits compared to procedure visits as this was required to build the clinic with the restrictions cited.

I personally attempted to assist in trying to optimize schedules, including sending messages requesting that open slots be filled and verbally encouraging the practice as well.[53] Early on, the scheduling service found it difficult to coordinate scheduling 30 minute appointments with 1 hour long appointments; as a temporary measure, these appointments were changed to 1 hour long.[54] By the time I had discussed with the <Pain-Mgmt-Chief> to change scheduling back to have slots of different lengths, we concluded

[51] Miscellaneous <Pain-Mgmt-Chief> and <WHS-Svc-Chief> emails re: filling open slots, 2020-2021.
[52] <Whistleblower#1> Miscellaneous communications re: filling slots, 2020-2022.
[53] <Whistleblower#1> Miscellaneous communications re: filling slots, 2020-2022.
[54] <Whistleblower#1> email to scheduling staff, re: temporary scheduling for slots 1 hour, 2020.

we had not choice but to wait for the orders from <WHS-Svc-Chief> as <WHS-Svc-Chief> had explicitly indicated he would be making changes in our scheduling.[55]

According to the OMI's analysis, the number of open slots appears to be attributed to the actual providers; instead, the question has repeatedly come up, even recently under a new temporary supervisor, as to why these open slots are not being filled by the MAS service who have been instructed to fill the slots. The WHS Program Manager, <WHS-Prgm-Mgr>, was given charge over the scheduling function; best I can tell, <WHS-Prgm-Mgr> did not enforce the instructions to keep our patient schedules full. I consider that with the information having been presented by the OMI team in their report in the way that it was, the reader may be inclined to inappropriately place the blame for this on the Pain Management Section providers and inaccurately believe that high-level analyses need to occur for this issue to be improved, when simple code enforcement on the matter of the scheduling service to fill these slots need only take place via the scheduling supervisory chain. Even as it stands, productivity for the Pain Management section is actually above the mean within the VA nationally, and simply filling the empty slots would increase access and decrease costs without any apparent downside or unforeseen costs. Hundreds of person-hours spent on additional analyses on this topic were and are simply unnecessary.

Office of Special Counsel File No. DI-21-000033, DI-21-000470 and D1-21-000503	**Office of Medical Inspector File TRIM 2021-C-29**
6) <WHS-Svc-Chief> violated VA directives 6500 (VA Cybersecurity Program) and 1907.01 (Health Information Management) by ordering the redaction of portions of medical records containing disclaimers from clinicians advising patients that denial or termination of community care programs was based on direct orders from <CTVHCS-CoS> and <WHS-Svc-Chief>.	Not addressed.

It is inaccurate to say that wording used in consult processing was used or written for the purpose of "advising patients that denial or termination of community care programs was based on direct orders from <CTVHCS-CoS> and <WHS-Svc-Chief>." To my knowledge, no such advisory was directed to the patients; that was not the purpose. Instead, some providers at CTVHCS wanted to appeal the decisions, and some had no idea that <WHS-Svc-Chief> was even involved in the decision-making.[56] Prior to <Pain-Mgmt-Chief> having informed me and the other pain physician of the wording he came up with to clarify matters, I used wording to convey what my understanding of the direction on consult processing was and from whom it originated; requesting providers had begun reaching out to us with questions and for resolution, but I was not empowered to help. To me it was obvious that I was implying that further discussion was deferred to <WHS-Svc-Chief>, although in case that was not enough, I began to direct/defer the requesting provider for the purpose of identifying practitioners for continuing care to <WHS-Pain-Chief> outright. <Pain-Mgmt-Chief> was encountering the same challenges that I was, and

[55] <WHS-Svc-Chief> emails re: Changes to scheduling, 2020.

[56] <OSC-VISN-Investigator#2> email, re: I am not sure why this would go to <WHS-Svc-Chief>, October 5, 2021.

thus he came up with more thorough wording to direct further discussion up the supervisory chain to decision-makers, including above <WHS-Pain-Chief>.

I have reviewed VHA Handbook 1907.01. I am not certain on the conclusion of the Report Writer which indicates that "it is not possible to redact consult entries in CPRS." I am left to wonder what then motivated <WHS-Svc-Chief> to apply such a strict deadline to <Pain-Mgmt-Chief> in regards to identifying all of the charts; I myself spent hours on this prior to <WHS-Svc-Chief> changing his instruction to have only <Pain-Mgmt-Chief> complete the task of identifying the charts; I would wonder why <CTVHCS-CoS> and <CTVHCS-Director> would not have informed <WHS-Svc-Chief> that such a thing could not be done, thereby allowing the Pain Management specialists to spend a great deal of time and effort in the task when that time and effort could have been spent on direct patient care. It maybe a matter of terminology, however. According to the HIM Erroneous Document Corrections Guidebook, there does appear to be a mechanism for such (red)action, although the terminology used in the Guidebook would either be "retraction" and/or "rescission" and/or "administratively correction" and/or "amendment."[57] Specifically, it is noted within the Guidebook that:[58]

"In all other cases, the changes will need to be made using VA FileManager "FileMan". Due to the low volume and lack of sufficient tracking, it is strongly recommended that the audit trail for these fields be turned on at the facility level. A facility policy must be in place that allows editing (deletion) of reason for consult and consult comments fields and an audit trail maintained. The policy must clearly state that the deletion is an effort of last resort, and include an approval process for such a deletion."

Regarding being unaware of any consults having entries redacted, I have not sought to discover this on my own. I suspect that the investigators could submit a LEAF request for processing to identify if any such charts were or were not actually redacted or retracted in whole or in part.

It is noted within the guidebook that:
"Making corrections or amendments to the consult fields should be an infrequent occurrence."

It is also noted within the guidebook that:
"There may also be situations when a request to amend a record would be inappropriate, such as when someone requests a note be deleted (retracted) from the health record, when the documentation appears to be accurate, relevant and timely for the patient care that was provided."

In this particular circumstance, the Report writer has stated that: "Although <WHS-Svc-Chief> did seek to have entries redacted in which he was inappropriately directly named; no entries were in fact redacted."

I take issue with that description as well as the comment that the whistleblowers included the wording being requested for redaction as simple "disclaimers" or that this wording was inappropriate. I had discussed directly with <OSC-VISN-Investigator#2> that the wording was intended not as a disclaimer but instead as per VHA Handbook 1907.01:

"Individual employee names are not to be included in health record documentation, *unless the purpose is to identify practitioners for continuing care*."

[57] VHA Handbook 1907.01 – Health Information Management and Health Records, March 19, 2015.
[58] HIM Erroneous Document Corrections Guidebook - Excerpts

As per direct discussion of this being the rationale as well as forwarded documentation to a <OSC-VISN-Investigator#2>, I do not believe there was anything inappropriate according to policy by directing requesting providers to <WHS-Svc-Chief> or <CTVHCS-CoS> to further address the questions/concerns (or ?appeals) that they had when their consult requests were being processed in a manner contrary to their expectation, as by directing the consults be processed in a certain way, <WHS-Svc-Chief> and/or <CTVHCS-CoS> had inserted themselves into the clinical decision-making regarding the care.

Office of Special Counsel File No. DI-21-000033, DI-21-000470 and D1-21-000503	**Office of Medical Inspector File TRIM 2021-C-29**
7) Since coming to the agency in May 2020, <WHS-Svc-Chief> has abused his authority by manipulating his clinical scheduling in the CPRS system.	<WHS-Svc-Chief> has been performing encounters without billing or engaging physician utilization.

The OSC investigation report concludes that **Allegation #7** is **substantiated**. The OMI investigation report concludes that this Allegation is **not substantiated**.

I will point out the following according to <OSC-VISN-Investigator#2>:

<Pain-Mgmt-Chief> "provides clinic scheduling grids and total patient counts indicating available clinic slots for two half days weekly with a total of 41 patient encounters during FY21 that did not begin until June 2021. Based upon guidance for VA physician staff and availability for clinical care, <WHS-Svc-Chief> should be engaged in clinical care on a 0.7 FTEE basis."

The OMI report frames the allegation differently, investigates it differently and reaches the opposite conclusion:

<WHS-Svc-Chief> "is mapped at 30% clinical and 70% administrative time since May 2021. He was previously mapped at 8.75% clinical and 91.25% administrative except for the first 6 weeks in his role when he was mapped at 100% administrative. A review of the <WHS-Svc-Chief>'s workload noted his productivity target fiscal year to date as of August 23, 2021, is 2,926 RVUs and his productivity is at 2,421.42 RVUs (83% of target). This illustrates the WHS Clinical Director has been performing encounters and delivering health care and services to patients.

"Our review of Temple PMT consults indicated the last completed PMT patient encounter occurred in December 2020.

"Interviewees advised us that there is a weekly informal meeting that includes the pharmacists and the WHS Clinical Director and noted it is almost the same type of meeting held previously with PMT. In the weekly meeting, patient cases are discussed … These weekly informal meetings are not documented in the patient's EHR. The informal meeting provides an avenue for the pharmacists to get recommendations from the WHS Clinical Director."

We can gather from this juxtaposition of information:

The vast bulk of billing/coding that <WHS-Svc-Chief> was doing at CTVHCS was performed off grid / not scheduled --- just as I informed and cautioned <CTVHCS-CoS> about during our first meeting in January of 2021; I have advised <CTVHCS-CoS> that many of the off-grid consults of <WHS-Svc-Chief> may involve controlled substances, no less.

Those visits which were billed/coded were performed in **violation of the VHA Directive 1230 on Outpatient Scheduling Processes and Procedures**.[59]

As <WHS-Svc-Chief> never ended up established a consultation process to his clinic, his actions in these matters represented **violations of VHA Directive 1232 Consult Processes and Procedures**.

In the description regarding the "informal weekly meetings" the OMI report establishes that patient cases were discussed, recommendations were given by the <WHS-Svc-Chief>, and these meetings were not documented; this seems to indicate that <WHS-Svc-Chief> was, in reality, managing these patients' care. I was not aware that these informal weekly meetings were occurring until I read the OMI report.

Office of Special Counsel File No. DI-21-000033, DI-21-000470 and D1-21-000503	**Office of Medical Inspector File TRIM 2021-C-29**
8) Unaddressed	<WHS-Svc-Chief> requested a subordinate to delegate prescription of controlled substances to a Nurse Practitioner, <WHS-NP>, who works under his supervision and his orders.

The OSC investigation report concludes with **Allegation #8 not addressed**. The OMI investigation report concludes that this Allegation is **substantiated**.

<OSC-VISN-Investigator#2> did not appear to address this allegation, although it was included in my Letter of Concerns which was sent to <OSC-VISN-Investigator#2>; it was also sent to <OSC-VISN-Investigator#1>, although the VISN does not appear to have forwarded that report on to the OSC. In my review of the allegations which were included in the report of <OSC-VISN-Investigator#2> and the lack of a report representing the work of <OSC-VISN-Investigator#1>, it appears that some of the matters raised in the course of the VA's investigation simply were not included in the report submitted to the OSC.

The OMI report substantiated that <WHS-Svc-Chief> "requested a subordinate to be the collaborating physician to the WHS Nurse Practitioner (NP), who works under his supervision and his orders; however subordinate declined and no further requests were made."

[59] The most recent issuance of the VHA Directive 1230, on June 1, 2022 adds Stop Code 674 "Administrative Patient Activities" as exempt; this issuance rescinds the prior version published on July 15, 2016; it seems that "Administrative Patient Activities" refers to interactions that are "not an encounter and not requiring independent clinical judgment in the overall diagnosing, evaluating, and treating the patient's condition(s)." and are non-count interactions.

That the subordinate declined does not explain the rationale behind <WHS-Svc-Chief> not having an active Texas medical license while conducting himself so as to medically direct management as the decision-maker in different patient case scenarios as previously noted; a reasonable person may conclude that it is more likely than not as <WHS-Svc-Chief> was asking his subordinate, <Pain-Mgmt-Chief>, to be the collaborating physician at all, that his request was a conscious and willful attempt to have <Pain-Mgmt-Chief> be the collaborating physician "on paper."

"As a result of not having a collaborating physician with a Texas license, the WHS NP cannot prescribe controlled substances which limits her care of patients in the PMS. Memorandum Buprenorphine/Naloxone Therapy for Opioid Use Disorder, dated June 25, 2021 does not list the WHS as one of the services affected by the policy related to Buprenorphine/Naloxone therapy for opiate use disorders."

WHS is likely not listed as one of the services affected by the policy precisely because the WHS was created to administer over complementary care services, not any aspect of traditional medical care delivery. Secondly, the date noted by the OMI team appears to be inaccurate; the cited memorandum was issued on June 25, 2019 per the OMI report's own references list. I believe the SOP on Buprenorphine which was voted on and passed by the Pain Oversight Committee and the Clinical Executive Council on July 21, 2020 would have superseded any prior memo at the facility to my knowledge, although the SOP was not made available for providers/services in what appears to be a deviation from the policy on availability previously referenced.

Office of Special Counsel File No. DI-21-000033, DI-21-000470 and D1-21-000503	**Office of Medical Inspector File TRIM 2021-C-29**
9) Unaddressed – Realignment of Pain Management under WHS	Aligning Pain Management under Whole Health places Veteran patients at risk.

The OSC investigation report concludes with **Allegation #9 not addressed**. The OMI investigation report concludes that this Allegation is **not substantiated**.

I raised the allegation to all investigative teams involved regarding the Realignment of the traditional Pain Management section under the Whole Health Service; I was concerned that the realignment may be consistent with a violation of any law, rule, or regulation, or gross mismanagement, a gross waste of funds, an abuse of authority, or a substantial and specific danger to public health or safety.[60]

The Report to the OSC which contained reports from <VISN17-HWE-Investigator> and <OSC-VISN-Investigator#2> but not <OSC-VISN-Investigator#1> did not address the allegation. The OMI team's report concluded that the realignment did not place veterans at risk (*the OMI report also represented that PMRS had been realigned under the Whole Health Service as well… this is inaccurate and did not occur*).

The Realignment is what enabled the Mission Act to be violated here at CTVHCS; the pain management providers were opposed to the instructions. I raised the matter up to the level of the CoS; I directly

[60] Miscellaneous investigators, emails re: Realignment, 2021.

related concerns that instructions given and enforced under threat of administrative action empowered by the Realignment led to the destabilization of care for numerous veterans and likely denial of services either temporally or otherwise.

Due to the alignment under the Whole Health Service --- the Complementary Care Service --- we were not able to count on the usual administrative approach to supervision of our section being one that is based in traditional medicine values and concepts and/or one that recognizes the importance of traditional medical direction and scientific thinking and understanding; there appears to be ample evidence that the disruption which occurred in regards to our clinical oversight and our veteran's rights and care occurred due to an alternate agenda of the WHS at CTVHCS and the actions of WHS personnel with the full support of facility and VISN leadership. I believe that what I was witnessing had the potential to affect multiple patients at this VA or across many VA facilities.

The VHA itself holds as Policy that complementary treatments in the VA are to be complementary and not alternative to traditional medicine.[61] Notably, some of the veterans who were denied community care when Pain Clinic consults were being requested were then redirected and seen by the <WHS-Svc-Chief>, who instead of performing a Pain Specialist evaluation, performed a Complementary-Integrative-Health evaluation. These evaluations were performed off of consults made to our Pain Clinic which is interventional in nature; I consider that such instructions regarding consult processing may have been less likely to have been instructed and/or so strictly enforced had they come from a physician strongly rooted in the practice of traditional medicine due to the fact that traditional medicine providers demonstrate a mutual respect for other medical disciplines.[62]

It is noteworthy that the WHS NP raised to the Professional Standards Board (PSB) here at CTVHCS her own concern regarding the appropriateness of her having been assigned by <WHS-Svc-Chief> to perform consultations off of the consult requests being made to the Pain Management (interventional/specialty) service; the PSB affirmed that as the WHS NP was not credentialed as a Pain specialty NP and was being assigned duties she was not trained for; it was therefore decided that she would not be made to utilize and resolve the consults that were requested of the Pain Management section; I believe, by the same rationale, the <WHS-Svc-Chief>, who was not credentialled as a Pain Management specialist, should not have been able to hold himself out as performing a Pain Management Specialty evaluation off of consult requests to our section; the primary reason for why he was able to use our consult requests to both perform his Complementary-Integrative-Health evaluations and deny Community Care consults in doing so, was the Realignment itself.[63]

I have been given the impression by <Pain-Mgmt-Chief> that the <WHS-Svc-Chief> pushed the <Pain-Mgmt-Chief> to take open stances that WH modalities are superior to interventional treatments; this type of behavior is incentivized by the Realignment itself. The alignment of any traditional medicine specialty under Whole Health runs the risk that scientific clinical ideas and approaches can again be subjugated to ones that characterize Whole Health modalities, many of which have their origins in mysticism or spirituality. The risk of confronting this possibility is a very real risk as well: the personal cost, in terms of time, money, professional and personal relationships, career stability and advancement, and stress for anyone who brings forward allegations or concerns when put in the same position of subjugation is astronomically high, and I speak from experience.

[61] VHA Directive - 1137 Provision of Complementary and Integrative Health (CIH)
[62] <OSC-VISN-Investigator#2> email, October 5, 2021.
[63] <WHS-NP>, emails re: privileging, October – November 2021.

<WHS-Svc-Chief> decided, contrary to the input of the Pain Management section, on which nursing staff is appropriate for the procedure suite. Regardless of who or if someone is correct on this topic, the fact is that <WHS-Svc-Chief> was in control of this decision here at CTHVCS by virtue of the Realignment regardless of who by name is/was the <Pain-Mgmt-Chief>. I raised questions to <OSC-VISN-Investigator#2> and the OMI team that I believe still need to be answered, regarding concerns under the current Realignment:

> Are resources being appropriately allocated?
> Does the current alignment cause resource management to be more appropriate or less appropriate to the level of care being delivered?
> Does the current alignment cause resource management to be more efficient or less efficient?
> Is there any unnecessary duplication of resources and resource management with the current alignment?
> Does the current alignment reduce accountability or increase it?
> Is the current alignment proving to be more "lean" or less lean?
> Does the current alignment subtract from process enhancement or add to it?
> Do patients view the current practice that some are seemingly subject to, functionally, due to current alignment, of needing to be seen by Pain Management prior to being able to considered for Acupuncture, as patient-friendly or patient-centered?
> Does the current alignment support the level of care that Pain Management specialists offer?
> Is the current alignment exposing veterans to additional or heightened risk scenarios?
> Does the current alignment alter process in regards to safety standards?
> Does the realignment under Whole Health, the current alignment, relieve the facility of the importance of fidelity to procedure room standards as pertain to surgical services offered at the facility?
> Are pain procedures more akin to falling under Surgical Services in regards to risks, invasiveness, operator skill set, etc, or more akin falling under Whole Health Clinical coaching?

Departmental structure and organization within hospital settings has long been a matter of interest. By aligning the procedurally-based subspecialty section of Pain Management under Whole Health, the service of complementary care modalities, the medical center gains nothing by way of returns to scale on the topic of minimizing duplicative support processes and gains nothing by way of returns to proposed efficiencies of shared service functions/goals --- the risks and corresponding discussions and foci of decision-making in interventional pain are more akin to any other procedurally-based traditional medical specialty and very dissimilar to the approach and function of the complementary care service which promotes itself as not being diagnosis-led, or diagnosis-based, even. Additionally, there are very real risks to administrating over traditional medical care under Whole Health from a Service/Supervision standpoint as evidenced by the following:

An actual scenario that has come up at another facility where the problem of a physician's oversight in the Whole Health Service is described:[64]

[64] VA-OIG REPORT #21-03339-208 - Deficiencies in Facility Leaders' Oversight and Response to Allegations of a Provider's Sexual Assaults and Performance of Acupuncture at the Beckley VA Medical Center in West Virginia, July 26, 2022.

VA-OIG REPORT #**21-03339-208** --- Deficiencies in Facility Leaders' Oversight and Response to Allegations of a Provider's Sexual Assaults and Performance of Acupuncture at the Beckley VA Medical Center in West Virginia

This investigation focuses on allegations of real or potential patient harm which highlights the following:

> *The facility's approach to the Medical Directorship/Chief's position of the Whole Health Service – "Complementary Care" service – can create liabilities to the VA, colleagues and veteran patients secondary to insufficient and ill-defined supervision of the position and poorly defined requirements for credentialling/privileging, due to its nature.*

Excerpts:

> The VA Office of Inspector General (OIG) conducted a healthcare inspection to examine the oversight of a provider, (subject physician), at the Beckley VA Medical Center (facility) in West Virginia, who engaged in inappropriate sexual conduct toward patients and practiced acupuncture without being credentialed. The OIG also reviewed leaders' awareness and response to the allegations of sexual assault and the subject physician's practice of acupuncture.
>
> The OIG determined the subject physician was hired as the facility's Whole Health Medical Director and credentialed and privileged to practice within the primary care service line. The subject physician's privileges also included the ability to perform OMT, myofascial techniques, and trigger point therapy. However, **the subject physician did not have the credentials and privileges to perform** acupuncture.
>
> The OIG identified **deficient oversight of the subject physician's clinical practice**. The OIG interviewed current and former facility leaders who provided conflicting information about responsibility for the subject physician's administrative and clinical supervision. The OIG found that none of the facility leaders responsible for oversight of the subject physician's clinical practice acknowledged responsibility for clinical supervision. The subject physician was also uncertain about who had responsibility for clinical supervision.
>
> The OIG concluded that current and former **facility leaders failed to provide adequate oversight of the subject physician's clinical practice** through the professional practice evaluation process. The facility leaders failed to complete the subject physician's FPPEs per VHA and facility policies.

Further, the VHA itself rightly holds as policy that complementary treatments in the VA are to be complementary and not alternative to traditional medicine as previously stated, although the current alignment incentivizes direct competition for resources.[65]

[65] VHA Memo - Compete for Resources - July 2017

The OMI phrased the allegation regarding diminishing resources as "planning to". It is important to note that prior to the Realignment, the Pain Management section had two scheduling staff, one of whom retired and left the section. The Pain Management section was not then authorized to fill the position. Instead, the WHS was started, and WHS was empowered to hire on an scheduling staff, who could then spend part of his/her scheduled time working in Pain Management clinic scheduling. It is important to note that prior to the Realignment, the Pain Management section had an NP who left the section. The Pain Management section was not then authorized to fill the position. Instead, the WHS was started, and WHS was empowered to hire on an NP, who was then directed to spend part of her scheduled time in the Pain Management clinic; furthermore, and importantly, one can plan to do something and then reverse course, which appears to be what has happened here.[66]

To be clear, we had repeatedly been supplied an LVN instead of an RN. Whether or not there is or is not an increased risk of having an LVN as opposed to an RN in the procedure suite is not practically determinable on the margin as the rate of adverse events in pain procedures is low statistically speaking. According to currently existing standards, we can review the differences in Scopes of Practice between LVNs and RNs in the state of Texas; we can also review 42 CFR 482, where we can see there is a difference in the delineation of function between and RN and an LVN when we compared Surgical Services under 42 CFR 482.51 and Outpatient Services under 42 CFR 482.54; we can also note that the RN is categorized as a "learned professional" in legislation and the LVN is not (**none** of which diminishes the importance and contribution of the LVN; I have worked with *many* great LVNs). Notably, the Pain Management Section provides services procedurally that are more akin to Surgical Services and the Pain Management section itself was aligned under Surgical Services prior to being realigned under the Whole Health Service.

By virtue of the Realignment alone, one would consider the silent argument that CTVHCS or any VA facility should staff the Pain Management section to a different, lesser standard than may be promoted under a Surgical Service. My opinion opposes that argument, so I have raised the issue up.
I put forth to <OSC-VISN-Investigator#2> and the OMI team that perhaps it could be looked into as to if the clinics that <WHS-Svc-Chief> reached out to on the topic of LVNs vs. RNs are appropriate for staffing for the interventional pain clinic in order to address whether those clinics … :

> "Have **LVNS instead of RNs?**
> *or*
> "If they simply agree 'LVN can assist so long as sedation is not being given' **while they themselves have RNs?**
> *or*
> "If <WHS-Svc-Chief> is representing their stances in a way that is **not accurate to begin with**?"

I was not given an answer to these questions by the investigators; answers to these questions were not included in the OMI report.

The OMI report states: "There are no reporting structure requirements or recommendations in the Executive Decision Memo Engaging Veteran · Lifelong Health, Well-being and Resilience Integrated Project Team dated March 4, 2020, thus leaving the reporting structure to the facility's discretion."

[66] <Pain-Mgmt-Chief> email, re: exchanging an RN for an LVN, January 13, 2021.

I believe I forwarded that referenced Executive Decision Memo (EDM) from 3/2020 to the OMI team.[67] I also forwarded them an email containing the EDM from 08/09/2019, which I had previously sent to <CTVHCS-CoS>, with highlighting on the following from the memo:[68]

> "Within the VHA Modernization Plan, **Whole Health is aligned with Mental Health as a Lane of Effort …**
>
> And
>
> "… each VISN support Whole Health Implementation **as a consistent and committed strategy** throughout the VHA …
>
> And
>
> "… consistent approach to funding and infrastructure will minimize variations across VHA in outcomes and, more importantly, in services that are available to Veterans. **By not supporting this recommendation, VISNs and medical center leadership will be left to determine individually the funding and infrastructure committed to Whole Health, ultimately leaving an inconsistent approach to the quality, quantity, and ultimately services available to Veterans nationally. Most importantly, it would be doing a disservice to the Veterans** that we serve each day …"

It seems to be that the potential disservice that is described in the memo became a reality here at CTVHCS. I sent the OMI emails where actual veterans conveyed the same conclusion without any prompting from and with my repeated apologies on behalf of the VA.[69]

Interestingly, the OMI report assessed a potential risk to patients due to the lack of direct involvement by PMS clinicians in the management patients with complex pain. The report goes on to describe a timeline of care regarding a particular veteran ("Veteran 2"):

November 26, 2019 - Request made by provider for Pain Clinic specialty consultation. Request was sent back to the requesting provider due to concerns regarding radiographic findings.

January 23, 2020 - Request made by provider for Pain Clinic specialty consultation. Request was sent back to the requesting provider, describing actions to be taken under the Stepped Care approach to pain at the facility.

June 11, 2020 - Request made by provider for Pain Management pharmacy who engaged with the veteran and discharged the veteran on October 28, 2020.

August 3, 2020 – Note from Palliative Care service indicating awaiting a consult from Pain Clinic specialty.

March 12, 2021 – CARA-PMT consult was requested.

April 16, 2021 – Additional comment placed requesting the consult be forwarded to the Pain Management clinic.

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[67] <Whistleblower#1> to OMI team, email re: 2020 EDM, August 10, 2021.
[68] <Whistleblower#1> to OMI team, email re: 2019 EDM, August 10, 2021.
[69] Miscellaneous, emails re: Veterans angry about handling of Pain Mgmt in relation to WHS, 2021.

OMI team conclusion: Reluctance of PMS physicians to engage with Veterans suffering from complex pain unless meeting strict criteria.

I am familiar with this case, as there was email correspondence on it, and it was discussed at/around the time of referral request to the CARA-PMT team.[70]

While the OMI team report puts the blame on the Pain Management section, it is important to note that <WHS-Svc-Chief> who had taken over the CARA-PMT was the one who stopped scheduling CARA-PMT meetings where such patient care was performed (as previously referenced). The "additional" comment placed requesting the consult be forwarded to the Pain Management clinic was by order of the <WHS-Svc-Chief>. A closer review of the documentation reveals that the desire of the requesting providers for evaluation was actually for the diagnosis of "Opioid Dependence" and it is actually the case, best I can tell, that the referring provider(s) were seeking evaluation and treatment via the Mental Health / Behavioral Medicine service for Opioid Dependence; best I can tell, MHBM did not provide that evaluation or service.

The OMI report goes on to assess a "reluctance" on the part of the Pain Management section to address "complex pain." I performed a search for this diagnosis and could not find it. I am aware of the diagnosis "Complex Regional Pain Syndrome" and when referring providers have a concern for this, our section readily accepts referred veterans for evaluation and treatment, regardless of whether or not the veteran is seeking interventional treatment.[71] I was surprised to see the OMI report clearly listing out numbers of prescriptions that the PMS providers had made (during the OMI team's elected timeframes) --- thereby confirming that our section's providers prescribes medications when we believe they are indicated --- while simultaneously seeming to put forth any claim that the section providers only provide interventions. Incidentally, the only other usage of the term "complex pain" I could find seemed to refer to "chronic pain" which is what our section evaluates and treats all day long.

In light of Veteran 2's case as presented by the OMI team and the documentation that I have within the email correspondence that I cite and provide, I can only conclude that the OMI report is using the term "complex pain" as a euphemism for Opioid Dependence / Opioid Use Disorder. As such, the apparent deficit that the OMI team is picking up on is not relevant to their investigation *of* the Pain Management section (based on allegations/disclosures brought forward *by the Pain Management section whistleblowers*), but instead is relevant to the needed review and investigation of the Mental Health / Behavioral Medicine Service; the actual reluctance that the OMI team seems to be identifying is the reluctance of the MHBM Service in evaluating and treating veterans for Opioid Dependence / Opioid Use Disorder. This reluctance is a primary input to the issue of no other service here at CTVHCS being capable of playing any meaningful role in the Stepped Care Model for OUD. Of note, in spite of the President's Commission on Combating Drug Addiction and the Opioid Crisis established by Executive Order in 2017 having put forth the goal of having the Primary Care Service play a pivotal role in engagement on screening and referring for Substance Use Disorders, they are hard pressed to do so without the leadership of MHBM:[72]

[70] Miscellaneous, email regarding the Veteran 2 referral, March 2021.
[71] Miscellaneous, emails regarding veteran case ?diagnosis of CRPS, 2021.
[72] President's Commission on Combating Drug Addiction and the Opioid Crisis established by Executive Order, 2017.

Final report (draft) – November 1, 2017:

> "The expectation of eliminating a patient's pain as an indication of successful treatment, and seeing pain as the fifth vital sign … was cited as a core cause of the culture of overprescribing in this country that led to the current health crisis. This must end immediately.
> "CMS remove pain survey questions entirely on patient satisfaction surveys, so that providers are never incentivized for offering opioids to raise their survey score; prevent hospital administrators from using patient ratings from CMS surveys improperly CMS to review policies that may discourage the use of non-opioid treatments for pain. All primary care providers employed by federal health systems should screen for SUDs and, directly or through referral, provide treatment within 24-to-48 hours.
> "Each physician employee should be able to prescribe buprenorphine (if that is the most appropriate treatment for the patient) in primary care settings."

I am left to wonder what happens when non-MH providers need help in evaluation and managing and prescribing Buprenorphine without the leadership of MHBM in this clinical area. When the diagnostic criteria are met, if providers of the MHBM service refuse to make the diagnosis and therefore do not treat the disorder, this serves to prohibit veterans from being able to obtain that necessary Mental Health care at the VA. Another sequence of events through which a veteran's ability to obtain such care may end up limited in the VA is when other issues that may coexist in the presentation with the veterans who are referred for Opioid Use Disorder are focused on by the MHBM service; for example, if the MHBM triaging function discusses coexisting pain instead of Opioid Use Disorder, then the veteran is likely to decline OUD treatment with MHBM; it is important to note that denial can be powerful in those who suffer of Substance Dependence.[73] Regardless of whether the opioids being used are prescribed to a person or not, that person can suffer from Opioid Dependence, and whether or not someone is taking opioids from one source or another is less a factor than the behaviors and experiences that characterize that usage. That the OMI team did not evaluate the MHBM service on this topic and instead decided to characterize Opioid Dependence as "complex pain" leaves a gaping hole in the analysis.

Attempting to reframe Opioid Dependence as "complex pain" is ill-advised, in my view; I provided the <OSC-VISN-Investigator#1> and the OMI team and with the specific Veteran's case, "Veteran 3"'s case, wherein the crux of the matter is clearly demonstrated, along with the actions that were enabled due to the Realignment of the Pain Management section under Whole Health; I cannot see how or why the OMI team decided to investigate the Pain Management section which raised the disclosures on these topics while simultaneously not reviewing, investigating, and forming assessments on underlying issues raised on this specific veteran's case. Nonetheless, this specific case serves to **at least partially substantiate** that realigning PMS under the Whole Health Service places patients at risk.

To add to the point of clinical efficiencies and appropriate use of consultation services, the OMI report mentions the following:

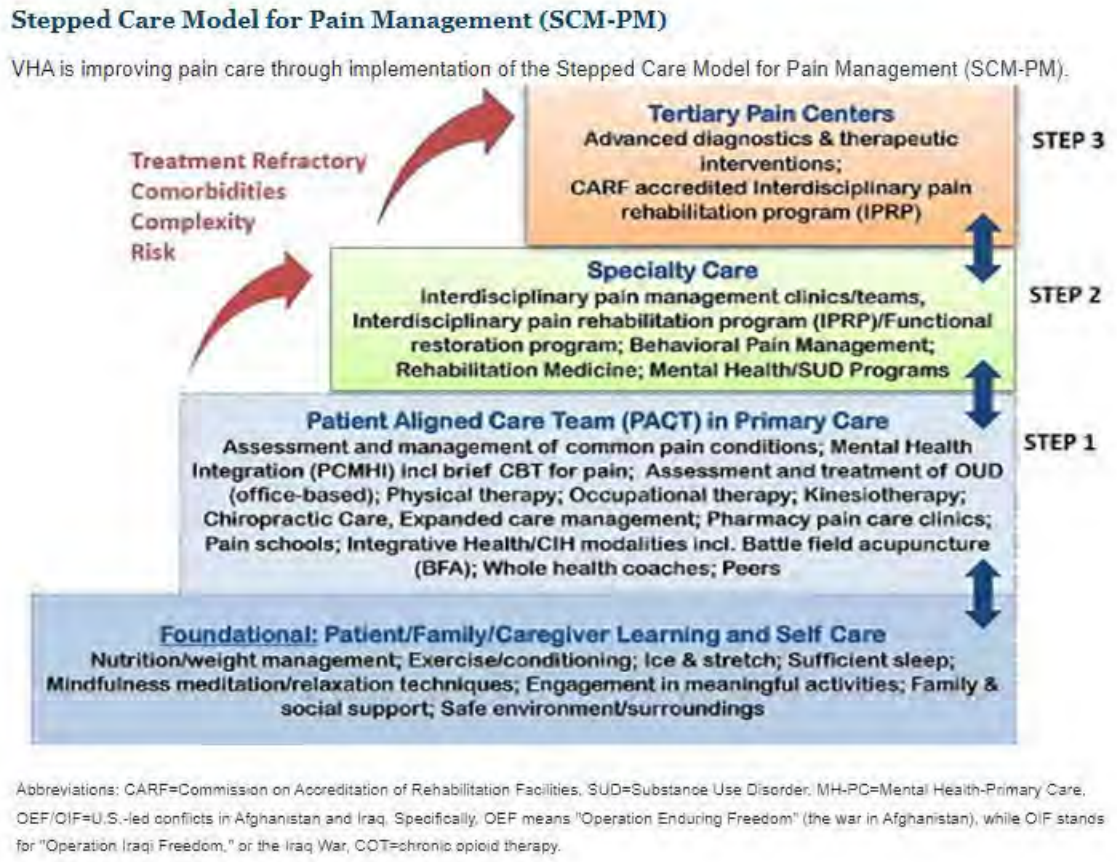
"Temple's implementation of the Stepped Care Model of Pain Management is problematic. The primary clinicians involved in managing opioids at Temple are the pain pharmacists who do not have the ability to prescribe controlled substances."

[73] <MHBM-ACoS>, email May 18, 2022.

“Although the components for an interdisciplinary pain management team are present at Temple, there is limited evidence of interdisciplinary team interaction.”

“The Comprehensive Addiction and Recovery Act (CARA) mandated PMT charter as written discourages use of PMS physicians except in the event of an interventional pain procedure. Guidance in the charter conflicts from the "Functions" and the "Elements" section.”

Here is information on the Stepped Care Model for Pain Management in the VA:



I specifically informed the OMI team that the Stepped Care Model for Pain was not being following here during their site visit. Although the OMI team seems to state directly that Temple’s implementation of the Stepped Care Model is problematic, and I draw from that that it needs to be implemented appropriately at CTVHCS, the fallout of not having done so --- any deviation from the model --- is being attributed to the Pain Management specialists who are Interventional Pain proceduralists by clinical focus. I described the inefficiency of this approach and conveyed how it was a very inefficient use of my time as an Interventional Pain specialist to be involved with much of what I have been tasked with, which has included a high degree of clerical work and does not count towards productivity measures attributed to “direct patient care”. *I have personally initiated communications with countless veterans on MyhealtheVet just so they could message me directly and I could address their queries myself, thereby taking the load off of the one scheduling staff we have assigned to our section (as the other was not replaced and instead the position was staffed under the broader Whole Health Service) and as we had not had a nurse assigned to the Temple location until just 1-2 months ago as of this writing… I digress.*

Long term opioids are still not recommended for initiation in most chronic pain presentations and the model itself describes how to address pain care presentations as escalations of care are required.[74] I repeat that while the OMI team report appears to attribute blame on the Pain Management section, it is important to note that <WHS-Svc-Chief> who had taken over the CARA-PMT was the one who stopped scheduling CARA-PMT meetings (empowered to do so via the Realignment) which had been where interdisciplinary care was occurring.

The conclusion that PMS clinicians failed to manage Veterans with complex pain is shocking to read. Is the 3-provider Pain Management section that exists for all of Central Texas – VA supposed to perform interventional pain procedures, be addictionologists, screen consults for chiropractic and acupuncture, and provide for follow-up care without follow-up appointments, without administrative time, no less? This is essentially what has been asked of us.[75]

Under the direction of <WHS-Svc-Chief> with the full support of <CTVHCS-CoS> and <CTVHCS-Director>, best I can tell, it got to the point early on where the Pain Management section was processing almost all consult requests for acceptance for scheduling here at the VA, regardless of what was being asked. It is true that veterans were sent to the community, as per OMI's own analysis, their reviewed random sample revealed that this was largely due to WAIT TIME and DRIVE TIME: "We randomly reviewed 10 consults referred to the community for pain management from December 2020 to June 2021 and noted 3 were referred because they met the drive time criteria, 6 met the wait time criteria and 1 was for a service not offered at Temple." We simply saw the patients who were scheduled, and what the OMI saw in their review is exactly what I had predicted to <CTVHCS-CoS> months earlier.

The OMI team describes that <CTVHCS-CoS> sought to create a one-stop location for Pain services for the facility; this stated goal, which supports the notion that other involved services can simply not play integral roles in pain care or in regards to other topically-related diagnoses, evidences an untenable stance, both financially and in terms of care flow and efficiency; the attempt to direct pain care in this fashion directly contradicts the VHA's Stepped Care Model for Pain.

"Opioid prescribing" and "Complex pain" are not the same thing; the two should not be equated. Efficient use of the Pain Management Specialty Service care, according to the Stepped Care Model for Pain, cannot be defined by a scenario where Primary Care will refer veterans presenting with the complaint of pain to PMS without addressing with initial care or by a scenario where MHBM triages consult requests in such a way that those who suffer of OUD/Opioid Dependence are not simply not going to be cared for by SUD Specialists. Of note, per the Mental Health literature, Buprenorphine/Suboxone is an indicated medication for the treatment of Opioid "Addiction" (Opioid Dependence/OUD) and patients very much benefit from having care with Substance Use Disorder / Mental Health specialists, whereas as opioids for chronic pain, per the Pain Management literature remain a relatively poor choice for managing chronic pain, and the benefit of having Pain Management specialists on board is that such physicians can be consulted and offer alternatives, interventions which are far preferred over long-term opioids.

The OMI team chose Veteran 1's case to illustrates the potential "serious consequences of opioid tapers and the impact of poorly managed chronic pain". Even this conclusion is questionable. The case

[74] Systematic Review on Opioid Treatments for Chronic Pain_ Surveillance Report 3
[75] <Whistleblower#1> to <OSC-VISN-Investigator#2>, email re: efficient use of time, November 19, 2021.

described seems to have described the impact of an opioid taper; the OMI team makes no mention as to whether or not the veteran had been assessed for or previously diagnosed with OUD by Mental Health, although from the case description, it appears *Mental Health likely diagnosed the veteran with OUD at some point in the described course of events and treated the veteran accordingly*. Instead of demonstrating the "serious consequences of opioid tapers and the impact of poorly managed chronic pain", it appears Veteran 1's case truly illustrates the importance of having the experts in Mental Health be actively engaged and involved in these presentations.

The OMI team did not substantiate that the WHS Clinical Director plans to reduce PMS resources... They indicated finding "a plan to increase resources including RN and LVN nurse staffing for PMS". They further conclude: "The PMS clinic is underutilized due to inefficient use of space, clinic appointment length, focus on interventional procedures, underutilization of the WHS NP and a lack of permanently assigned nursing staff."

Phrased in this fashion, I can see how the OMI did not substantiate the allegation.

More appropriately, resources *were* reduced under the WHS.[76]

An NP left PMS and authorization was not given to rehire for PMS; the realignment occurred; an NP was then hired under WHS.
Scheduling staff left PMS and authorization was not given to rehire for PMS; the realignment occurred; a scheduling staff was then hired under WHS.
There were repeated substitutions of an LVN for an RN; in some scenarios, no nurse was supplied, and I had to find my own.
I could not offer certain procedures at some point due to undersupplying of certain needle types for weeks.
Certain procedures were more time-consuming due to undersupplying of certain syringe types for multiple months.
I was denied procedural trays appropriate to my practice for approximately 1.5 years.
I have not been able to perform a certain type of procedure for 8 months due to equipment inefficiency.
How the OMI can come up with a conclusion that there is underutilization of the WHS NP, when the WHS NP left WHS because she did not feel it was right to hold herself out as performing Pain Management specialty consultations when she was not hired or credentialled for that when taking up the role is unclear to me.

[76] Miscellaneous, emails re: Nursing staffing and Supply resources, 2021.

Office of Special Counsel File No. DI-21-000033, DI-21-000470 and D1-21-000503	**Office of Medical Inspector File TRIM 2021-C-29**
10) Unaddressed	d. Whole Health is not tracking Buprenorphine as part of the VA 's long-term opioids monitoring.

The OSC investigation report concludes with **Allegation #10 not addressed**. The OMI investigation report concludes that this Allegation is **not substantiated**.

I am not sure what allegation the OMI team was responding to when commenting on how CTVHCS tracks Buprenorphine. I am not aware of any such allegation being raised in regards to their paraphrased allegation.

Instead, I had raised a very real public health and safety concern in one of my additional/amended disclosures directly to the OSC and brought it up again with additional details/concerns to the <OSC-VISN-Investigator#2> and the OMI team. An excerpt of those emails to the investigators reads as follows:[77]

"As I have conveyed previously, one of the problems with VISN 17's (maybe other/all VISNs also) **not tracking** Buprenorphine as an opioid included in the measure for New Long Term Opioid Patients, while **tracking** Buprenorphine products for the SUD16 parameter, is that it can appear that there are decreasing total opioid prescriptions, decreasing co-prescribing of opioids and benzodiazepines, and increasing treatment of OUD, even when OUD is not diagnosed. (*If this tracking behavior has changed since I last reported the concern, I would not know, as I have been formally or functionally removed by <WHS-Svc-Chief> from: - the VISN 17 Pain Stewardship Committee Meetings (my patient care slots don't get blocked off), - the CTVHCS Pain Oversight Committee (<WHS-Svc-Chief> directly removed me), - the CTVHCS Pain Management Team (my patient care slots don't get blocked off)... I am kept in the dark.*)

"The decision to track and not track Buprenorphine in this fashion (much like *<WHS-Svc-Chief>'s* attempt to coerce us to prescribe it) is concerning because morbidity and mortality may even go up, instead of down; by the time dissemination of the drug is entrenched in prescriber habits and clinical approaches with sewn-in clinical/diagnostic ambiguity, it may be too late to reverse. Notably, if typical dosing regimens that are used in the treatment of OUD are instead used in the treatment of chronic pain due to confounding of approach (e.g. "CPOD"), this may well result in an excess of Buprenorphine over what the prescribed-to patient/veteran needs; this increases the risk of diversion and the downstream effects on the community at large. The harms of this possibility becoming reality **may take months to years before becoming apparent**.

"Could the characteristics of Buprenorphine that make it a good option for the treatment of OUD make it more worrisome to the patient/veteran and the community when utilized in the treatment of chronic pain? Does the duration of action of the drug along with the potential prescribed dosages facilitate intrapersonal and interpersonal behavior via economies of sorts, with their attendant incidences of fatal synthetic and/or illicit drug consumption? This question seems far more relevant to the current wave of

[77] <Whistleblower#1> to <OSC-VISN-Investigator#1> and <OSC-VISN-Investigator#2> and OMI team, re: Letter of Concerns, 2021.

opioid related deaths than does the focus on trying to get intra-facility measures cited above looking better and better."

When <*WHS-Svc-Chief*> was removed from direct clinical care in 1/2022, it became apparent as to behaviors surrounding opioids in these situations seems to unfold. Although a claim was made to the Pain Management section that Buprenorphine has been an excellent way to get patients off of opioids, not only is it noteworthy that Buprenorphine is *still* an opioid, but we were seeing scenarios where <*WHS-Svc-Chief*> was actually taking veterans who were on Buprenorphine and putting them onto or back onto *other* opioids. As further communications have unfolded, it appears that the claim is now being made that the full agonist opioids should somehow be the standard of care for people who do not want to be on buprenorphine or otherwise come off of opioids, even without a diagnosis of Opioid Dependence or OUD. Seemingly, attempts are currently being made to try to coin new diagnostic entities (which can be summarized as "does not want to come off of opioids" best I can tell) with the endpoint being a justification of a standard where opioids such as methadone, morphine, and oxycodone, are again the preferred treatment for chronic pain. Some clinicians embrace this approach; I notice this embrace more amongst my colleagues trained in Internal Medicine and Addictionology; while the Interventional Pain specialists I know seem to have a different view. This treatment trajectory is consistent with what led to the Opioid Crisis to begin with in my opinion. However, I will state clearly that there is not value in categorizing opioids as "good" or "bad"; different clinicians and different patients are bound to have differing views. Scientific investigation and discourse should continue unabated. The delivery of healthcare services that I provide is likely not benefited by having the clinical views of other specialties or individual providers' determinations dictated onto me via a Realignment under the Whole Health Service as the vehicle. Clinicians can reassess their own clinical stances over time.

I had supplied information from the American Association of Poison Control Centers' National Poison Data System 37th Annual report to my supervisory chain and to the investigators; I feel it is important to note that Buprenorphine enjoys a healthy representation in the report.[78] I will comment that it appears that less people are dying with the medication; having said that, there is no delineation in the data for what patient subpopulations are represented in the data; I do not believe that the data distinguishes between events as to if the involved persons are ones who suffer of Opioid Dependence / OUD, suffer of chronic pain, suffer of both, or suffer of neither. That ambiguity presents a danger. I can also say that based on what I have seen here at this facility, embracing that ambiguity may actually increase the free flow from a person being on Buprenorphine to being on a full agonist opioid (and not decrease it) and therefore those events listed in the National Poison System's Annual Reports may be listed under other / full agonist opioid data points that are not free from influence of interactions with Buprenorphine (remote prior; recent prior; +/- concurrent; near future; far future) and because of that, one cannot say that a higher number of events listed for other opioids should lead to the conclusion of encouraging greater usage of buprenorphine. Even in the setting of OUD, the real goal is not to save a person's life during a short period of time capture but rather to save that life continuously.

The OMI team report notes that the "review requested by Temple for a comprehensive review of PMS by the National Program Office for Pain Management, Opioid Safety and the Prescription Drug Monitoring Programs has not yet occurred at the time of our investigation."

[78] <Whistleblower#1> to <CTVHCS-CoS> re: 2019 National Poison Data System, 37th Annual Report.

If this references the Systems Redesign project which happened earlier this year in 2022, I found it odd that as a Board-certified Pain specialist, I was not allotted time to sit down and speak with the analysts. Instead, I had 5 minutes in passing, and all I could really relay at that time was that CTVHCS is likely losing millions in dollars to the community simply for having not followed the Stepped Care Model for Pain; <Pain-Mgmt-Chief> asked him to send me comments/sources.[79] Throughout the entire time the PMS has been realigned under Whole Health, including now, following the OMI report, all of the PMS clinicians are either entirely excluded from relevant matters of system-wide policy relevant to Pain with the exception of the <Pain-Mgmt-Chief> who continues to have a significantly limited role following having had nearly all of his function previously transferred to the then <WHS-Svc-Chief> .

My understanding of HRO principles espoused by the VA are that: there should be a Culture of Safety, where routine reporting of errors and safety conditions is not punished and does not lead to professional ostracization; there should be Continuous Process Improvement where staff across departments are encouraged to contribute, and not be sidelined; there should be a Deference to Expertise where front-line providers (*without any mention of excluding board-certified specialists),* are sought out for their input in building a safer, more effective organization; there should be a Preoccupation with Failure where staff members should work to focus on errors and catch and present risks; there should be a Reluctance to Simplify and getting to the root causes of a problem should be a primary goal, not an after-thought; there should be encouraged a Duty to Speak Up where staff feel empowered to raise issues and leadership is committed and engaged in understanding and addressing those issues with a cooperative approach and without fear of reprisal.

One of the ways that VA affirms its' commitment to the nation's veterans is by promoting innovation in healthcare. The incorporation of different approaches is part of that commitment. Tensions can arise over the procedures and appropriate arrangements of the implementation of new initiatives. Years ago , when I embarked on my journey with training in medical school, I learned professionals in medicine are often viewed differently than professionals in other disciplines; as a student, I learned physicians have to practice and promote ethical decision-making, innately lead teams of fellow physicians, physician extenders, nurses, and those of the allied professions, and offer best in class care of whatever it is we have specialized in, which is the primary purpose. Thankfully, the Cardiac surgeon is not obliged to be a Cardiologist, nor is an Addictionologist expected to learn and perform spinal injections! It has been said that *knowledge is power* --- we offer up our strengths. Each member contributes something special. “Product lines” in healthcare are diverse as represented by the many specialties that exist in medicine, each with their own sets of aptitudes; this must be recognized as the team is all *but powerless … if we do not acknowledge it.* The delivery of a broad spectrum of care takes a great deal of commitment. So also does Cultural Change benefit from a committed, consistent approach. When complementary techniques are introduced to established approaches in healthcare, it is important to recognize and preserve the foundations of both. Scientific thought and reason define the practice of medicine; what drives the acceptability of innovation in medicine will always be these time-honored, steady and reliable, “Incumbent” views. Innovation to the System can cause apprehension, being received as a “Challenger” of sorts --- as the established model, defined by being diagnosis-led, focuses on *disease* and “syndrome”. Whole Health *modalities* are different in that regard, while what has been called the Whole Health *concept*, patient-centeredness, is *actually* a concept that can pervade the innovation as it does the established model.

[79] <Whistleblower#1> to <Pain-Mgmt-Chief> re: Stepped Care Model, April 15, 2022.

The Prime Directive should be the same. In Medicine, the Prime Directive has always been and continues to be to Do No Harm, and so, we are cautious by our very nature: We would rather not prove something is unsafe before we identify safety concerns, *as even one adverse event is too many*. Prevention is key, a concept which pervades traditional medicine and Whole Health alike. With the right expertise and a culture of courage, we can continue to improve in a safe and effective manner in good faith. I personally have lost entire weekends to this endeavor of raising these disclosures and the aftermath of having done so. I have lost multiple LEAVE days. I had come to work early on multiple days and left hours after my end of tour on many days; I still do. I read up on related matters nightly. In attending to these matters which I have raised and their sequelae, I have spent over 1,000 hours of my own (non-tour) time on these matters. I have concerns about the influence that a Realignment of traditional medicine section/services under a Whole Health Service has on clinical autonomy --- Moral Agency in determining best medical practice --- which may in turn run the risk of negative effects on the healthcare services being received by Veterans. It is my belief that this Realignment and these substantiated allegations --- which in my view represent predictable consequences --- should be reversed, so as to not serve to promote any disservice to the Veterans that we serve each day.

I gain nothing by taking anything away from Whole Health or complementary modalities; I have enjoyed meeting and getting to know many of my colleagues in Whole Health. I have referred veterans for different services offered under Whole Health, including acupuncture, chiropractic care, and yoga. I have promoted the availability of these services; some veterans really enjoy different of these such services and are grateful that the VA has offered them. I think there are potential benefits to the concept of patient-centered care which is supposed to characterize “Whole Health” as a concept, and its incorporation into healthcare. There are, in existence, complementary modalities, “programmatic components”, which are to be housed under a “Whole Health” (programmatic) section/service. Complementary care modalities (programmatic) are not somehow more patient-centered (concept) than traditional medicine (programmatic), however; there is, in existence, traditional medicine, which, in my opinion, differs from complementary care… by definition and by being diagnosis-led. It is ok for there to be differences, and those differences are important to recognize. These approaches can co-exist, but we must be wary of any ill-effects due to clinical or administrative confounding.

When faced with choices in the dutiful practice of medicine, the charge is to know oneself, to know one’s aptitudes and one's own breadth and limitations. Compassion defines the art of medicine, while many facets determine the practice of it. Discretion and Duty go hand in hand because there are always choices to be made, good or bad. When faced with the impossible choice, to know and not heal, or to heal and not know, one manages to make a choice, opting to choose neither and, in a nod to Moral Agency, instead practices on one's medical license ... and herein is the liability of said Agency in the Practice of Medicine. When acting as a physician (even as a bad one!), one must use discretion to respect the standard of “Do No Harm” in the course of professional practice, which can suffer not of ruin.

Sincerely,

Whistleblower #1

Reference 1

[redacted]

From: [redacted]
Sent: Monday, February 8, 2021 12:55 PM
To: [redacted]
Subject: RE: Information Needed

Thanks!

[redacted]
VISN 17 Human Resources Specialist (Executive Employee/Labor Relations Specialist)
Department of Veterans Affairs
VA Heart of Texas Health Care Network
[redacted]

How was my service today? We value your feedback – please click on the link to take the HR Quick Card Survey

From: [redacted]
Sent: Monday, February 8, 2021 11:54 AM
To: [redacted]
Subject: RE: Information Needed

Ok. Yes sir.

I will certainly be getting back to you.

[redacted]

From: [redacted]
Sent: Monday, February 8, 2021 12:54 PM
To: [redacted]
Subject: RE: Information Needed

The memorandum I have is from the Office of Special Counsel. OSC File No. DI-21-000033 dated November 17, 2020.

[redacted]
VISN 17 Human Resources Specialist (Executive Employee/Labor Relations Specialist)
Department of Veterans Affairs
[redacted]

How was my service today? We value your feedback – please click on the link to take the HR Quick Card Survey

From: [redacted]
Sent: Monday, February 8, 2021 11:51 AM

To: [redacted]
Subject: RE: Information Needed

More specifically, what party conveyed to you::

“allegations you raised regarding the CTVHCS Pain Management Clinic”

I am asking to assure that I am communicating with the correct party.

From: [redacted]
Sent: Monday, February 8, 2021 11:58 AM
To: [redacted]
Subject: Information Needed
Importance: High

Good morning [redacted]

I am coordinating the investigation into the allegations you raised regarding the CTVHCS Pain Management Clinic. I have an outside investigator working on it and he asked me to see if I could get some information from you to assist him. Specifically:

1. A statement of your current concerns.
2. Any correspondence regarding such matters that you consider inappropriate, or which you think might contribute to our understanding of the situation.”

Please let me know if you have any questions. Thanks and have a great day!

[redacted]
VISN 17 Human Resources Specialist (Executive Employee/Labor Relations Specialist)
[redacted]

How was my service today? We value your feedback – please click on the link to take the HR Quick Card Survey

[redacted]

From: [redacted]
Sent: Friday, February 12, 2021 3:37 PM
To: [redacted]
Cc:
Subject: Interview

Good afternoon [redacted]!

Hope you are well. The investigator in the OSC case we previously discussed would like to interview you. His name is [redacted] and he is an outside party employed at the [redacted] Texas VA. He would like to set aside 90 minutes for the interview, with the understanding that if you or he feel that more time is needed, a follow up interview could be scheduled. [redacted] has time on Friday, February 19. He is available from 0900-1200 and 1230 to 1600. Are you available on that day and if so, what time would work for you? Also be advised that as a bargaining unit employee, you may bring a Union rep for the interview as well if you so choose. Please be advised that this you are not the subject of this investigation, you are only being interviewed so he can gain information he needs to pursue the issue that was reported.

I also want to take this time to let you know that if you believe that you have been, are being, or are in the future, subject to retaliation for you protected disclosure, there are avenues available for you to seek relief. You can bring that to me, [redacted], VISN 17 HRO, The Office of Accountability and Whistleblower Protection (OAWP), the OIG, or the Office of Special Counsel. If you have any questions whatsoever, please don't hesitate to reach out to me. I am here to answer any questions you might have.

Thanks and have a great holiday weekend,

[redacted]
VISN 17 Human Resources Specialist (Executive Employee/Labor Relations Specialist)
Department of Veterans Affairs
[redacted]

How was my service today? We value your feedback – please click on the link to take the HR Quick Card Survey

Reference 2

[redacted]

From: [redacted] (OAWP)
Sent: Tuesday, June 1, 2021 1:17 PM
To: [redacted]
Subject: OAWP case number 21-TempleTX-16893 closure notification for OMI acceptance

Dear [redacted],

On May 15, 2021, the VA Office of Accountability and Whistleblower Protection (OAWP) received your allegations related to violations of law, rule, or regulation and patient care concerns. Due to the nature of these allegations, the matter was presented to the VA Office of Medical Inspector (OMI) for consideration. The OMI accepted the matter on June 1, 2021.

If you provided consent for the release of your name, OMI will contact you upon initiation of their investigation. Upon completion of the investigation, individuals may request copies of records maintained regarding themselves through the Privacy Act. Other agency records not regarding themselves can be requested through a Freedom of Information Act (FOIA) request. VACO FOIA requests may be submitted by electronic submission form at www.va.gov/FOIA/Requests.asp or email to VACOFOIAService@va.gov.

Because your allegations were accepted by the OMI, OAWP no longer has oversight of the investigation. As such, OAWP case number 21-TempleTX-16893 has been closed. Please note that this notice is not a judgment on the merits of your allegations. OAWP will continue to investigate OAWP case number 21-TempleTX-16894.

If you believe you have experienced whistleblower retaliation as a result of making this disclosure, you may contact OAWP by completing our online Intake Form at www.va.gov/accountability, by email to oawp@va.gov, or toll-free at 855-429-6669. You may also file a complaint alleging whistleblower retaliation with the U.S. Office of Special Counsel (OSC). OSC is an independent agency responsible for enforcing whistleblower protections. More information on OSC can be found on their website at https://www.osc.gov or by telephone at (800) 872-9855. You may also contact the VA's Office of Inspector General to report criminal activity, fraud, waste, abuse, or safety issues at (800) 488-8244 or through their website at http://www.va.gov/oig/hotline.

If you have questions or concerns regarding this notification, please feel free to contact oawp@va.gov.

Sincerely,

[redacted]
Intake & Referral Analyst
Office of Accountability and Whistleblower Protection (OAWP)
U.S. Department of Veterans Affairs
[redacted]

OAWP's Online Disclosure Portal Form
Anonymous Toll-Free Disclosure Hotline:855-429-6699

Reference 3

[redacted]

From: [redacted] (OAWP)
Sent: Friday, May 28, 2021 8:29 AM
To: [redacted]
Subject: RE: Update? --- OAWP case SUB-Temple-TX-16,455

Hello [redacted],

I received the documents that you provided. The Office of the Inspector General declined your matter, your matter is being transmitted to the VHA Office of the Medical Inspector.

Your allegations of Whistleblower Retaliation is in que for assignment of an investigator. Please be advised that our Investigations Division receives a high volume of cases, the estimated time from submission to completion of an OAWP investigation is approximately 120 days though in some instances an investigation is completed sooner. Thank you for your patience, you will be contacted once an investigator is assigned.

[redacted]
Intake & Referral Analyst
Office of Accountability and Whistleblower Protection (OAWP)
U.S. Department of Veterans Affairs
[redacted]

OAWP's Online Disclosure Portal Form
Anonymous Toll-Free Disclosure Hotline:855-429-6699

From: [redacted]
Sent: Friday, May 28, 2021 9:15 AM
To: [redacted]
Subject: Update? --- OAWP case SUB-Temple-TX-16,455

Hello [redacted],

(1) Please confirm receipt of prior email containing word document:

- [redacted]

(2) Please give me an update on assignment to the investigator.

I really appreciate any and all attention on this that can be given.

Thank you,

[redacted]

Reference 4

[redacted]

From: [redacted]
Sent: Tuesday, February 16, 2021 7:52 PM
To: [redacted]
Subject: Information request
Attachments: [redacted] Letter regarding concerns_02162021.pdf [redacted] Correspondence regarding concerns_2_02162021.pdf [redacted] Correspondence_regarding_concerns_3_02162021.pdf

Hello [redacted]

Please see attached

[redacted]

What follows is a list of issues I have referred to Office of Special Counsel:

(1) There are patient safety concerns surrounding recent actions by [redacted] Director of Whole Health at CTVHCS. Both during the Subcommittee on Buprenorphine when he attempted rescind the Subcommittee's SOP, and then followed by his repeated efforts to rescind the SOP even after its having been voted on and accepted by the CEC, these actions were contrary to the best interests of the patients and the applicable professional standard care. In addition, [redacted] has also sought to pressure and coerce professionals to prescribe Buprenorphine/products in circumstances, and in a manner, outside of the standard of care [redacted] has indicated to several professionals that the difference between Opioid Use Disorder (OUD) and chronic pain in terms of prescribing buprenorphine is "academic". He has said the same thing of the difference between OUD and Complex Persistent Opioid Dependence. In neither case is the assertion true. [redacted]s presentation of the matter and omission of critical facts regarding the importance of diagnosis, which is relevant to prognosis and treatment approach, serves as clinical misdirection to our colleagues engaged in patient care.

(2) [redacted] has performed unsolicited/unrequested self-consultations on numerous patients, with whom he had not had previously established relationships and/or requests for consultation. These self-consults appear to involve patients whose names he had access to, first, as a member, and then, as the chairman, of the CTVHCS Pain Management Team. I do not believe these self-consults are consistent with regulation or with VA policy. This self-consultation behavior also includes patients with whom [redacted] would actually only be performing administrative functions as the section Chief. It is my understanding that although his role was to be administrative, he turned these interactions into billed self-consultations. These actions exceed [redacted]s authority and violate law and regulation. I am unable to supply information on the extent of such consultations, as to my understanding, [redacted] clinic schedule has remained blocked off with no availability ever having been listed.

(3) The continued alignment of the traditional section of Pain Management under Whole Health is a concern; Whole Health, as the home of CIH was never intended to administrate over traditional medicine --- certainly not a specialty service which falls under a separate ICC altogether. The alignment is inconsistent with VA policy and creates impediments to care for pain management patients. As it is done in other VA facilities, Whole Health was intended to be vertically and horizontally integrated with Mental Health and Primary Care per the VHA executive decision memo of 3/2020. The concern with the current misalignment at CTVHCS is that the appointment of a clinical director over Whole Health and subsequent/concomitant alignments of any traditional medicine specialty under its administration serves as pathway for any provider meeting criteria for hire for the Whole Health Clinical Directorship, which has included at different facilities, physical therapist(s), psychologist(s), nurse practitioner(s), and physician(s) of different specialties, to have clinical and administrative scope beyond

his/her training, expertise, and credentialing over the providers of the misaligned traditional specialties. As such, the alignment of a traditional medical specialty under Whole Health can not only function contrary to the ICC classifications, it can also create a mechanism by which National and/or local hiring criteria and credentialing processes which are applied to providers in traditional medical specialties can be bypassed. Notably, this is exactly what has happened here at CTVHCS. As a result, the Pain management section here has become stifled and restricted from advancing its standard of care.

(4) [redacted] has been instituting a centralized consult pathway in Whole Health for pain management. In his plan, to get to the traditional specialty of Pain Management, veterans now are forced through the Whole Health / "Complementary Integrated Health" barrier. The veteran does not get to choose that their referral is now being screened/triaged by Whole Health personnel or "coaches" who are not clinicians. Under the current consult pathway, non-clinician coaches are in charge of screening physician referrals. This is contrary to the best interests of the patients, and not consistent with the applicable professional standard of care. In direct contradiction to the VHA directive 1137, it is crystal clear that [redacted] is creating a scenario where the non-disease focused treatment approaches that are supposed to be complementary to traditional pain care are actually being presented as mutually exclusive options to traditional pain care, and non-physicians are controlling the course of care for potential pain management patients/candidates.

Under this system, veterans "cannot do everything at once - they can choose acupuncture, chiropractic, or pain clinic. they can certainly go to the other services later." These restrictions force veteran movements through the centralized consult pathway violate 38 CFR § 17.33 - Patients' rights. This also violates several VA policies that establish the proper role of CIH and complementary care. Please recall that according to Memo VAIQ 7811817, Attachment 1, "Additionally CIH services may need to compete for resources with existing VHA programs." Because of the realignment of the Pain Section under Whole Health, there is now direct competition for resources between Interventional Pain and Whole Health. Again, this is contrary to regulation and policy – VHA DIRECTIVE 1137 Transmittal Sheet May 18, 2017; PROVISION OF COMPLEMENTARY AND INTEGRATIVE HEALTH (CIH): "It is VHA policy that CIH is <u>not</u> to be used as an alternative to conventional medicine; it must <u>only</u> be used to complement conventional medicine."

(5) The Pain Management physicians are now being instructed by [redacted] to deny services (community referrals) owed to veterans by federal regulation/law. [redacted] recently directed pain management physicians not to make community referrals, even when the individual physician and veteran believe a community referral is appropriate and necessary. This restriction constitutes a violation of 38 U.S. Code § 1703 and 38 CFR § 17.4010. Instead, the recent limitation appears to

force veterans receiving pain management care in the community to return to CTVHCS for care. After recent instructions from [redacted] it is my understanding that pain management physicians are now only permitted to make (or continue) a community referral for drive-time, wait time issues, and immediate post-op patients; recently [redacted] has also added "procedures we do not do" to that list.

These restrictions are contrary to law and deny veteran patients the care due to them. The limits on community referrals (or continued community care) forces pain management physicians to expand to treat OUD and/or prescribe more buprenorphine products. The restrictions placed by [redacted] will likely destabilize the care many of these veterans are currently receiving in the community.

(6) [redacted] intends to remove the RN from the pain management procedure suite and to replace staffing of this position with an LVN. Simultaneously, he is planning to have an RN perform Whole Health functions. This is a stark example of the dilution of pain management resources under the CTVHCS misalignment. Because the Pain Section is now under Whole Health, Interventional Pain resources are being diminished and reallocated toward Whole Health. As [redacted] is the Director of Whole Health, the end result is that Whole Health is actively drawing resources away from the Pain Management section. This is contrary to VA policy, and it is impacting significantly the interventional pain management care that can be provided to patients. The current misalignment of Pain Management under Whole Health incentivizes exactly this very specific decision-making.

Of note, having an RN for the procedure suite is important due to their broader scope of practice/training/education compared to that of an LVN; the RN scope of practice is far more relevant and appropriate to the tasks and purposes of nursing personnel assigned for interventional pain procedures. Not having an RN present for interventional procedures increases the risk to veterans.

(7) Based on my understanding of the information from [redacted] VISN 17 tracks New Long Term Opioid Patients as a measure; it does not, however, track Buprenorphine as one of those opioids. VISN 17 therefore kicks Buprenorphine products out of long term opioid tracking and yet very much tracks Buprenorphine products via the SUD16 parameter. The SUD16 parameter theoretically tracks those veterans who have been diagnosed with OUD and receive medication treatment for it, *although even vague opioid diagnostic listings* can suffice as the denominator of this parameter. It can appear that there are decreasing total Opioid prescriptions, decreasing co-prescribing of Opioids and Benzodiazepines, and increasing treatment of OUD — all by selecting whatever diagnosis is selected to match the denominator for the SUD16 parameter, even if actual OUD is *not* diagnosed. This is concerning because morbidity and mortality may even go up, instead of down. It is unknown to me what the other VISNs are doing in relation to tracking the Buprenorphine via their various dashboards. Monitoring the drug in one regard, but not

the other, incentivizes prescription of the drug in a more profound fashion; by the time dissemination of the drug is entrenched in prescriber habits and clinical approaches with sewn-in clinical/diagnostic ambiguity, it may be too late to reverse.

Reference 5

VHA Executive Decision Memo – Engaging Veterans in Lifelong Health, Well-being and Resilience Integrated Project Team, March 4, 2020

Reference 6

[redacted]

From: [redacted]
Sent: Friday, September 17, 2021 8:22 AM
To: [redacted]
Subject: FW: In Regard to Continued Calls for Intervention

Hello [redacted]

Here is the forwarded copy of the email, in case of any issue with it as an attachment.

Be well sir,

[redacted]

From: [redacted]
Sent: Thursday, May 20, 2021 6:55 AM
To: [redacted]
Cc: [redacted]
Subject: In Regard to Continued Calls for Intervention

[redacted]:

First and foremost, I appreciate your efforts on behalf of your Veterans. Interventional pain management is a vital component of the care we offer our Veterans under the overarching Pain Management umbrella. I have heard from each of you (often on the same massage string) that you have concerns that span several subjects. Most recently has been the claim of Hostile Work Environment.

At each complaint, an appropriate management review or action was completed to assess your concerns. The matter of a Hostile Work Environment was leveled against [redacted] Taking this seriously, [redacted] consulted with the Acting Network Director. It was the Acting Network Director's recommendation to have a disinterested 3rd party from outside the organization conduct a Fact Finding. [redacted] recommended [redacted] by name.

I understand that one or more of you have requested the report under the Freedom of Information Act. The Release of Information office will process your request(s) as it does all requests.

I am aware of reports generated by one or more of you in regard to your work environment. That is your right and I encourage you to do so as you deem necessary. [redacted] has developed a plan of action to address recommendations and observations stemming from the Fact Finding on the claim of Hostile Work Environment that will improve the operations in your area. While I understand that [redacted] did not find that the concerns rose to the level of a hostile work environment changes and improvements in current processes may move forward to create a more pleasant environment for all.

Reprisal for protected activity is prohibited and will not be tolerated. However, the assignment of work is a managerial right. You may not personally agree with supervisory instructions, but all communications should adhere to the VA ICARE values. Respect is one that comes to mind. Tone and tenor of everyone's discourse - verbal or written – should fall within the parameter of these core values.

I hold dearly your rights to practice medicine as reflected in your education, licensure and experience. You are independently credentialed providers. By the same token, all providers are subject to FPPE and OPPE processes in addition to peer review when appropriate. We all have the responsibility to evolve our craft as evidence-based science emerges to continue to practice to the community standard of care. I encourage all providers to be life-long learners in their field.

The on-going professional relationships within our services are very important. I encourage all staff, whether management, labor, supervisor, to focus on our Mission. Contribute to improving our processes and accept responsibility for their performance and actions.

Sincerely,

[redacted]

[redacted]
Director, Central Texas Veterans Health Care System
[redacted]

Click Below for CTVHCS HRO Website

ZERO HARM | High Reliability Organization Live and Accountably

How is VA Quality? Click the links below.
https://www.onlinejacc.org/content/76/9/1111
Journal of the American Medical Association
Osmosis
https://link.springer.com/article/10.1007/s11606-018-4433-7
https://www.newsweek.com/americas-best-addiction-treatment-centers-2020/texas

[redacted]

From: [redacted]
Sent: Tuesday, April 13, 2021 11:56 AM
To: [redacted]
Subject: RE: Request for Interview

[redacted] – [redacted] is not able to meet at 1330 today. Would 0900 on Friday work?

[redacted]

Corporate Compliance Officer
CTVHCS
[redacted]

From: [redacted]
Sent: Tuesday, April 13, 2021 11:48 AM
To: [redacted]
Subject: Re: Request for Interview

Ok thank you

[redacted]

Get Outlook for iOS

From: [redacted]
Sent: Tuesday, April 13, 2021 11:47:11 AM
To: [redacted]
Subject: RE: Request for Interview

Yes, sir. I'll set up a Teams meeting for you for 1330 today.

[redacted]

Corporate Compliance Officer
CTVHCS
[redacted]

From: [redacted]
Sent: Tuesday, April 13, 2021 11:46 AM
To: [redacted]
Subject: Re: Request for Interview

I think we coincidentally wrote each other at the same time!

Can we try for 1330?

If I cannot make that, I will email you.

I am having a procedure today.

[redacted]

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From: [redacted]
Sent: Tuesday, April 13, 2021 11:44:18 AM
To: [redacted]
Subject: Re: Request for Interview

Hello [redacted]

The earliest I could speak today would be 1330.

It may be better for us to try tomorrow or later this week.

[redacted]

Get Outlook for iOS

From: [redacted]
Sent: Tuesday, April 13, 2021 8:14:13 AM
To: [redacted]
Subject: Re: Request for Interview

Hello [redacted]

I am on sick leave today on account of a dental issue. I may have one or more appointments today, including potential surgery/procedure.

However, I can likely speak **at 1300 today.**

Will that work for [redacted]?

[redacted]

Get Outlook for iOS

From: [redacted]
Sent: Monday, April 12, 2021 3:08 PM
To: [redacted]
Subject: Request for Interview

[redacted] -

[redacted], VHA National Director, Anesthesia, has been asked to conduct a fact-finding into concerns raised by Pain Clinic providers. He would like to interview you as part of that fact-finding and would like to complete that as soon as

possible. Below are time that [redacted] has blocked on his calendar for these interviews. Would one of these times work for you? The interview will be conducted via Teams and is anticipated to last approximately 30 minutes.

Tuesday, April 13, 2021 1100 – 1400
Wednesday, April 14, 2021 0900 – 1200
Friday, April 16, 2021 0900 - 1200

Thank you!

[redacted]

[redacted]
Corporate Compliance Officer
Office of the Director
Central Texas Veterans Health Care System
[redacted]

Act with Integrity. If you have integrity concerns, speak up!
Consult the Code of Integrity: va.gov/healthcareexcellence/code
Integrity Concerns: CBI HelpLine 1-866-842-4357, vhacbihelpline@va.gov

Reference 7

Department of Veterans Affairs

Memorandum

Date: April 7, 2021

From: [redacted] Central Texas Veterans Health Care System [redacted]

Subj. Fact Finding: Hostile Work Environment in [redacted]

To. [redacted]

Thru:

1. This memorandum is to appoint you to conduct a fact-finding into allegations of a hostile work environment in the [redacted] of the [redacted] at Central Texas Veterans Health Care System. You are to investigate allegations that the [redacted] is creating hostile work conditions.

2. Please make a determination of the following.

   a. Has the [redacted] created an environment that is toxic?
   b. What are the circumstances surrounding these allegations?

4 [redacted] will provide training and technical support.

5. Provide your report to me by Monday, May 3, 2021.

[redacted]

cc: [redacted]

Reference 8

FACT FINDING REPORT FORM

Fact finding is a balanced and fair review process conducted by a manager or service chief that involves the collection of factual information (NOT opinions) about an adverse event or alleged adverse event. The purpose of a fact finding is to get credible information that can be used to determine the appropriate action in response to the event.

The fact finding should be completed within of discovery.

Checklist of Documentation to be Included:

Documentation may include, but is not limited to:

☐ **Any prior verbal or written counseling's, disciplinary actions, etc.**

☐ **Standard Operating Procedures (SOPs), local/national policies and procedures, functional statements**

☐ **Any past documentation of trainings, educational sessions attended, Performance Improvement Plan education, etc.**

☐ **Reports of Contact from any or all: staff, patients, families and others who would have been involved in or observed the event and personal documented review of the alleged incident.**

Service- Level Review

Date & Time of Event	
Date & Time Event Reported	April 7 2021
Location of Event	Pain Clinic at Central Texas VA
Name & Title of Person Conducting Review	[redacted], Chief of Anesthesiology and Pain Management Dallas VA.

Initial Notification of Event		
Who was notified of event?	By Whom?	Date & Time of notification

Incident Summary: *provide brief description of event to include dates, times, persons involved, potential witnesses etc.*

There is a complaint from the pain providers with the allegation that a hostile work environment exists in the Pain Management Section of the Whole Health Service since the arrival of [redacted]

FACT FINDING REPORT FORM

Investigation Plan: *detail the steps you plan to take to conduct a thorough investigation. Please include names of potential witnesses, records and/or documents to be checked, etc.*

I plan to interview [redacted] and [redacted], and [redacted] ([redacted]) who may add to the discovery of this allegation.

Interviews: *List identified witnesses below and interview times/dates and representative present (if applicable)*

Witness Name & Job Title	Date/Time	Representative Offered (circle one)	Representative Name (if present)
[redacted]	[redacted]	Yes / No / NA	
[redacted]	[redacted]	Yes / No / NA	
[redacted]	[redacted]		
[redacted]	[redacted]		
[redacted]	[redacted]		
[redacted]	April 16 at 9:00amCT		

FACT FINDING REPORT FORM

Evidence Obtained: *List all documents and/or records reviewed for this fact finding. (i.e., T&L Records, Reports of Contact, Policies, emails, etc.). All documents must be attoched to this form upon completion. Be sure to maintain a* ***full copy of*** *all evidence* ***for your files.***

Findings and Conclusions: *Based on the data collected, what conclusions can be made regarding this event? Be sure to include what evidence you considered when drawing your conclusians regarding this event.*

There is certainly a very difficult environment in the area of pain management. There is loss of respect and trust between leadership and the pain providers and it is difficult to know how this started.

[redacted] and [redacted] concerns:

From what I can gather when I interviewed [redacted] and [redacted] the complaints are the following –

1. Realignment without consultation
2. Realignment was a retaliation for an EEO filed in 2019

Prior to [redacted] it seems that the pain clinic and procedures were functioning in isolation to the overall need of the hospital and the veterans. The pain providers, [redacted] and [redacted] were doing what they believe is best for the patients they are managing. They are very unhappy about the realignment under Whole Health because they believe that they should have been consulted before the execution of the realignment. To my knowledge, the [redacted] has the authority to realign any department and does not necessarily need input from any stakeholders. However, the [redacted] did present the plan of realignment at the [redacted] and the vote for realignment was unanimous. So, concerns #1 and #2 are unfounded

3. [redacted] of Chairs of Committee [redacted] to [redacted] has the authority to change any chairs of committees as [redacted] sees fit. So, the complaint has no basis.

4. Change of direction in the function of the pain service from solely interventional to a mixture of interventional and prescription of pain medication.
   [redacted] and [redacted] have the authority to change the functions of the pain service. In an ideal world, they could have asked for input from the pain providers on how to provide a pain service that is best for the Veterans.
5. Concern about the recommendations for pain management by [redacted]
   [redacted]
   Pain management in any VA facility needs to follow the direction set by [redacted]
   [redacted]
6. Concern about not following "Directive" from VACO
   [redacted] and [redacted] are confused about the difference between directives and guidance. All VA facility needs to be in compliance with all directives and be aware of all guidance. Guidance is normally sent out as a memo to help some VA facilities and may not apply to all.
7. Concern about managing patients with Opioid Use Disorder (OUD)
   OUD is a difficult disorder to treat and I believe addiction specialists need to be involved. It is probably best to leave the pain providers to remain as interventionist. This also makes sense from a business angle since pain providers are highly paid.
8. Concern about leave
   The pain providers do not seem to understand the VA regulations about leave and that [redacted] is following all regulations on leave. Of course, as a [redacted] also has some leeway of approving leave on some exceptional circumstance.
9. Concern about not having enough administration time.
   [redacted] is labor mapped with 50% administration time. According to the guidance [redacted] should only be allowed 20% [redacted] needs also understand that [redacted] should be available on a 24/7 basis according to the handbook (excerpt included below).

   > *A FT physician is employed on the basis of availability for duty 24 hours a day, 7 days a week and thus remains ineligible for premium pay under VA Handbook 5007, Part V. No extra amount in addition to the regular per annum rate shall be payable to these employees for duty on a legal holiday, Saturday or Sunday, at night, on overtime, comp time, or for on-call duty*

   In addition, [redacted] productivity is low and should have ample time to perform some of the administrative tasks given to [redacted] by [redacted]

10. Concern about being fired.
    This seems more of a state of mind rather reality.

11. Concern about [redacted] inserting [redacted] within the clinical decision-making of the pain management team.
    I have not been provided with any evidence of this claim.

[redacted] concern:

1. Pain Clinic setup is not effective
   [redacted] stated that the 4-hour pain conference, established by [redacted] is not effective and wanted to try a different approach. [redacted] has the authority to do this.
2. All providers should be able to prescribe buprenorphine
   As I mentioned above, it is probably best to leave this to mental health and addiction specialist.
3. Pain clinic's providers are not engaged in the direction [redacted] wants the pain clinic to go
   This is always a difficult topic for [redacted] They always have the difficult task of getting buy-in from his/her providers for any change to be successful.
4. [redacted] is concerned that there are no quality monitors for pain procedures.
   [redacted] is correct. They should be monitoring patient satisfaction and infection rate.
5. Instructions given to [redacted] for the pain clinic providers are embellished by [redacted] causing even more confusion.
   [redacted] may need to eliminate the layer between [redacted] and the pain providers and gives [redacted] instructions directly to the pain providers.

[redacted] and [redacted] concerns:

According to [redacted] and [redacted] pain management has got a lot worse since the arrival of [redacted] All consults need to go to Whole Health Service before they can go to the pain section. They stated that this delays care to the patients and the review by Whole Health staff does not add any value to patient care. It only adds delays and by the time the consult reaches the pain providers, the time may have passed the 28 days required by the Mission Act. The patients would then be entitled to be sent to the community. According to some staff I interviewed, the patients are still kept in-house. In additional, [redacted] and [redacted] also mentioned that providers are encouraged to prescribe narcotic for treatment of pain.

[redacted] needs to revisit the system of consult to the pain service and review the 1st line medication to patients with chronic pain. I believe there is confusion about the messaging from [redacted] I strongly recommend that [redacted] clarifies [redacted] message. I believe that [redacted] meant to state that buprenorphine may be helpful in weaning patients off narcotics.

Productivity concerns:

The average productivity of my pain physicians is about 4400 RVUs. Productivity of pain physicians at Central Texas VA seems low. [redacted] administrative time should not be more than 20%. His productivity in [redacted] would then be [redacted] [redacted] productivity

seems reasonable. But [redacted] productivity is the lowest among the [redacted] His RVUs in FY 2021 are only 225.45.
[redacted] productivity also needs some improvement. [redacted] labor mapping on administration needs to be decreased from over [redacted]

Quality concerns:

I have interviewed [redacted] does not know [redacted] because [redacted] before [redacted] joined [redacted] But [redacted] has heard from [redacted] staff that [redacted] has weakness in both clinical practice and procedural competence. In addition, [redacted] has forwarded me an email from [redacted] In [redacted] email [redacted] mentioned [redacted] concerns about the type of injections done by pain providers at Central Texas VA.
It is important for Central Texas VA to adopt some qualities measures for pain service. An audit on the wait time between origination of pain consults to patients seen in pain clinic would be helpful.

Conclusions:

There is no doubt there is a difficult environment in the pain management area. I believe the causation of this environment is multifactorial. [redacted] could have done a better job convincing [redacted] pain providers about the new direction of the pain clinic. It is critical to obtain buy-in from all stakeholders for any change to be successful. Dr [redacted] also have a major contribution to the difficult environment. They have been disrespectful to [redacted] and treated [redacted] as a colleague rather than a [redacted] There is a lack of trust and respect mainly from Dr [redacted] and [redacted] I find a profound lack of professionalism and a strong element of insubordination by [redacted] Dr [redacted] and [redacted] Whether any action needs to be taken is up to the supervisor.
I do not believe that there is a hostile environment created by [redacted] but rather a difficult environment created by all involved, especially by [redacted] Dr [redacted] and [redacted]

Recommendations:

1. [redacted] needs to have a mentor to help [redacted] navigate the multifaceted angle of pain management.
2. The relationship between Whole Health/ Pain Management and the primary care physicians needs to be revisited.
3. [redacted] needs to clarify [redacted] messaging to primary care physicians about the use of buprenorphine.
4. Pain providers are highly paid providers and it is more business sense to leave the bulk of their work in performing interventional procedures.
5. Apart from [redacted] productivity of the [redacted] is very low. It is important to schedule more clinic visit for new and follow-up patients and to at least couble the

daily number of pain procedures. An audit on productivity for all staff in Whole Health would also be helpful.

6. Quality is always difficult to monitor in any medical specialty and especially so in pain medicine. At the very least, there should be a monitor of patient satisfaction in the pain clinic and for pain procedures. Other quality indicators such as infection rate or low success rate in pain procedures should be monitored. I also recommend that a senior pain specialist perform a site visit to review the types of procedures performed. In addition, an audit to identify the number of new patients seen in the pain clinic beyond the 28 days would be helpful.
7. An investigation, toward whether there were any implied or other types of threat toward [redacted] from [redacted] is recommended.
8. Opioid Use Disorder (OUD) is a complex disease and it is probably best to limit the addiction specialist and mental health to deal with OUD and the prescription of buprenorphine.
9. National Center for Organization Development may be able to help provided all parties are willing to have an open mind about the difficult environment.

Evidence:

The concerns, and my findings and opinions are derived by the interviews with the different persons below and the attached documents. A summary of my notes is included below.

Interview with [redacted]

[redacted] claimed that there are many lies and untrue statements about [redacted] Before [redacted] in [redacted] was mainly an interventional pain specialist. Although [redacted] was [redacted] for several years, [redacted] took over as [redacted] soon after [redacted] with the help of [redacted]

[redacted] said that [redacted] made a lot of contributions to the pain service – under CARA [redacted] established a pain management team to fit CARA requirement and established a charter for the team. The team has managed many complex pain patients.

[redacted] welcomed the [redacted] and to support [redacted] took a 2-day course on whole health. [redacted] believes that whole health approach is a good alternative to just medication.

[redacted] said that [redacted] wants to follow the recommendation of [redacted] but [redacted] does not believe that what [redacted] said should be the "law".

Pain management committee is not active anymore. Previously they used to manage patients from "Storm".

[redacted] has produced nothing. [redacted] just put on a show. There was a pain management service agreement finalized in 2016. [redacted] revised it under whole health. There is a lot of cheating. Prior to [redacted] they were performing mostly interventional procedures and sometimes prescribe some narcotics. After [redacted] They are coerced into prescribing more [redacted] even forced them to do all medications management.

started to and mentioned that performance pay would be "affected". also told that performance pay will be affected whenever there are more than 3 patient complaints. told that this is not fair because there are different types of complaints. told is not comfortable managing patients with OUD (Opioid Use Disorder) and that these patients would be more appropriately taken care by mental health.
felt was after in believes and believes that was to be said was never consulted about Whole Health. said there was some involved with Nevertheless, still wants this to be successful and wanted to meet with every week. But also said that there are and cannot wants to
also said has and that and is concerned about how
cannot understand why was by the and
also said wants VA Temple to succeed and to minimize community care.

Interview with

pain clinic for to for and
and the pain clinic when
under the Whole Health Service and are and
Since Temple VA, made all pain providers accountable. Before many patients were sent to the community and costing Temple VA was only seeing patients on and and has a tendency of patients.
believes that is very good and a much better clinician than thinks that exposes the patient to too much radiation with fluoroscopy. also believes that was run out of Temple VA by now works in the also said that does not like to work with and is super paranoid. files unfounded EEOs against anyone who disagrees with especially also mentioned a particular incident when providers, including was managing a patient without a chaperone. When spoke up, believes an EEO was filed against
thought that is and will always agree what says.
also said that is brilliant and will always listen to your opinion.

Interview with

has filed an EEO complaint against and has amended the complaint with additional concerns to the original one.

[redacted] said that [redacted] filed a EEO complaint against the former [redacted] and [redacted] in [redacted] In [redacted] recent EEO complaint, [redacted] mentioned that [redacted] realigned pain clinic under whole health in retaliation to the EEO complaint [redacted] filed in [redacted]
[redacted] also said [redacted] has heard from [redacted], that [redacted] was disrespectful to [redacted] during a meeting and that I need to talk to [redacted] to hear it directly from [redacted]

Interview with [redacted]

[redacted] said that [redacted] is very passionate and was not disrespectful toward [redacted] also that [redacted] was a very direct and just stated [redacted] opinion.

Interview with [redacted]

[redacted] has been at Temple VA since [redacted] is an [redacted] in [redacted] and had [redacted]
Soon after [redacted] met with all stakeholders for Whole Health and mentioned that the main objective of whole health is to reduce reliance on opioids. [redacted] wanted everyone to increase the use of buprenorphine to get patients off narcotics.
[redacted] does not think the pain clinic setup is effective. One example is that the 4-hour multidisciplinary meeting is not productive. [redacted] has spoken to [redacted] about how to proceed for improvement. [redacted] was not happy with the change.
[redacted] has a difficult relation with [redacted] because [redacted] does not want to listen to the changes [redacted] is trying to implement. [redacted] also said [redacted] personally attack anyone who does not agree with [redacted] others who disagreed with [redacted] in meetings. One example is when a [redacted] raises the possibility of using [redacted] for treatment. [redacted] openly disagrees with the [redacted] even though that is not [redacted] expertise.
Before the realignment of pain to Whole Health, [redacted] met with [redacted] and [redacted] believes [redacted] supported the realignment.
[redacted] stated that there were no quality monitors for pain procedures. And needed to implement one.
[redacted] is also concerned that many functions have been inappropriately delegated to admin staff because clinical judgement is needed for those functions.
Many times, when [redacted] gave [redacted] a message to send to [redacted] staff, [redacted] embellishes on the instruction and make it more confusing.

Interview with [redacted]

[redacted] has been at Temple VA since [redacted] and has been [redacted] for [redacted]
[redacted] said that [redacted] were having challenges taking care of pain patients and wanted the pain section to be a more comprehensive program. [redacted] have complained to [redacted] about the quality of pain management in the pain clinic
The [redacted] of pain at the [redacted] called [redacted] to voice [redacted] concern about the quality of pain management at Temple VA. When this was communicated to [redacted] the latter filed an EEO against [redacted] and [redacted] had to [redacted]

Pain service was under PM&R and realigned under Surgery. The realignment of pain to Whole Health was discussed at the [redacted] and the vote was unanimous with [redacted] votes with [redacted] abstention from [redacted]
In my [redacted] interview with [redacted] forwarded me [redacted] dated [redacted] in which [redacted] stated [redacted] was [redacted] Central Texas VA because of [redacted] and [redacted] about [redacted] In that [redacted] did not explicitly elabcrate on the source of [redacted] but the implication is that it may be due to events with [redacted]

Interview with [redacted]

[redacted] has been at the Temple VA for [redacted] and [redacted] in pain procedures for [redacted]
[redacted] has close rapport with all the pain providers and has seen and talked to [redacted] and [redacted] are extremely good with patients and [redacted] believes that both use the fluoroscopy machine appropriately.
[redacted] said that [redacted] Dr [redacted] and [redacted] have a growing frustration and have to endure a hostile environment created by [redacted] believes that it is inappropriate for [redacted] to assess [redacted] when [redacted] was assessed as [redacted] also believes it is unfair to [redacted] that the [redacted] by [redacted] for years have been taken away from [redacted]
[redacted] thinks that [redacted] may not last even if he wants to stay. He is afraid that if he is reassigned to [redacted] he may also be harassed. [redacted]

Interview with [redacted]

Before he accepted the job at Temple VA, he reviewed all the job offers in detail. He accepted the one in Temple VA because he considers that [redacted] at the top of the list for standard of care.
During the interview, [redacted]s unhappiness in his present position came across very clearly.
Many changes were made since joined. He believes the changes made was pushing the limit on patient safety and he does not want to commit malpractice. He said he believes that that there is an agenda to stop critical function and to get him fired. He believes that he has been told not to see follow-ups. This wil diminish the number of appointments and makes him less productive.
He repeated several times that he has been targeted and he will get fired.
He also said that [redacted] lies about him addressing [redacted] when he has never done so.
He said that [redacted] wants to lead everything toward Whole health, which is direct conflict with the direction of the pain clinic. He believes that whole health should be compl mentary to traditional medicine and not replace it. Many of the changes are in direct contradiction to VHA directive. VHA and non-VHA guidelines are not being followed. He has written to [redacted] about his concerns and a solution to his concerns.
He is also concerned that mental health is not on-board partnering with the pa n clinic to treat patients with OUD.
When I raised the issue whether NCOD will help improve the environment, he said he does think not it will help since he has lost trust in [redacted]

Interview with [redacted]

was recruited in by the to perform pain procedures. Plan was under PM&R and realigned to Surgery Service and then under Whole Health Service.
concern is whether has privileges to manage patient with OUD and addiction problem because had in those areas. is also concerned that has changed from the time was hired. In the latest needs to prescribe narcotic to at least 5 patients and the patients' complaints not to exceed a certain number. recognizes that the pain population tend to have more complaints than the rest of VA population and feels that now needs to make the patient happy. also said that this is changing usual way of treating patients with chronic pain.
Under the Whole health Service, has to accept all consults even though does not know how to work up some medical condition such as mesenteritis. said that often the veterans would be very unhappy when they had to wait several weeks to see a provider who does not know how to manage the medical condition. fears the threat of administration if does not accept the consult.
When I asked "what would be the solution to the problem in Whole health" said that the service should hire some providers with expertise in OUD. Mental health Service has pushed back on management of patients with OUD.
also said the department is scary and is contemplating dreads going to work.
is not against Whole Health, just the way things are done. always feels threatened.

Interview with

I called because used to work at does not know left before joined providers relayed to that has weaknesses in both clinical practice and procedural competence.

Interview with

is very unhappy with the current system of pain management. Before could refer patient to the pain clinic easily. Now the all consults need to go to whole health before patients can be seen by pain providers. concern is that providers getting the consult in whole health are not equipped to manage patients with chronic pain and this step only delays patient care. is also concerned that appointments with the pain clinic is mostly over 30days because all pain consults need to whole health first.

Interview with

has been at Central Texas VA for and been the for last has now for stated that the in Whole Health is a total disaster. does not agree with the direction Whole health is taking. tried to partner with in a collegial way, but does not listen and is not keen on taking advice. also said that the way Whole Health wants PCP to consult pain clinic through Whole Health is not traditional.

FACT FINDING REPORT FORM

wants the PCP to enter a RTC to Whole Health as a system of consult. encourages the prescription of even in patients screened for

Interview with

told me that Central Texas VA partly because of who was of department in stated that the department was not functioning properly and that is difficult to work with. also said that many staff in the pain department are not comfortable working with because has intimidating them on several occasion. also mentioned that is not supportive of staff and is not trustworthy. wanted everyone to agree with all the time. Is very smart on writing, embellishing everything to make look good. also believes that may have written to OIG about this.

Actions to be Taken: *Based on the findings and conclusions, what action(s) have been or will be taken?*

Identified Issues/Contributing factors	Action Plan/Proposed Disciplinary Action	Responsible Person	Anticipated/ Actual Date of Completion

Please print and sign form. All documents must be attached to this form upon completion.

Person completing fact finding: _____ Digitally signed Date: 2021.05.11 11:51:44 -05'00' _____ Date

Section Chief Concurrence: _____ _____ Date

Service Chief Concurrence: _____ _____ Date

Service Chief Comments: *this could be specific information/statement related to service level training that has already occurred uniqueness of the position and/or criticality of the incident on hospital operations, etc.*

FACT FINDING REPORT FORM

If proposing adverse action, please notify ER/LR Section Chief Human Resources at Ext. 10655

pv 01. Labor Map & Person Class Validation by

Productivity Measure, RVU Sum, Encounters, Normal Scheduled FTE,

Productivity Measure	Provider ID	
Productivity Measure		(181001)
RVU Sum		(181001)
Encounters		(181001)
Normal Scheduled FTE		(181001)
Adjusted MD FTE (C)		(181001)
% MD FTE (C)		(181001)
% Admin FTE		(181001)

Fiscal Year

Adjusted MD FTE (C), % MD FTE (C), % Admin FTE by Time and Provider ID, Person Class, Aggregat

Person Class	Aggregate Specialty	FY 2019
Internal Medcine Addiction Medicine (181001)	Psychiatry	
Internal Medcine Addiction Medicine (181001)	Psychiatry	
Internal Medcine Addiction Medicine (181001)	Psychiatry	
Internal Medcine Addiction Medicine (181001)	Psychiatry	
Internal Medcine Addiction Medicine (181001)	Psychiatry	
Internal Medcine Addiction Medicine (181001)	Psychiatry	
Internal Medcine Addiction Medicine (181001)	Psychiatry	

FY 2020	FY 2021
2,837.37	2,043.51
79.40	160.74
37	85
.35	1.00
.02	.08
5.92%	8.75%
94.08%	91.25%

Productivity Measure, RVU Sum, Encounters, Normal Scheduled FTE, MD FTE (C), Adjusted MD FTE (C), % MD FTE (C), % Admin FTE, % Education FTE and % Research FTE by [illegible]

		FY 2019 Raw Measure	FY 2020 Raw Measure	FY 2021 Raw Measure	
Productivity Measure	[redacted]	4020.45			
Productivity Measure			5442.38	4425.82	
Productivity Measure		4011.45	2459.57	1440.06	
Productivity Measure		4570.01	4125.91	3136.77	
RVU Sum		2965.90			Numerator in the Productivity Measure
RVU Sum			1096.43	245.45	Numerator in the Productivity Measure
RVU Sum		1945.27	2124.61	1244.34	Numerator in the Productivity Measure
RVU Sum		1506.84	1809.49	1057.52	Numerator in the Productivity Measure
Encounters		979.00			
Encounters			291.00	105.00	
Encounters		1519.00	1105.00	457.00	
Encounters		1018.00	291.00	359.00	
Normal Scheduled FTE		0.70			
Normal Scheduled FTE			0.96	0.37	
Normal Scheduled FTE		1.00	1.00	1.00	
Normal Scheduled FTE		1.00	1.00	1.00	
Adjusted MD FTE (C)		0.64			Denominator in the Productivity Measure
Adjusted MD FTE (C)			0.20	0.16	Denominator in the Productivity Measure
Adjusted MD FTE (C)		0.91	0.91	0.47	Denominator in the Productivity Measure
Adjusted MD FTE (C)		0.41	0.44	0.11	Denominator in the Productivity Measure
% MD FTE (C)		100%			
% MD FTE (C)			55%	95%	
% MD FTE (C)		95%	100%	100%	
% MD FTE (C)		50%	45%	50%	
% Admin FTE			5%	5%	
% Admin FTE		5%			
% Admin FTE		50%	55%	50%	? [illegible] High Admin ... is removed from Adj. Clinical FTE

From:
To:
Subject:
Date: Friday, May 7, 2021 11:46:07 AM

From:
Sent: Tuesday, May 14, 2019 8:00 AM
To:
Cc:
Subject:

On my way in to work this morning, I ran into I was from and saw along the ; told I heard was

confirmed that, saying because of

should also let you know have expressed about will be talking some more with today and will talk with

---

Central Texas Veterans Health Care System
Temple, TX

Central Texas Veterans Health Care System

[redacted]

From: [redacted]
Sent: Monday, May 3, 2021 12:23 PM
To: [redacted]
Subject: RE: Fact-finding --- Pre-interview statement

CORRECTION:

1st meeting with [redacted] **and the union was January 29th, 2021.**

[redacted]

From: [redacted]
Sent: Tuesday, April 13, 2021 9:32 PM
To: [redacted]
Subject: Fact-finding --- Pre-interview statement

Hello [redacted]:

Please accept this pre-interview statement for your fact-finding.

Timeline:

1) 9/2/2020 – 9/3/2020 – Exchange with Coding/HIMS in which self-consultations are discussed
   a. [redacted] was copied/included on this exchange.
   b. At one point, in a forwarded email, [redacted] (HIM specialist) asked the question of [redacted] (Chief, HIMS/Privacy/FOIA officer at CTVHCS) "Is the question can PMT members contact the patient before the PMT meeting?"
   c. Picking up on this important question having been asked, I asked [redacted] what the answer was in one of my email replies.
   d. When the direction of the content being discussed focused more and more on this critical point of the discussion, [redacted] dropped my name off of the email exchange, copied our CoS, [redacted], and claimed I was disrespectful. I felt that he sought to hurt my reputation and relationship with the CoS on account of certain consultation behavior being questioned in an open forum with HIMS/Coding.
2) 9/29/2020 – CoS Memo goes out indicating that effective 10/11/2020, Pain Management section is being realigned to the Whole Health service and that my supervisor, rater of record and Service Chief will change to [redacted]
3) 10/09/2020 – OSC complaint submitted by me
4) 10/10/2020 – OIG complaint submitted by me
5) 10/11/2020 – Pain Management section is realigned under Whole Health
6) 10/15/2020 – Correction to CoS Memo goes out indicating that effective 10/11/2020, Pain Management section is being realigned to the Whole Health service and that my supervisor and rater of record **will not change** and Service Chief will change to [redacted]
   a. Of note, this updated memo is sent out after [redacted], Section Chief of Pain Management, reached out to HR to inquire as to whether or not he was a Tier 1 or Tier 2 employee at this point, as all aspects of his position as Section Chief of Pain Management were taken from him, including: Chairmanship of the POC,

Chairmanship of the PMT, Point of Contact for Pain Management for CTVHCS, and supervision of [redacted] and [redacted] as Pain Management physician staff.

7) 10/20/2020 – [redacted] sends out email stating: "We will be updating the OPPE"
   a. I believe this serves as [redacted] written verification that he was transparently changing my work duties.
8) 10/23/2020 – 1st Meeting 1-on-1 with [redacted] (he refused the presence of my first-line supervisor, [redacted]):
   a. During this meeting, he asked me if I was straight out of fellowship; this is in spite of the fact, that by now, it had come up a few times, that I left an Academic/University practice (that I had been at for several years) to come to the VA here. This question/accusation of my being a "private practice" doctor is one he would later repeat on different occasions.
      i. I find this is intended as an insult by [redacted].
      ii. I believe this is also intended by him in an attempt to discredit me.
   b. He stated to me bluntly that it was the Chief of Staff's decision to move pain under Whole Health, and that the decision was finalized after having pulled all the sections service chiefs.
   c. In the middle of his discussing Whole Health, he indicated to me that **my leave and my time cards and all those things go through a chain of command.** He stated this in the middle of my trying to let him know that I was ready for him to go ahead and tell me about Whole Health, as that is what he has been talking about; apparently, he did not like that, not understanding that I truly wanted to hear about Whole Health. I noted this point, because I found it very strange for him to interrupt his discussion of Whole Health, my OPPE, and treating OUD with this aside about my time cards and leave going through a chain of command.
      i. I found this to be a threat of sorts; his subsequent conduct supports that [redacted] would use leave requests and time cards as avenues of attack and leverage.
   d. It seemed clear to me that he wanted me to feel he had power over me amidst a discussion that "leadership" would be deciding what I would or would not be expected to prescribe.
      i. This caused me to feel uneasy; it is a fact that "leadership" has been cited in prior OIG investigation(s) for inserting him/her/them-selves into clinical care between the provider and the patient.
   e. I learned later on, that [redacted] has made the claim that I addressed him as [redacted] during this meeting. **This is wholly inaccurate.**
      i. When I met him for the meeting, I had said "Dr. [redacted], how are you?"
      ii. I believe he has stated this claim of how I greeted him then to others in order to prejudice others against me as "disrespectful."
      iii. The only people I call by first name in the entire hospital are my clinic/procedure room staff, and even then, I often even call them "Mr [redacted]" or "Ms [redacted]" or "Ms. [redacted]" or "Ms. [redacted]."
9) 11/3/2020-11/6/2020 – An inpatient consultation request was received by our service. I spoke to the requesting care team; with their agreement, the consult request was discontinued with the instruction to contact me back (I gave them my contact information) if my services were needed (I can give additional details, if desired).
   a. At exactly 4:28pm on 11/3/2020, 2 minutes prior to my end of tour, [redacted] contacted me and seemingly kept trying to force me to see the patient STAT. He said he would call the attending himself to discuss the case, he did that, and then he contacted me back saying that seeing the patient tomorrow would be fine. He sounded irritated throughout the phone call.
   b. I saw the patient and left a note on 11/4/2020.
   c. [redacted] contacted me on TEAMS and stated that the housestaff needed more help and he made mention of a PCA. I did not recall recommending a PCA in my note, and I spent 30 minutes trying to figure out where this request came from. I found out that this section of the hospital did not have PCAs…it turns out this recommendation came from [redacted] himself…
   d. [redacted] claimed I had recommended to cut the patients opioids in half; he ultimately found out this was false after he further reviewed the information in CPRS, but not before interrupting my care of other patients to inquire of me. I am not sure how he had come to his initial conclusion, based on the information in the chart.
   e. [redacted] went on at a later date to claim I left 2 notes on the chart, when I had left 4 notes.

f. He seemed to not understand that I recommended an Infectious Disease consult. The recommendation was appropriate, and management of the patient was optimized on the basis of the ID consultant's recommendation(s). [redacted] did not seem to understand that.

g. My experience with the behavior of [redacted] in the management of this patient was that **he was overbearing, he wanted to manage things through me, and he constantly seemed to misinterpret the facts**; this includes his misunderstanding of whether or not medications were changed. All in all, **I felt that as he could not find anything wrong with my management, he simply imagined wrong-doing so as to justify my needing his "close supervision."** This was not conducive to the delivery of good care. **These themes are ones which have characterized his interactions with me, both administratively and clinically,** while I have been under his administration in his role as Director of Whole Health and administrator over the Pain Management section.

10) 12/03/2020 – [redacted] asked for opinions about mandating training for the x-waiver on physicians during a POC meeting; I indicated that it is grossly inappropriate and unethical. [redacted] claimed they were not mandating the X-waiver be obtained, only completing the course. To be clear, however, [redacted] was very much simultaneously altering the Performance Pay of the Pain Management physicians (*not* offering special incentive pay as per the VHA Notice on Buprenorphine prescribing for OUD) to indicate that we are to obtain the X-waiver and treat "Complex Persistent Opioid Dependence" with the appropriate medications (he very clearly has indicated Buprenorphine/Suboxone in numerous discussions).

a. I found this to be unethical and this made me very uneasy being under him; the misinterpretation of the VHA directive/memo on removing barriers for buprenorphine prescribing into the frank coercion of the pain doctors at CTVHCS being made to perform such management or lose bonus monies seems wrong to me.

11) 12/08/2020 – [redacted] approves and then rescinds approval for procedure trays and indicates to me that he realizes that I am used to how things are "done in the private sector or private practice"

a. I learned later on that [redacted] has accused me of going over his head to [redacted], the Deputy CoS, to inquire as to obtaining these trays. **This is wholly inaccurate.**

i. I had asked [redacted] in my email exchange with him if I could communicate directly with the parties that requested of him to "limit items in the inventory". [redacted] responded by stating that "is not how this works."

ii. To my knowledge and recollection, I have never interacted with [redacted] on this topic, or any other. I do not believe I had ever met [redacted], neither in person, nor by telephone, nor by email, nor by TEAMS, nor by any other method.

12) 12/10/2020 - My child's daycare was to be closed from December 28-30th, 2020. Knowing this, I had already talked with my family about my mother coming for December and looking after our children as required during this timeframe. My mother informed me on 12/10/2020, that she had just seen her orthopedic physician and that she would be getting surgery on 12/11/2020, which she did. When I found out on 12/10/2020 that she was getting surgery, I requested those dates off; [redacted] declined to let me have those days off as my supervisor, the Director of Pain Management, was already to be off on those days already. Notably, I did not even have patients on 2 of the 3 days that my children needed to be watched, and inpatient consultations had thus far, occurred at a frequency of once every ~6 months. Nonetheless, [redacted] displayed no interest in trying to accommodate me and was punitive and harsh in his email response to me, stating "any further discussion with this would be considered a failure to follow orders"

a. I can perhaps understand the stance of not allowing me the leave.

b. I cannot understand indicating that even discussing the matter would be a failure to follow orders. [redacted] did not defer the matter to my first-line supervisor to my knowledge; he simply ordered there should be no more discussion on the matter.

c. The fact that [redacted] could offer no other solution where compromise could be reached shows me plainly that he expressly did not want to accommodate my family need; my wife and I had checked with childcare providers even with a couple of weeks in advance; we could find no one.

d. If it looks objective, but affects some parties more than others, then the impact is not objective, and in this case and others, [redacted] manner of code enforcement somehow manages to have the greatest impact on me.

13) 12/10/2020 – The date that needles that I had requested while under the Department of Surgery (prior to 10/11/2020) --- and then re-requested under Whole Health on 11/20/2020 (as Surgery did not reorder them, due to the realignment) --- were actually ordered for me by Whole Health.

14) 12/18/2020 – 2nd Meeting 1-on-1 with [redacted] (he refused the presence of my first-line supervisor, [redacted] for this meeting even with [redacted] literally outside of my office door):

a. [redacted] had initially requested a meeting of me at noon on 12/16/2020. Abruptly, he sent me a text at 11:55 am that same day, indicating that "I'm sorry – I need to reschedule. Will send a new invite."

b. On 12/18/2020, he messaged me on Microsoft Teams, indicating that he wanted me to come see him in his office after my last patient. I messaged him back clearly stating that he had given us a lot of work (the clerical work that assistants would seemingly do) and that I had patients and I do work on CPRS for patient care as well. He responded by saying he would come to me sometime in the afternoon. Towards the end of the day, **somewhat before 4:00pm CST** (my tour of duty ends at 4:30pm), I messaged [redacted] to let him know that I was free.

c. [redacted] then gave me a copy of a Letter of Counselling; this was on 12/18/2020, although the letter had been dated 12/17/2020 by [redacted] or whoever drafted it at his direction, per the date on the letter. The letter of counselling is based in critical omissions to the point of its content being deceptive, and by its content, it served also to deliver a threat to me / my continued employment with CTVHCS.

d. Upon receipt, I tried calling my attorney, and I also immediately texted him for a callback. My attorney called back very shortly thereafter, and I put the phone on speaker. I stated that [redacted] wanted me to sign a letter of counselling. [redacted] asked who it was; my attorney confirmed he was my attorney, and then he asked [redacted] to clarify that the letter was only an acknowledgement of receipt and not an agreement as to the factuality of the claims in the letter. [redacted] did not answer that directly, replying after that, merely that my agreement or not was irrelevant and that I was to sign an acknowledgement. While looking at the letter, I remarked out loud, with [redacted] listening in the room right next to me, to my attorney, that in the letter, I was being asked to do something (take a course) not simply acknowledge the letter. I was advised that it is ok to go ahead and sign. The coursework [redacted] required me to enroll in is "TEACH and motivational interviewing classes" insinuating that I need help with this (I do not think anyone would agree).

e. I responded by saying I disagree with this, and that there were no patient complaints against me that I was aware of; [redacted] claimed otherwise. I asked which. He could only cite one PATS-R complaint; I recounted the fact that I was not even involved in the direct care of that patient; the complaint was because I had denied the patient's referral to community care as the referring provider had not clearly stated the DST (re: the justifiable "reason") for the referral; in my discontinuation of the consult request, I specifically wrote back to the referring provider that if the referral was for specifically for "continuity of care" to resubmit the consult and state it clearly, as different providers in their requests use different words, continuity, continuation, community, at times meaning the same thing and other times meaning different things from each other; the actual meaning of each requestor has not strictly correlated to their intent, and how the words are being used can play a role in appropriateness of forwarding to the Care in the Community (CITC) section. Regardless, I was never otherwise involved in the care of that patient and the primary care provider failed to resubmit the consult request with the DST clearly stated… [redacted] had no other complaints he could bring to me about me.

i. Incidentally, [redacted] would go on to limit our clinical-decision making in consult processing so as to block as many consult requests/renewals to CITC / the community as possible. Ironically, at this point in time, the only complaint against me he could cite was the one above, in which I did not send a consult request on to CITC…

ii. As additional review of [redacted] actions towards me will reveal, [redacted]s conduct had thus become characterized by **solicitation of complaints** from veterans, with [redacted] using his position of administration over the Pain Management section as a justification to insert himself into clinical care, perform unrequested clinical consults and generate both complaints against me as well as billable encounters for himself.

f. I let him know that I did not appreciate being put in positions where he asks everybody for their opinions, only so he can accuse and blame me afterwards when I comply by giving my opinion.

g. **At 5:50 pm on the same date**, Friday, 12/18/2020, [redacted] sent an email to all of the clinicians (pain management physicians and chiropractors) that have been placed under Whole Health to enroll in TEACH and motivational interviewing classes. He has never mentioned any of this to us clinicians before. I have to conclude that [redacted] is now asking all of the clinicians under him to do this so as to deflect and make it seem as if this was not a punitive measure just to me, given that I specifically mentioned this to my attorney on the phone while [redacted] was present. The content of the Letter of Counselling is very informative in regards to [redacted] intent; his email at 5:50 pm is similarly very informative as to his intent. I believe he sent this email and generalized the requirement to the other providers so as **to unlink this from his specification in the Letter of Counselling**, as now it can no longer be said it was directed at me alone. **The timeline speaks volumes**. It is obvious to even the most casual of observers, that [redacted] had only sent the email when he did, because I made mention of this requirement directed at me in the Letter of Counselling to my attorney in front of him, that very same day just a few hours prior.

15) 12/21/2020 – [redacted] sends out an email to a group of recipients describing what he refers to as de-prescribing of some patients, citing "without any documented aberrant behavior"

h. The phrase "there are no aberrant behaviors" would later become a phrase that [redacted] blames me for including in my own charts --- in spite of the fact that he himself seemed comfortable using it.

i. Although [redacted] is not the clinical chief over the Pain Management section, he has made comments and given instructions as to what we can and cannot include in our charting.

16) 12/21/2020 – I receive a notification from my childcare provider that I must pick up my children by 3:00 pm due to a water issue at the facility (re: state and/or county laws/regulations regarding the same)

j. At 2:04 pm, I messaged [redacted] on TEAMS to inform him of this.

k. At 2:05 pm, he replied back "Have you exhausted all other options for childcare?"

l. At 2:06 pm, I replied back "That's all I have. I have no other option right now. I am waiting to hear back from you.

m. He did not respond.

n. I continued: "I need to go right now. I am leaving right now [redacted]. If you need me, please email me. I will call [redacted] to reschedule the remaining two patients"

o. [redacted] simply decides not to respond. He does not approve or disapprove. He does not refer me to my first-line supervisor, [redacted]. He simply elects not to respond.

p. At 6:01 pm on the same date, he sends out an email indicating:

i. "You must receive authorization for leave, in all circumstances, from your immediate supervisor before requesting that the AMSAs cancel appointments. AMSAs cannot cancel appointments until they receive authorization by the appropriate supervisor…

ii. "[redacted] is the supervisor for [redacted]…"

iii. "Please be aware that leaving your duty stating without receiving authorization is considered absence without leave and can result in administrative action…"

iv. "For annual leave … Under exceptional circumstances, annual leave can be granted with less than 45 days' notice, based on service needs, but only with Chief of Staff concurrence."

17) 1/11/2021 – [redacted], our CoS, hears from us during our **first meeting** with him and the Union on this date, that [redacted] has created an unbearable work environment and that our work conditions have been affected negatively. To my best understanding, nothing was done by the CoS office in regards to this complaint being raised during this meeting.

18) 1/20/2021 – I filed a JPSR in regards to a veteran's care where [redacted] decision-making caused a veteran's care to be unduly restricted in a way that increased risk to the veteran, while simultaneously escalating what started out as a veteran request into 2 complaints against me; this is against a backdrop of [redacted] having altered our Performance Pay to indicate that any 3 complaints (validated or not) would cause us to lose some portion of compensation/performance pay.

19) 2/8/2021 – [redacted], our CoS, hears from us during our **second meeting** with him and the Union on this date, that [redacted] has created an unbearable work environment and that our work conditions have been affected

negatively. To my best understanding, nothing was done by the CoS office in regards to this complaint being raised during this meeting.

20) 3/15/2021 – [redacted], our CoS, hears from us during our **third meeting** with him and the Union on this date, that [redacted] has created an unbearable work environment and that our work conditions have been affected negatively. To my best understanding, nothing was done by the CoS office in regards to this complaint being raised during this meeting.

21) 3/15/2021, later on – It is not until [redacted], in writing, to the union, [redacted], **writes down the request for an investigation into the hostile work environment** does any movement occur on the environment being looked into.

22) 3/25/2021 – [redacted] called me in the morning (actually, this delayed my leaving my house by a few minutes), indicating that he was calling off sick. It was rainy during my drive, and I had arrived at the parking lot at work at 8:03 AM. The parking lot is relatively small and around 0800 cars are coming and going. I reached my clinic at 8:08 AM, spoke to the clinic assistant and then two nurses. By the time I got to my computer and was able to TEAMS message [redacted] (the assistant indicated he was trying to reach me... as [redacted] had put [redacted] first scheduled procedure patient in my 0800 slot. My work phone was locked as I could not get in with what I thought was my password), it was 8:10 AM. [redacted] spoke to me on TEAMS and indicated that the first patient was coming from further out and he wanted me to do the veterans procedure. I told him that I would do the planned procedure if my evaluation indicated it was warranted. **His response was that the veteran was expecting it**; expecting a procedure is not an indication to do one, and I felt that he was pushing me to take on that mentality and approach to the patient without even having seen him yet. He also indicated to me that it is past 08:07, then I must request the time off in a 15 minute increment and made some comment about me needing to have a strategy for running my clinic, etc... he did not ask me at all as to why I was there after 08:07 AM… I requested that he discuss the matter with [redacted]. He replied that since [redacted] was out today, that **he was my supervisor today**.

a. I evaluated the veteran and evaluation-wise, doing the previously planned procedure was appropriate in my opinion based on my interview and examination, but **I do feel [redacted] pushed me to do it under his personal viewpoint that "veteran expects it" outweighs my own clinical opinion**.

b. My experience has been that [redacted] has taken any opportunity to interact directly with me as opposed to go through [redacted], my first-line supervisor, **in spite of the fact that our CoS, [redacted], had stated bluntly that [redacted] should not be reaching over [redacted] to get to me.**

23) On four separate occasions, [redacted] sought to use his position of power over me to exert his physical presence upon me:

a. The first 1-on-1 meeting with me on 10/23/2020; he refused my first-line supervisor's presence.

b. The second 1-on-1 meeting with me on 12/18/2020; he refused my first-line supervisor's presence, although this supervisor ([redacted]) was right outside of my door.

c. He knocked on my door on 2/26/2021 and when he saw me, he stated something like "Oh. This isn't [redacted] office." I do not recall the exact words, but it was said in such a way as to sound like a question, while being a statement.

i. By this point, [redacted] had been to our clinic location several times. I do not believe that he did not know my office was not that of [redacted].

ii. This was on the same date that [redacted] instructed [redacted] to counsel me for how I processed consult requests under [redacted]s new rules. In retrospect, it appears clear to me that [redacted] **wanted additional counselling on my record.**

1. As it would become later apparent, [redacted] had wanted us to abandon our consultation template without actually asking us to abandon the template; this is evidenced by his non-response to this very question that I posed in an email, copied to our CoS, [redacted], on 3/01/2021.

2. The directive to abandon our typical consult processing came from [redacted], afterwards, at [redacted] direction per my understanding, but not before [redacted] had me "counselled" on record **yet again**.

d. On March 30 (it may have been March 31), [redacted] came to our clinic space and knocked on my door; when I came out of my office, he was walking away. I asked what I could do for him, and he stated he was "checking out the space." He was accompanied by one of our AMSAs, who witnessed this.

i. This was on the same date that [redacted] of Patient Safety questioned me about my most recent JPSR report (I have filed several by now) via TEAMS in spite of her agreement to email me, as the JPSRs I have submitted contained the legitimate reporting of patient safety concerns in relation to the conduct of [redacted] and upstream contributors to the same --- again, as it pertains to the care of our veterans. [redacted] included [redacted] on subsequent email correspondence regarding the same JPSR reporting; in short, while the JPSR system is intended to provide an avenue to report safety concerns without fear of reprisal, [redacted] approach to the matter on TEAMS and her decision to copy [redacted] on email correspondence concerning the very same JPSR(s) that pertain to his conduct, served to expose me to further hostility while simultaneously dis-incentivizing me to submit any further JPSRs.

ii. If it is true that [redacted] was "checking out the space", I cannot explain why he felt the need to knock on my door with no agenda or question for me. He had seen my office before, on more than one occasion.

e. In short, [redacted] has sought to intimidate me on multiple occasions with his physical presence. Between this and the fact that he has had his administrative subordinates ask for our home addresses (which is not required to give, per my exchange with HR), I have come to feel extraordinarily uneasy with having any interaction with him.

24) I have lost count of the number of times that [redacted] has threatened counselling, reprimand, and administrative action for any reason he could find. He has buffered himself by commanding [redacted] to be the one to deliver his messages. [redacted] has created an environment where the pain management physicians are constantly scared of making a "mistake" against the backdrop of his vague and constantly changing instructions.

a. What I see is that when attempts to abide by his instructions are made with reasonable fidelity, if there is any disagreement or fallout with other physicians, [redacted] has simply blamed us for not understanding his instructions. Simultaneously, he has repeatedly refrained from putting things in writing, commanding [redacted] to do that for him, and then blaming him when the fallout occurs.

b. It has gotten to the point that we are afraid of discontinuing any consultation request, even when they fail to meet whatever [redacted] criteria-of-the-moment are for fear of punishment.

25) [redacted] has repeatedly sought to cause the pain management physicians to appear as if in need of education, and as being unaware of various topics.

a. He has conducted himself in this fashion with the endpoint of discrediting me and us to the CoS.

b. He has conducted himself in this fashion to damage relationships between us and our colleagues in other departments/specialties.

c. He has conducted himself in this fashion to justify that his being given an administrative function over the Pain Management section is enough to validate his clinical insertion and interference with my and our direct clinical care of patients.

d. It appears that [redacted] **repeated acts of degradation and undue blame against me and us serve, in his eyes, as validation of his own claim to expertise in the field of pain management.**

i. I believe that he misrepresents us to cause us to look worse in our profession and to our colleagues, with several goals:

1. Of making himself appear superior. I believe that he does this in part due to his not having met the hiring criteria/qualifications that were applied to pain management physician staffing at CTVHCS in 2019/2020. Consequently, he engages in speech and behavior to damage our profession and careers here at CTVHCS so as to lift himself up.
2. Of providing a scapegoat for unpopular and/or unethical and/or potentially illegal actions that he has undertaken here at CTVHCS.
3. Of justifying his behavior of self-consultation, which further justifies his keeping his clinical grid closed for appointment booking and additionally justifies his performing

unrequested consults to generate production for himself and to generate opportunities to solicit complaints against me and us.

Please accept this document and which illustrates much, but not all, of [redacted] conduct towards me in his creation of a work environment that I believe a reasonable person would conclude is contrary to the fulfillment of work duties. The conduct and actions which have been undertaken against the Pain Management section is serious and pervades our work environment. Per my best understanding, I do feel that I have been targeted with the highest degree of scrutiny by [redacted]

In his position as Director of Whole Health, [redacted] has advanced his personal agenda of his assessment of how addictionology should be practiced and used all available resources to attempt to force this field of practice upon us. To be clear, this is not even a part of our practice; we practice interventional pain management, and that was the reason I was recruited to CTVHCS. Nonetheless, prescribing Suboxone for [redacted] reasons, and [redacted] push for Whole Health has overtaken our reasons for hire, causing significant hindrances to my performance of my job, my actual hired-for duties.

[redacted] has offered us federal monies to provide opioids to veterans for the non-covered service of treating the non-validated entity "Complex Persistent Opioid Dependence," a proposed entity that is cited in **only 2 citations** out of over **32 million citations** for biomedical literature catalogued within Pubmed. My resistance to his coercion of this, along with the OSC and OIG complaints I have submitted in general as well as the JPSR complaints I have submitted concerning actions which have caused close calls / ongoing elevated risks for veterans has caused me to draw the bulk of his ire.

However, as [redacted] is my first-line supervisor, [redacted] **has specifically reached over** [redacted] **to prepare me for termination by way of false accusations and critical omissions so as to "tee up" my termination with unsupported, fraudulent letters of counselling and other "education", so as to satisfy the documentation of stepwise discipline**; in this way, as [redacted] is aware that I am a probationary employee, he can have me terminated or simply have my employment not renewed when the time comes. When [redacted] frustration at not being able to coerce [redacted] more successfully into disciplining me on different occasions has grown to a boiling point, [redacted] has settled, on occasions, for punishing [redacted] for his decision to not take a punitive attitude to me.

By altering our Performance Pay and coercing us to treat OUD or whatever version of it [redacted] believes in, [redacted] **has dramatically changed our conditions of employment; he has changed my conditions of employment even further with an astounding level of scrutiny. He has made false accusations against me to justify the scrutiny**. [redacted] has generalized his punitive behavior to the Pain Management section physicians as a whole, although I do perceive it is to a lesser degree than to which he has focused on me. As [redacted] has generalized his punitive behavior to all three of the pain management physicians employed by CTVHCS, he may claim that his actions are for legitimate purposes. I believe, however, that such generalization may serve as pretext for the hostility and harassment that is being experienced.

For a few months in a row, in spite of [redacted] knowing that the Pain Management Team and the Pain Oversight Committee met at certain designated times, he had it arranged such that I could not attend the meetings, functionally removing me from these teams/committees during that timeframe. Perhaps to him it did not matter, as his letter of counselling to me, cited earlier, served also as a gag order against me speaking my opinion, thus forcing my silence at any subsequent meeting I have been present for. He has expended great efforts soliciting complaints against me primarily, and to a lesser degree, my colleagues; this may give the appearance of indiscriminate behavior. He has altered our performance pay to cause us to receive smaller bonuses. [redacted] has attempted to force my first-line supervisor to initiate an FPPE on me; [redacted] indicated his intention to have it done. The Chief of Staff has been aware of the environment [redacted] has set upon me and my colleagues for months; best I can tell, he did not intervene to improve our work conditions.

[redacted] has insulted our work and knowledge to his superiors and to our colleagues, allowing us also to be blamed for his decision-making, with the real possibility of straining relations between the providers of CTVHCS.

A reasonable person would not believe that daily, or near daily, emails from [redacted], and his phone calls to my first-line supervisor about me, wherein [redacted] tries to find **something, anything at all,** negative to criticize me about, and failing that, simply fabricating complaints to criticize me over, constitute any sort of normal behavior. [redacted] **conduct, actions, and speech to me and about me have been severe, extremely frequent, and threatening.**

Currently, I have a dental abscess, and I am on antibiotics for it; I underwent a dental surgery/procedure today for the same. I have been experiencing physical pain over these past few days. Due to [redacted] handling of me, thus far, however, I had been very afraid of calling off sick from work to get it addressed; I recall my initial 1-on-1 meeting with [redacted] during which he brought up leave and timecards going through a chain of command, and my perception, then and now, of that discussion is that it was meant as a showcase of his leverage on me. This behavior is not normal. Simply surviving [redacted] has affected my work life and my family life. [redacted] focus on me and his concrete actions amount to a brand of harassment and hostility that I have never been subject to in my life.

I look forward to speaking to you during our interview. Please be aware that my administrative time was taken away from me when we were moved under Whole Health, and I will likely have patients scheduled, so it is possible that we may have to reschedule our interview date/time.

[redacted]

From: [redacted]
Sent: Thursday, May 13, 2021 11:00 AM
To: [redacted]
Cc: [redacted]
Subject: RE: Threats and harassment

[redacted] has now received the fact finding. In accordance with HR guidance, the fact finding can only be released via FOI. You may contact [redacted] to request a copy.

[redacted]
Director, Central Texas Veterans Health Care System
[redacted]

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Journal of the American Medical Association
Dartmouth
https://link.springer.com/article/10.1007/s11606-018-4433-7
https://www.newsweek.com/americas-best-addicition-treatment-centers-2020/texas

From: [redacted]
Sent: Thursday, May 13, 2021 10:57 AM
To: [redacted]
Cc: [redacted]
Subject: RE: Threats and harassment

Hello to all,

Would anyone have an update?

[redacted]

From: [redacted]
Sent: Friday, May 7, 2021 12:58 PM
To: [redacted]
Cc: [redacted]
Subject: RE: Threats and harassment

Hello [redacted]

I also would like this report.

I've never experienced anything like this.

[redacted]

From: [redacted]
Sent: Friday, May 7, 2021 10:42 AM
To: [redacted]
Cc: [redacted]
Subject: RE: Threats and harassment

[redacted],

I am requesting that the **full report of** [redacted] **be released as is, with no redactions, no additions, and as soon as it is completed**, to the three providers in the Pain Management Section.

Please let me know if this is not possible, so we may request it under the Freedom of Information Act.

Respectfully,
[redacted]

From: [redacted]
Sent: Thursday, May 6, 2021 1:32 PM
To: [redacted]
Cc: [redacted]
Subject: RE: Threats and harassment

[redacted]

The Fact Finding has been largely completed, from my understanding; it is pending being rendered in near term. When completed, the report will be provided to [redacted]

Thanks.

[redacted]
Director, Central Texas Veterans Health Care System
[redacted]

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https://www.onlinejacc.org/content/76/9/1112
Journal of the American Medical Association
Dartmouth

[redacted]

From: [redacted]
Sent: Thursday, May 6, 2021 1:05 PM
To: [redacted]
Cc: [redacted]
Subject: RE: Threats and harassment
Importance: High

[redacted]

As we, the providers of the Pain Management Section, have not received any response from [redacted] to this very important and very critical matter, I am escalating our appeal to end this Hostile Work Environment and to remedy this situation, up the chain of command, to your attention as the Director of this Medical Center.

Please respond to remedy this awful situation ASAP.

Respectfully,
[redacted]

From: [redacted]
Sent: Tuesday, May 4, 2021 11:29 AM
To: [redacted]
Cc: [redacted]
Subject: RE: Threats and harassment
Importance: High

[redacted],

I am adding to [redacted] comment that this Hostile Work Environment is not imaginary, it is a matter of fact in our everyday life under [redacted] This is taking a toll on our lives and function. When I sleep, I am thinking of [redacted], I have nightmares about him, and I wake up expectant of more hostility and more harassment. Certainly, our lives under [redacted] are miserable. I shall no longer be ashamed to hide the fact that because of this Hostile Work Environment under [redacted], I am now [redacted].

Let it be clear, providers at the Pain Management Section are not opposing change, we are specifically against the hostility, intimidation, harassments, and setup for failure that we are exposed to under the leadership of [redacted]. We are no longer able to trust him. The behavior and actions of [redacted] are well documented, they are not hidden and they are not imagined.

[redacted], you were clearly informed of [redacted] harassment and intimidation to us on several occasions. Providers of the Pain Management Section held three meetings with you, specifically to discuss these problems. The first meeting was on January 29, 2021, the second on February 8, 2021, and the third was on 03/15/2021. After the third meeting, the pain management providers realized that these meetings were to no avail, Therefore an investigation into a Hostile Work Environment was requested.

The Pain Management providers gave [redacted] a massive file full of evidence of abuse, harassment, lies, intimidations, confusing orders, and setup for failure. I do not believe that there is any question about the occurrence of a hostile work environment against the pain management providers. I do not believe that anyone can hide or twist the facts that were presented to [redacted] in this file of massive evidence.

This Hostile Work Environment is taking a toll on our lives and function. It is certainly affecting the care that we render to our Veterans. It should not be allowed to persist. This is not what the VA ICARE is about. [redacted], you have the power to end it. [redacted], **end this Hostile Work Environment NOW.**

Respectfully,
[redacted]

From: [redacted]
Sent: Tuesday, May 4, 2021 10:18 AM
To: [redacted]
Cc: [redacted]
Subject: RE: Threats and harassment

Hello [redacted]

My thinking is that the physicians of the Pain Management section have had relevant concerns regarding the treatment experienced under [redacted] / Whole Health communicated to the investigator fairly thoroughly by this point.

I consider that perhaps the investigator would, by now, have sufficient information to make his determination on the topic of a hostile work environment as it pertains to us.

I am hoping that if the facility has topics of other/administrative concern, that any queries revolving around other such matters are not cause for any delay in the matter of our work environment.

Is there a timeline for the investigator's report?

This has really been a horrible experience.

Thank you sir,

[redacted]

From: [redacted]
Sent: Monday, May 3, 2021 6:46 PM
To: [redacted]
Cc: [redacted]
Subject: RE: Threats and harassment

Yes [redacted] is investigating these reports. The effort remains ongong.

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

From: [redacted]
Sent: Monday, May 3, 2021 12:04 PM
To: [redacted]
Cc: [redacted]
Subject: RE: Threats and harassment

[redacted]:

[redacted] is coordinating that effort with [redacted] and others. I have added [redacted] to this response.

Thanks.

[redacted]
Director, Central Texas Veterans Health Care System
[redacted]

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Journal of the American Medical Association
Dartmouth
https://link.springer.com/article/10.1007/s11606-018-4433-7
https://www.newsweek.com/americas-best-addicition-treatment-centers-2020/texas

From: [redacted]
Sent: Monday, May 3, 2021 11:03 AM
To: [redacted]
Cc: [redacted]
Subject: RE: Threats and harassment
Importance: High

[redacted]

On March 15, 2021, I have requested an investigation into a Hostile Work Environment that the Pain Management Section providers are being subjected to under the leadership of [redacted] My request was based on strong evidence and reports from my employees, [redacted] based on my own experience with [redacted]

The pain management providers at the Pain Management Section are seeking from you the answers to the following questions:

1. Has an investigation into the Hostile Work Environment been requested?
2. Was [redacted] the investigator for the requested Hostile Work Environment?
    a. If yes, did he find a Hostile Work Environment or not?
    b. If no, What was he investigating? i.e., What exactly was his investigation about?

Kindly respond to these questions ASAP

Wit much appreciation,
[redacted]

From: [redacted]
Sent: Monday, May 3, 2021 10:11 AM
To: [redacted]
Subject: RE: Threats and harassment

Hello [redacted]

Please let me know in regards to my questions.

Thank you!

[redacted]

From: [redacted]
Sent: Thursday, April 29, 2021 10:07 AM
To: [redacted]
Subject: RE: Threats and harassment

Hello [redacted]

(1) May I ask, who is that assigns the fact-finder?

(2) Also, to be clear, was the fact-finder assigned for purpose of the hostile work environment investigation that [redacted] had requested?

Thank you,

[redacted]

From: [redacted]
Sent: Thursday, March 25, 2021 8:28 AM
To: [redacted]
Subject: RE: Threats and harassment

[redacted] is out on sick leave today.

I arrived today at 08:08 AM on account of the rain/weather (earlier than that if you count having to wait for traffic in the CTVHCS parking lot itself...).

[redacted] took the opportunity to scold me about not arriving prior to 08:07 AM; I asked him to go through [redacted].

[redacted] reminded me that in [redacted] absence, he is my direct supervisor.

This was not the appropriate time, when patients are needing to be attended to, to use [redacted] absence as an excuse to exercise his right to interact like this.

He never even bothered to ask me why I was not here prior to 08:07 AM.

There is something wrong with all of this... this is not normal behavior, it seems to me...

[redacted]

From: [redacted]
Sent: Thursday, March 25, 2021 7:48 AM
To: [redacted]
Subject: RE: Threats and harassment

We are in the process of bringing in a fact finder from outside of this facility to look into the issues. We hope to have someone identified very soon. We want to ensure we identify a neutral party to address these allegations. Thank you.

v/r

[redacted]
EEO & ADR Program Manager
Harassment Prevention Coordinator
Central Texas Veterans Health Care System
[redacted]

Self-identification of a disability:
https://secure.vssc.med.va.gov/sf256/

Self-identification of Race and Ethnicity:
https://secure.vssc.med.va.gov/sf181/

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From: [redacted]
Sent: Wednesday, March 24, 2021 9:58 AM
To: [redacted]
Subject: RE: Threats and harassment

Please give us an update.

This environment is affecting everything, including care.

Thank you,

[redacted]

From: [redacted]
Sent: Friday, March 19, 2021 9:45 AM
To: [redacted]
Subject: RE: Threats and harassment

The goal is to get this started next week.

v/r
[redacted]
EEO & ADR Program Manager
Harassment Prevention Coordinator
Central Texas Veterans Health Care System
[redacted]

Self-identification of a disability:
https://secure.vssc.med.va.gov/sf256/

Self-identification of Race and Ethnicity:
https://secure.vssc.med.va.gov/sf181/

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From: [redacted]
Sent: Friday, March 19, 2021 9:44 AM
To: [redacted]
Subject: RE: Threats and harassment

Is there any timeline for the assignment of a fact-finder to be made?

From: [redacted]
Sent: Friday, March 19, 2021 9:40 AM
To: [redacted]
Subject: RE: Threats and harassment

Good Morning Everyone,

A fact-finder is being assigned to look into the alleged issues within this service. More to follow. Thank you.

v/r
[redacted]

EEO & ADR Program Manager
Harassment Prevention Coordinator
Central Texas Veterans Health Care System
[redacted]

Self-identification of a disability:
https://secure.vssc.med.va.gov/sf256/

Self-identification of Race and Ethnicity:
https://secure.vssc.med.va.gov/sf181/

Looking for EEO and Diversity & Inclusion Training? Take part in the EEO Institute 2021 EEO Training

From: [redacted]
Sent: Friday, March 19, 2021 9:34 AM
To: [redacted]
Subject: RE: Threats and harassment

At some point, does the Director not step in and put a stop to this?

Is there any update?

I am tired of coming to work with bated breath wondering what harassment or threat will come next from [redacted]

It is not right for CTVHCS to recruit me only to let me be subject to this kind of treatment.

[redacted]

From: [redacted]
Sent: Friday, March 19, 2021 9:09 AM
To: [redacted]
Cc: [redacted]
Subject: RE: Threats and harassment

As I remember, in these meetings, [redacted] promised to put things on hold for now. However, all I see is a blatant escalation of the threats and harassment by [redacted] I wonder if [redacted] is really serious in these meetings or just buying time.
[redacted]

From: [redacted]
Sent: Thursday, March 18, 2021 11:42 AM
To: [redacted]
Subject: RE: Threats and harassment

Of note, this hostile environment is one that I had brought up directly in all 3 of the meetings that we had with [redacted] and the Union.

[redacted]

From: [redacted]
Sent: Tuesday, March 16, 2021 12:40 PM
To: [redacted]
Subject: RE: Threats and harassment

I feel the same way.

This has been horrible and unrelenting.

[redacted]

From: [redacted]
Sent: Monday, March 15, 2021 7:05 PM
To: [redacted]
Cc: [redacted]
Subject: RE: Threats and harassment
Importance: High

I am requesting an official investigation into a **Hostile Work Environment** that members of the Pain Management Section are subjected to under the leadership of [redacted]

Members of the pain management section are experiencing emotional distress, sleep disturbance, and eating disorder, etc. secondary to the continuous harassment and emotional abuse by [redacted] Please help ASAP.

[redacted]
Chief, Pain Management Section

From: [redacted]
Sent: Monday, March 15, 2021 12:20 PM
To: [redacted]
Subject: Threats and harassment

The Three Pain management Doctors have made complaints of threat and harassment from their chief [redacted], We have made [redacted] aware of his behavior and many occasions nothing has change. Labor is asking that someone investigate these allegations.

[redacted]

From: [redacted]
Sent: Tuesday, May 11, 2021 10:12 AM
To: [redacted]
Subject: RE: Requests/Update

I have submitted a preliminary report to the VISN. I will be checking back with them when I get back from vacation on Monday.

From: [redacted]
Sent: Monday, May 10, 2021 9:58 AM
To: [redacted]
Subject: RE: Requests/Update

Hello sir,

[redacted]

Thank you,

[redacted]

From: [redacted]
Sent: Tuesday, May 4, 2021 11:31 AM
To: [redacted]
Subject: RE: Requests/Update

Thank you very much.

[redacted]

From: [redacted]
Sent: Tuesday, May 4, 2021 11:31 AM
To: [redacted]
Subject: RE: Requests/Update

I am hoping to have a report in to the VISN by the end of the week.

From: [redacted]
Sent: Tuesday, May 4, 2021 9:17 AM
To: [redacted]
Subject: Requests/Update

Hello sir,

I have continued to send you items as they have come up; I hope these things are useful to you.

Would you have any further update at this time?

Thank you,

[redacted]

[redacted]

From: [redacted]
Sent: Tuesday, July 21, 2020 3:25 PM
To: [redacted]
Cc: [redacted]
Subject: Buprenorphine SOP
Attachments: EXHIBIT A_Buprenorphine SOP 07062020 - CFU edit.docx; APPENDIX H _ Induction_ Buprenorphine.docx; APPENDIX A _ DSM V _ Excerpt _ Opioid Related Disorders.pdf; APPENDIX B _ OBOT _ Criteria _ Buprenorphine.docx; APPENDIX C _ DEA _ LETTER re BUPRENORPHINE.pdf; APPENDIX D _ Buprenorphine formulations for Chronic Pain Management in Patients with OUD March 2020.pdf; APPENDIX E _ Products _ Buprenorphine _ 07062020 - CFU edit.docx; APPENDIX F _ Information _ History and Pharmacology.docx; APPENDIX G _ Pain _ Buprenorphine law _ 07062020 - CFU edit.docx

Importance: High

Good afternoon [redacted]

Please help us render the attached Buprenorphine SOP and its Appendices A through H, compliant with the approved VHA SOP format. This SOP has been approved by the COS and the CEC today 07/21/2020.

Once completed, please send to me the final formatted form, so I may verify the integrity of content and send for publishing.

Thanks,
[redacted]

Reference 12

VHA Notices Mandatory Business Rules for Local Policy Development, 2019-2021.

Reference 13

VAOIG-21-03195-189 - Pharmacists' Practices Delayed Buprenorphine Refills for Patients with OUD, June 30, 2022.

VA National Standards of Practice

Providing Feedback on Draft National Standards of Practice

Prior to publication of national standards in VA policy, the general public and VA employees are invited to participate in the development process by providing feedback on draft standards. Public and employee participation is appreciated and will help VA ensure the quality of the standards. VA will give serious consideration to all comments received on each national standard.

Each draft national standard of practice will be posted for a period of 60 days to both the Federal Register and to a VA intranet page for employees to provide comments. The Federal Register is the official publication site for rules, proposed rules, and notices of Federal agencies and organizations, as well as executive orders and other presidential documents. VA employees may provide feedback through VA internal mechanisms.

This website page provides the posting date, closing date, and identifying information for each occupation's national standard.

National Standards of Practice Open for Feedback

Title of Standard	Date Posted	Comment Due Date	Federal Register Number	Regulations Document ID
Kinesiotherapist (https://www.regulations.gov/document/VA-2022-VACO-0001-0204)	7/29/2022	9/27/2022	2022-16326	VA-2022-VACO-0001-0204
Ophthalmology Technician (https://www.regulations.gov/document/VA-2022-VACO-0001-0201)	7/29/2022	9/27/2022	2022-16325	VA-2022-VACO-0001-0201

National Standards of Practice Closed for Feedback

Title of Standard	Date Posted	Date Closed	Federal Register Number	Regulations Document ID

Blind Rehabilitation Specialist	7/1/2022	8/30/2022	2022-14033	VA-2022-VACO-0001-0192
Certified Nurse Midwife	5/25/2016	7/25/2016	2016-29950	VA-2016-VHA-0011
Clinical Nurse Practitioner	5/25/2016	7/25/2016	2016-29950	VA-2016-VHA-0011
Clinical Nurse Specialist	5/25/2016	7/25/2016	2016-29950	VA-2016-VHA-0011

National Standards of Practice Still In Development

Acupuncturist

Art Therapist

Audiologist

Certified Registered Nurse Anesthetist

Certified/Registered Respiratory Therapist

Chiropractor

Clinical Pharmacist Practitioner

Cytotechnologist

Dance/Movement Therapist

Dental Assistant

Dental Hygienist

Dentist

Diagnostic Radiologic Technologist

Dietitian

Drama Therapist

Genetic Counselor

Histopathology Technologist

Licensed Practical/Vocational Nurse

Licensed Professional Mental Health Counselor

Marriage and Family Therapist

Massage Therapist

Medical Technologist

Music Therapist

Nuclear Medicine Technologist

Occupational Therapist

Occupational Therapy Assistant

Optometrist

Orthotist/Prosthetist

Peer Specialist

Perfusionist

Pharmacist

Pharmacy Technician

Physical Therapy Assistant

Physical Therapist

Physician

Physician Assistant

Podiatrist

Psychologist

Radiologist Assistant

Recreation Therapist

Registered Nurse

Rehabilitation Counselor

Social Worker

Speech Language Pathologist

Therapeutic Medical Physicist

Therapeutic Radiologic Technologist

and-your-va-benefits)

**VA will provide a summary of submitted feedback following the closing date of the Federal Register. The summary of feedback may take several months to compile.*

Updated 7/8/2022

return to top

Reference 15

VA/DoD CLINICAL PRACTICE GUIDELINE FOR THE MANAGEMENT OF SUBSTANCE USE DISORDERS, 2021.

Reference 16

VA/DoD CLINICAL PRACTICE GUIDELINE FOR THE MANAGEMENT OF SUBSTANCE USE DISORDERS, 2015.

Reference 17

VA/DoD CLINICAL PRACTICE GUIDELINE FOR OPIOID THERAPY FOR CHRONIC PAIN, 2017.

Reference 18

The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder: 2020 Focused Update. J Addict Med. 2020 Mar/Apr;14(2S Suppl 1):1-91.

CTVHCS FY 2021 STAFF PHYSICIAN PERFORMANCE PAY CRITERIA

Reference 19

Name: [redacted]

Service/Section: Whole Healh - Pain Section

FISCAL YEAR 2021	Met	Not Met	N/A	% of Perf. Pay Max	% Perf. Pay Earned	Comments	Performance Goals
GOAL 1: PRODUCTIVITY/EFFICIENCY/QUALITY				50.0%			
>85% clinic utilization aggregate at the end of the fiscal year based on the clinic utilization standardization summary (CUSS) report.				25.0%			[redacted]
Meets or exceeds median productivity target per SPARQ for the fiscal year. (Meets Target = full 25%, 90% of target = 10%, 80% of target = 7.5%)				25.0%			
GOAL 2: PATIENT EXPERIENCE and CLINICAL CARE	**Met**	**Not Met**	**N/A**	**50.0%**			
Obtain X-waiver and manage 5 patients with concurrent chronic pain and complex persistent opioid dependence using appropriate medications.				20%			
No greater than 3 documented complaints from staff or patients during the fiscal year				10%			
Institute patient satisfaction improvement program based on Whole Health principles and document positive results (20%; 10% each for program and results)				20%			
TOTAL PERFORMANCE PAY EVALUATION:				**100%**			

"I understand the target goals and am aware of the need to maintain my license to practice. Actions jeopardizing my license would prevent me from receiving pay for performance. In addition, my conduct and being subject to disciplinary action might affect my ability to receive pay for performance. I have reviewed these pay for performance goals, understand the criteria to meet the goals, and have had the opportunity to ask questions. My signature indicates my understanding of this."

Employee Signature (Communication of Goals):

12/30/2020

[redacted]

Signed by: people

Service Chief Signature (Communication of Goals):

12/28/2020

[redacted]

Service Chief Signature (Review of Achievements):

X _____

[redacted]

Clinical Director, Whole Health & Integrated .

Employee Signature (Communication of Achievements):

X _____

[redacted]

Reference 20

[redacted]

From: [redacted]
Sent: Wednesday, December 30, 2020 4:25 PM
To: [redacted]
Subject: RE: FY21 Performance Pay criteria
Attachments: P4P Whole Health Service FY2021 - [redacted] xlsx
Signed By: [redacted]

Ok. Here.

The signatures show if you click "Enable Editing" up at the top.

[redacted]

From: [redacted]
Sent: Wednesday, December 30, 2020 4:21 PM
To: [redacted]
Subject: RE: FY21 Performance Pay criteria

Hello [redacted]

I have tried a few different ways to do as you have asked, but each time I try to share this back to you, signed, Excel pops up a message saying that doing so will remove/invalidate the signatures. As such, I printed it out after electronically signing it and scanned it in as a PDF. I suspect this does not suit your purpose, however, but I am not sure what else to do...

I will keep trying to send this back to you as a signed Excel copy...

I have previously indicated my disagreement with this, and as such, I see no reason to re-hash that conversation...

[redacted]

From: [redacted]
Sent: Monday, December 28, 2020 4:53 PM
To: [redacted]
Subject: FY21 Performance Pay criteria

[redacted]

I have attached your Performance Pay Criteria for FY21. Please review, then sign electronically in box 15 and return to me by email.

Let me know if you have any questions about this. I plan to schedule a meeting of the Pain Management Section when everyone returns from leave.

[redacted]

From: [redacted]
To:
Subject: RE: FY21 Performance Pay criteria
Date: Wednesday, December 30, 2020 4:21:00 PM
Attachments: [redacted] Performance Pay [redacted] 2021.docx

Hello [redacted]

I have tried a few different ways to do as you have asked, but each time I try to share this back to you, signed, Excel pops up a message saying that doing so will remove/invalidate the signatures. As such, I printed it out after electronically signing it and scanned it in as a PDF. I suspect this does not suit your purpose, however, but I am not sure what else to do...

I will keep trying to send this back to you as a signed Excel copy...

I have previously indicated my disagreement with this, and as such, I see no reason to re-hash that conversation...

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Sent: Monday, December 28, 2020 4:53 PM
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[redacted]

I have attached your Performance Pay Criteria for FY21. Please review, then sign electronically in box 15 and return to me by email.

Let me know if you have any questions about this. I plan to schedule a meeting of the Pain Management Section when everyone returns from leave.

[redacted]

[redacted]
Clinical Director, Whole Health and Integrated Health Service
Central Texas VA Healthcare System

[redacted]

[redacted]

From: [redacted]
Sent: Tuesday, April 6, 2021 9:16 AM
To: [redacted]
Subject: #NNT=2

Follow Up Flag: Follow up
Flag Status: Flagged

Todays PMT meeting (no patients during today's meeting). 04/06/2021, was the first time [redacted] described NNT=2 for patients who have OUD and who had been on heroin. Prior to today, he constantly said it vaguely making no distinction OUD and Chronic pain, and not even mentioning heroin.

He still did not even mention that the Cochrane review that the above comes from, specifically excluded studies with patients with chronic pain and "iatrogenic OUD."

[redacted]

From: [redacted]
Sent: Tuesday, October 5, 2021 11:45 AM
To: [redacted]
Subject: RE: NNT=2

Hello [redacted]

I really try to avoid making blanket statements. To be clear, to my recollection, there may have been one other incident/email where I felt a reasonable person would conclude that [redacted] appropriately made the link between OUD and the NNT; however, on most occasions by far that I was witness to, I believe [redacted] approach was to use wording so as to confound the issue.

Over the past few months, [redacted] has removed me from meetings; I no longer know what claims [redacted] is making in open forum.

[redacted]

From: [redacted]
Sent: Tuesday, October 5, 2021 11:21 AM
To: [redacted]
Subject: FW: NNT=2

Hello [redacted]

As per the discussion during part 1 of our formal interview.

[redacted]

From: [redacted]
Sent: Tuesday, April 6, 2021 9:16 AM
To: [redacted]
Subject: NNT=2

Todays PMT meeting (no patients during today's meeting), 04/06/2021, was the first time [redacted] described NNT=2 for patients who have OUD and who had been on heroin. Prior to today, he constantly said it vaguely making no distinction OUD and Chronic pain, and not even mentioning heroin.

He still did not even mention that the Cochrane review that the above comes from, specifically excluded studies with patients with chronic pain and "iatrogenic OUD."

Reference 21

Mattick RP, Breen C, Kimber J, Davoli M. Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence. Cochrane Database of Systematic Reviews 2014, Issue 2. Art. No.: CD002207.

Reference 22

[redacted]

From: [redacted]
Sent: Monday, November 22, 2021 8:23 AM
To: [redacted]
Subject: OSC Investigation — OUD and Consults and Patient Care and Staffing under Whole Health

Hello [redacted]

Because of [redacted]

- this veteran was taken away from his care in the community.
- this veteran was taken off of Suboxone (prior diagnosis: Opioid Dependence).
- this veteran is made to beg for a response from [redacted]

Best I can tell, [redacted] has never physically examined this veteran --- not even once.

No one at this facility seems to be holding [redacted] to task.

He has disrupted the care of this veteran and many others.

This is dangerous.

This veteran already had a recent suicide attempt. His suicide attempt apparently was with Rum and Hydrocodone. Would his prior diagnosis and behavior cause an Addictionologist to recommend/prescribe Buprenorphine or Buprenorphine/Naloxone?

Recently,, we had an all day [redacted] Whole Health [redacted] did not address the MHV message sent in by the veteran. When the patients message him, he simply lets the messages escalate. It gives the outward appearance that [redacted] is too busy to provide the patient care to which he constantly claims commitment . The veteran's message was assigned to me by support staff (again) and re-assigned it to [redacted] (again).

I left a note on CPRS regarding the veteran's message; one of the Pharmacy specialists processed the refill.

Why is this being allowed to go on?

Who is keeping this clinical conduct in check?

Can the hiring of an individual into the Whole Health Clinical Directorship allow the Clinician to escape meaningful clinical supervision/oversight?

Isn't that what has happened here?

Isn't this a risk to the veterans?

[redacted] [redacted] risk of dying because of series of actions/events regarding the Whole Health Service which have unfolded here at CTVHCS?

Sincerely,

[redacted]

[redacted]

From: [redacted]
Sent: Friday, November 19, 2021 1:22 AM
To: [redacted]
Subject: [redacted] - Escalated Message(s)

The following [redacted] the Triage group: Pain Management - Central Texas VA@ have been escalated.

+ 2 messages Assigned to [redacted]

If the escalated message was originally placed in your Inbox, a copy of it is available to view in the Escalated folder.

To read the message(s) in the Escalated folder, please access [redacted]. This is an automated, system generated message that cannot be turned off. Please do not reply to this message.

Go to [redacted]

[redacted]

From: [redacted]
Sent: Monday, November 22, 2021 8:25 AM
To: [redacted]
Subject: OSC Investigation - - OUD and Consults and Patient Care and Staffing under Whole Health

Hello [redacted]

This veteran's case is an important one; your team should understand what is happening on the ground.

I tried to refer the veteran to our SUD clinic here at CTVHCS for evaluation and treatment for his diagnosis of Opioid Dependence. The consult was blocked; AUD instead of OUD was discussed; I asked again... and so on.

The veteran recently had a suicide attempt.

//

Re: [redacted]

//

I had submitted a few JPSRs on this veteran's care; it might be good to review the methods being employed here regarding clinical behavior that is concerning.

[redacted] has succeeded in creating the situation he sought to create:

(1) Intervene on the clinical processing side of pain consult request processing to stop consults being sent to CITC, to force us to stop consults from being sent to CITC, and to force this consult processing behavior for a long stretch of time, resulting in behaviorial change on the part of at least some referring providers so they no longer feel they can directly ask for continuity of care with CITC with any sort of consistency, and also resulting in destabilization of the care of the affected veterans.

(2) This has resulted in a veteran who had been diagnosed with Opioid Dependence from his outside pain clinic here in Texas (the veteran carries the same diagnosis as far back as at least [redacted]) having his CC-Pain consult expiring and being scheduled here.

(3) Per JLV, the veteran has a documented history of alcoholism; the veteran denied the diagnosis when I spoke to him during our initial evaluation, but he stated that he did have some issue with alcohol in the past.

(4) I referred the veteran to SATP for evaluation and management of his **Opioid Dependence (the outside pain clinic even cites the corresponding ICD code)** and cited his prior diagnosis of alcoholism so as to highlight that this is not a simple case.

(5) MHBM-SATP asks to resubmit the request differently as it is not emergent.

(6) MHBM-SATP contacts the veteran but only discussed ?alcohol with the veteran.

(7) MHBM-SATP finally contacts the veteran and discusses the topic of Opioid dependence with the veteran who they chart as relating he uses buprenorphine for pain (this only happens after I leave an additional note on the chart repeating the request that they speak to him and discuss the actual reason I had placed the consult in the first place).

(8) Keep in mind, the veteran is actually on Suboxone.

(9) MHBM staff [redacted] "build a chart" by repeatedly stating that the veteran takes buprenorphine for pain --- as if the patient's denying a diagnosis of Opioid Dependence and stating it is for pain supercedes his having been diagnosed with Opioid Dependence.

(10) [redacted] was copied on my initial evaluation --- and [redacted] did not sign the CPRS alert for my initial evaluation last I saw --- he ultimately received a message about Suboxone, apparently; [redacted] then creates a chart note, signing it on 4/15/2021.

(11) In his note, [redacted] states:

a. “He was seen in the pain clinic. Provider referred him to SATP, but he was not advised that the purpose of this referral was for opioid dependence.”
    i. This is false; I introduced the topic to the veteran gently and discussed the reason for referral, citing prior documentation. I did not advise him of the 6 hour time commitment per week (please see the consult requests under the consult tab).
b. “Indication for Buprenorphine is for pain and physiologic dependence.”
    ii. The outside pain clinic note states “Opioid Dependence” with its correct, corresponding ICD code.
c. “It is not clear from the records or patient interview that the patient meets full criteria for OUD.”
    iii. … never mind that Suboxone is approved to treat Opioid Dependence, studies were done on Opioid dependence, there are no recognized differences of significance from a treatment perspective re: Opioid Dependence and OUD as diagnoses…
    iv. [redacted] does not document any discussion at all with the veteran to support that it is not clear if the veteran meets criteria for OUD --- and [redacted] is a certified addictionologist.
    v. [redacted] does not cite chart review to support his claim of a lack of clarity either.
    vi. [redacted] simply throws out and/or does not review anything in the chart he does not like --- or does not meet his endpoint --- and then states whatever he likes in order to meet his endpoint.
d. [redacted] states “He ran out of his medication almost 1 month ago.”

(12) [redacted] states “Even if he does meet criteria, buprenorphine would be appropriate as it was effective for analgesia for him, and it is safer than full-agonist opioids.”

a. **And right here is the culmination** --- [redacted] has come up with a way to <u>support MHBM’s stance of disavowing responsibility for treating OUD/Opioid Dependence</u> while simultaneously <u>asserting an indication for his opioid of choice for chronic pain</u> --- as if “being safer than full-agonist opioids” **becomes an indication for prescribing a controlled substance/opioid**.
    i. It is hard not to notice when he switches terminology in his chart note, initially referencing the suboxone that the veteran is actually on. At the point of creating his “Impression/plan,” he cites “chronic back pain” and “possible complex persistent opioid dependence”, which is not only not a validated diagnosis and not represented in the ICD/CPT terminology, but also is only “possible” even according to [redacted]. At this point in his documentation, of his impression/plan, [redacted] changes to using buprenorphine as the terminology.

ii. Simultaneously, as [redacted] has over the course of one entire year had no clinics set up for him --- refusing to accept consultation requests and scheduling patient visits as is done by other services in the hospital standardly --- and he sees (best I can tell) only veterans that he self-consults on, and as he has forced upon the interventional pain management this clinical thought process, enforced via changes to Performance Pay and now changes to our OPPE, indicating to others that interventional pain will be prescribing opioids (**for his indications, as he has wielded his administrative power over us**), [redacted] has found a way to promulgate the following:

1. Mental Health can continue to refuse to treat OUD / Opioid Dependence.
2. Opioid(s), at least anything Buprenorphine, are now indicated for all chronic pain again --- under the banner of "being safer than full-agonist opioids" and "as it was effective for analgesia" (the latter argument is what caused the opioid epidemic to proliferate in the first place).
3. Interventional Pain Clinic will divert resources away from the supply side intervention of pain procedures towards treating OUD / Opioid Dependence for the entire facility, as **MHBM refuses to treat it, by refusing to diagnose it**, even though MHBM are the leaders in substance dependence by virtue of their selected occupations/training, knowledge base, expertise and experience in substance use disorders and other/comorbid mental health disease.
4. Primary Care can simply disavow dealing with [redacted] if it is an opioid, Interventional Pain will deal with it … *especially* if it is not indicated in the first place for chronic pain.
5. With all of the above, the OSI and CARA laws/initiatives are both functionally neutralized; MHBM/PC/PACT [redacted] to lead, evaluate, and treat clinical presentations that not only fall within their purview but require their leadership.
6. [redacted] is selling to the VISN and to CTVHCS that his quest is about treating OUD; what he is really doing is forcing us to distribute his narcotic of choice for his personal indication for chronic pain; we do not agree with long-term opioids, including buprenorphine products, being the indicated treatment for most patients with chronic pain.
7. **VISN 17 Pain Stewardship is not tracking Buprenorphine products as opioids for pain (although that is exactly what being sold here**); buprenorphine products are only tracked via the SUD16 parameter (although MHBM refuses to diagnose OUD/Opioid dependence).
8. [redacted]. I do not understand why, [redacted]

[redacted], MHBM/PC/PACT were not aligned with Whole Health and these departments are not leading in this matter. Instead, [redacted] and Whole Health have been placed atop Interventional Pain of the Specialty Care ICC and he has done everything to coerce us to do his will against our clinical judgment, affecting the care of our veterans --- like this veteran here.

9. The facility can keep opioids in house by hiring on interventional pain specialists, forcing them to do opioids instead (Change duties → OPPE/FPPE → FPPE → Termination or leave so I/we can at least still practice medicine somewhere), and thereby spend less on CITC, in regards to any veterans that are being given or going to be given opioids in the community --- and CTVHCS numbers will look great via the SUD16 parameter.
10. By forcing us under Whole Health, [redacted] may be able to count our services provided in the numbers needed as meeting the requirements for VERA dollars/compensation from VHA for CTVHCS, **although I am not sure about this last point.**

Did a veteran suffer for [redacted] actions?

-His referring provider wanted the veteran to have continuity with the CC-Pain provider who had an addictionology professional on staff; some referring providers still try to ask; others know that [redacted] has been blocking these referrals so they no longer ask, they just allude.

-MHBM disavowed the care by denying the diagnosis.

-[redacted] simply recreated the chart in his own image and still did not provide actual care for the veteran --- even though he has been promoting to everyone how important his cause is (whatever that cause actually is).

-What is the status of the veteran's care from a mental health and/or opioid use/disorder standpoint now, due to [redacted] approach?

-What about the veteran's suicide attempt a few months ago --- with hydrocodone and rum? Does the veteran actually have OUD and did the conduct of the MHBM department providers and [redacted] increase the veteran's risk of suicide?

As an aside:

a. According to Lin et al (2020), and this study examined the topic in the VHA. “In FY 2017, 41% OUD only; 22.9% OUD + 1 SUD; 35.9% had OUD + >= 2 SUDs”, which means in ~60% of patients with at least OUD, it less likely that simply prescribing suboxone after taking an 8 hour class will be sufficient management.

b. According to Hser et al (2017), “Most OUD patients (64.4%) had chronic pain conditions, and among them 61.8% had chronic pain before their first OUD diagnosis.”

c. According to Greene et al (2015), “The topic of diagnoses of Opioid Dependence (DSM-IV) vs. Opioid Use Disorder (DSM-V) seems to have been a point of contention for some members of the Mental Health Department; it should be noted that: of lifetime OUD in those with LTOT has been shown to be virtually the same if using DSM IV or DSM V criteria.”

d. According to Dennis et al (2015), Pain has no impact on outcomes for patients on buprenorphine or combination buprenorphine-naloxone.

e. Patients and their treating clinicians may be concerned that treatments proven effective in different OUD populations may not be effective for patients with chronic pain, or may not be necessary for patients who have become addicted to prescription opioid analgesics. This concern has been unfounded and was addressed by Weiss and colleagues in the Prescription Opioid Abuse Treatment Study (POATS).

Sincerely,

[redacted]

[redacted]

From: [redacted]
Sent: Monday, November 15, 2021 2:12 PM
To: [redacted]
Subject: OMI - - Diagnosing (or not) and Treating (or not) OUD

Hello OMI team,

This veteran's case is an important one; your team should understand what is happening on the ground.

I tried to refer the veteran to our SUD clinic here at CTVHCS for evaluation and treatment for his diagnosis of Opioid Dependence. The consult was blocked; AUD instead of OUD was discussed; I asked again... and so on.

The veteran recently had a suicide attempt.

//

Re: <REDACTED> <REDACTED>

//

I had submitted a few JPSRs on this veteran's care; it might be good to review the methods being employed here regarding clinical behavior that is concerning.

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(1) Intervene on the clinical processing side of pain consult request processing to stop consults being sent to CITC, to force us to stop consults from being sent to CITC, and to force this consult processing behavior for a long stretch of time, resulting in behaviorial change on the part of at least some referring providers so they no longer feel they can directly ask for continuity of care with CITC with any sort of consistency, and also resulting in destabilization of the care of the affected veterans.

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(12) [redacted] states "Even if he does meet criteria, buprenorphine would be appropriate as it was effective for analgesia for him, and it is safer than full-agonist opioids."

a. **And right here is the culmination** --- [redacted] has come up with a way to <u>support MHBM's stance of disavowing responsibility for treating OUD/Opioid Dependence</u> while simultaneously <u>asserting an indication for his opioid of choice for chronic pain</u> --- as if "being safer than full-agonist opioids" **becomes an indication for prescribing a controlled substance/opioid**.
    i. It is hard not to notice when he switches terminology in his chart note, initially referencing the suboxone that the veteran is actually on. At the point of creating his "Impression/plan," he cites "chronic back pain" and "possible complex persistent opioid dependence", which is not only not a validated diagnosis and not represented in the ICD/CPT terminology, but also is only "possible" even according to [redacted]. At this point in his documentation, of his impression/plan, [redacted] changes to using buprenorphine as the terminology.

ii. Simultaneously, as [redacted] has over the course of one entire year had no clinics set up for him --- refusing to accept consultation requests and scheduling patient visits as is done by other services in the hospital standardly --- and he sees (best I can tell) only veterans that he self-consults on, and as he has forced upon the interventional pain management this clinical thought process, enforced via changes to Performance Pay and now changes to our OPPE, indicating to others that interventional pain will be prescribing opioids (**for his indications, as he has wielded his administrative power over us**), [redacted] has found a way to promulgate the following:

1. Mental Health can continue to refuse to treat OUD / Opioid Dependence.
2. Opioid(s), at least anything Buprenorphine, are now indicated for all chronic pain again --- under the banner of "being safer than full-agonist opioids" and "as it was effective for analgesia" (the latter argument is what caused the opioid epidemic to proliferate in the first place).
3. Interventional Pain Clinic will divert resources away from the supply side intervention of pain procedures towards treating OUD / Opioid Dependence for the entire facility, as **MHBM refuses to treat it, by refusing to diagnose it**, even though MHBM are the leaders in substance dependence by virtue of their selected occupations/training, knowledge base, expertise and experience in substance use disorders and other/comorbid mental health disease.
4. Primary Care can simply disavow dealing with [redacted] if it is an opioid, Interventional Pain will deal with it … *especially* if it is not indicated in the first place for chronic pain.
5. With all of the above, the OSI and CARA laws/initiatives are both functionally neutralized; MHBM/PC/PACT [redacted] to lead, evaluate, and treat clinical presentations that not only fall within their purview but require their leadership.
6. [redacted] is selling to the VISN and to CTVHCS that his quest is about treating OUD; what he is really doing is forcing us to distribute his narcotic of choice for his personal indication for chronic pain; we do not agree with long-term opioids, including buprenorphine products, being the indicated treatment for most patients with chronic pain.
7. **VISN 17 Pain Stewardship is not tracking Buprenorphine products as opioids for pain (although that is exactly what being sold here**); buprenorphine products are only tracked via the SUD16 parameter (although MHBM refuses to diagnose OUD/Opioid dependence).
8. [redacted]. I do not understand why, [redacted]

[redacted], MHBM/PC/PACT were not aligned with Whole Health and these departments are not leading in this matter. Instead, [redacted] and Whole Health have been placed atop Interventional Pain of the Specialty Care ICC and he has done everything to coerce us to do his will against our clinical judgment, affecting the care of our veterans --- like this veteran here.

9. The facility can keep opioids in house by hiring on interventional pain specialists, forcing them to do opioids instead (Change duties → OPPE/FPPE → FPPE → Termination or leave so I/we can at least still practice medicine somewhere), and thereby spend less on CITC, in regards to any veterans that are being given or going to be given opioids in the community --- and CTVHCS numbers will look great via the SUD16 parameter.
10. By forcing us under Whole Health, [redacted] may be able to count our services provided in the numbers needed as meeting the requirements for VERA dollars/compensation from VHA for CTVHCS, **although I am not sure about this last point.**

Did a veteran suffer for [redacted] actions?

-His referring provider wanted the veteran to have continuity with the CC-Pain provider who had an addictionology professional on staff; some referring providers still try to ask; others know that [redacted] has been blocking these referrals so they no longer ask, they just allude.

-MHBM disavowed the care by denying the diagnosis.

-[redacted] simply recreated the chart in his own image and still did not provide actual care for the veteran --- even though he has been promoting to everyone how important his cause is (whatever that cause actually is).

-What is the status of the veteran's care from a mental health and/or opioid use/disorder standpoint now, due to [redacted] approach?

As an aside:

a. According to Lin et al (2020), and this study examined the topic in the VHA. "In FY 2017, 41% OUD only; 22.9% OUD + 1 SUD; 35.9% had OUD + >= 2 SUDs", which

means in ~60% of patients with at least OUD, it less likely that simply prescribing suboxone after taking an 8 hour class will be sufficient management.

b. According to Hser et al (2017), "Most OUD patients (64.4%) had chronic pain conditions, and among them 61.8% had chronic pain before their first OUD diagnosis."

c. According to Greene et al (2015), "The topic of diagnoses of Opioid Dependence (DSM-IV) vs. Opioid Use Disorder (DSM-V) seems to have been a point of contention for some members of the Mental Health Department; it should be noted that: of lifetime OUD in those with LTOT has been shown to be virtually the same if using DSM IV or DSM V criteria."

d. According to Dennis et al (2015), Pain has no impact on outcomes for patients on buprenorphine or combination buprenorphine-naloxone.

e. Patients and their treating clinicians may be concerned that treatments proven effective in different OUD populations may not be effective for patients with chronic pain, or may not be necessary for patients who have become addicted to prescription opioid analgesics. This concern has been unfounded and was addressed by Weiss and colleagues in the Prescription Opioid Abuse Treatment Study (POATS).

Sincerely,

[redacted]

[redacted]

From: [redacted]
Sent: Monday, November 15, 2021 2:12 PM
To: [redacted]
Subject: OMI - - Diagnosing (or not) and Treating (or not) OUD

Hello OMI team,

Highlighting mine.

Questions:

- Even if the veteran meets criteria for OUD, is it that **Buprenorphine** would be appropriate? Or would **Buprenorphine-Naloxone** be (more) appropriate?
- Was [redacted] correct in his MOUD training course: "Only one indication for mono-product and that's pregnancy."
- Is the wording here in the note confusing / based in confounding?

Sincerely,

[redacted]

//

Re: <REDACTED> <REDACTED>

//

<REDACTED>

LOCAL TITLE: WHS INTEGRATED MEDICINE TELEPHONE NOTE
STANDARD TITLE: INTEGRATIVE HEALTH NOTE
DATE OF NOTE: APR 12, 2021[redacted] ENTRY DATE: APR 12, 2021[redacted]
[redacted] EXP COSIGNER:
URGENCY: STATUS: COMPLETED

Received message regarding suboxone.

Called patient, confirmed ID by name and SSN.

He reports that he has had chronic back pain since he was injured in an explosion[redacted]

He reports numbness and shooting pain going down leg. Also has a throbbing sensation.

Had surgery[redacted] -[redacted] did not help.

He reports he was being treated with Suboxone 2mg/0.5mg divided qid. Was able to function on this. He ran out of his medication almost 1 month ago. He has been [redacted].

He was seen in the pain clinic. Provider referred him to SATP, but he was not advised that the purpose of this referral was for opioid dependence.

[redacted] ED last week - was given an analgesic by injection.

Impression/plan:

1. chronic back pain
2. possible complex persistent opioid dependence

Reviewed PDMP. Patient received another refill from the community provider.

Indication for buprenorphine is for pain and physiologic dependence. It is not clear from the records or patient interview that the patient meets full criteria for OUD.

Even if he does meet criteria, buprenorphine would be appropriate as it was effective for analgesia for him, and it is safer than full-agonist opioids.

Would still recommend integrative approaches to pain management.

Will followup to continue discussion of Mission, Aspiration, and Purpose.

[redacted]
Chief of Whole Health Service
Signed: 04/15/2021[redacted]

[redacted]

From: [redacted]
Sent: Friday, November 19, 2021 11:22 AM
To: [redacted]
Subject: OMI --- Diagnosing (or not) and Treating (or not) OUD --- FW: Secure Message Notification - Escalated Message(s)

Hello OMI team,

Because of [redacted]

- this veteran was taken away from his care in the community.
- this veteran was taken off of Suboxone (prior diagnosis: Opioid Dependence).
- this veteran is made to beg for a response from [redacted]

Best I can tell, [redacted] has never physically examined this veteran --- not even once.

No one at this facility seems to be holding [redacted] to task.

He has disrupted the care of this veteran and many others.

This is dangerous.

This veteran already had a recent suicide attempt. His suicide attempt apparently was with Rum and Hydrocodone. Would his prior diagnosis and behavior cause an Addictionologist to recommend/prescribe Buprenorphine or Buprenorphine/Naloxone?

Yesterday, we had an all day long Whole Health standdown; [redacted] did not address the message. When the patients message him, he simply lets the messages escalate. It gives the outward appearance that [redacted] is too busy to provide the patient care to which he constantly claims commitment . The veteran's message was assigned to me by support staff (again) and re-assigned it to [redacted] again).

I left a note on CPRS regarding the veteran's message; one of the Pharmacy specialists processed the refill.

Why is this being allowed to go on?

Who is keeping this clinical conduct in check?

Can the hiring of an individual into the Whole Health Clinical Directorship allow the Clinician to escape meaningful clinical supervision/oversight?

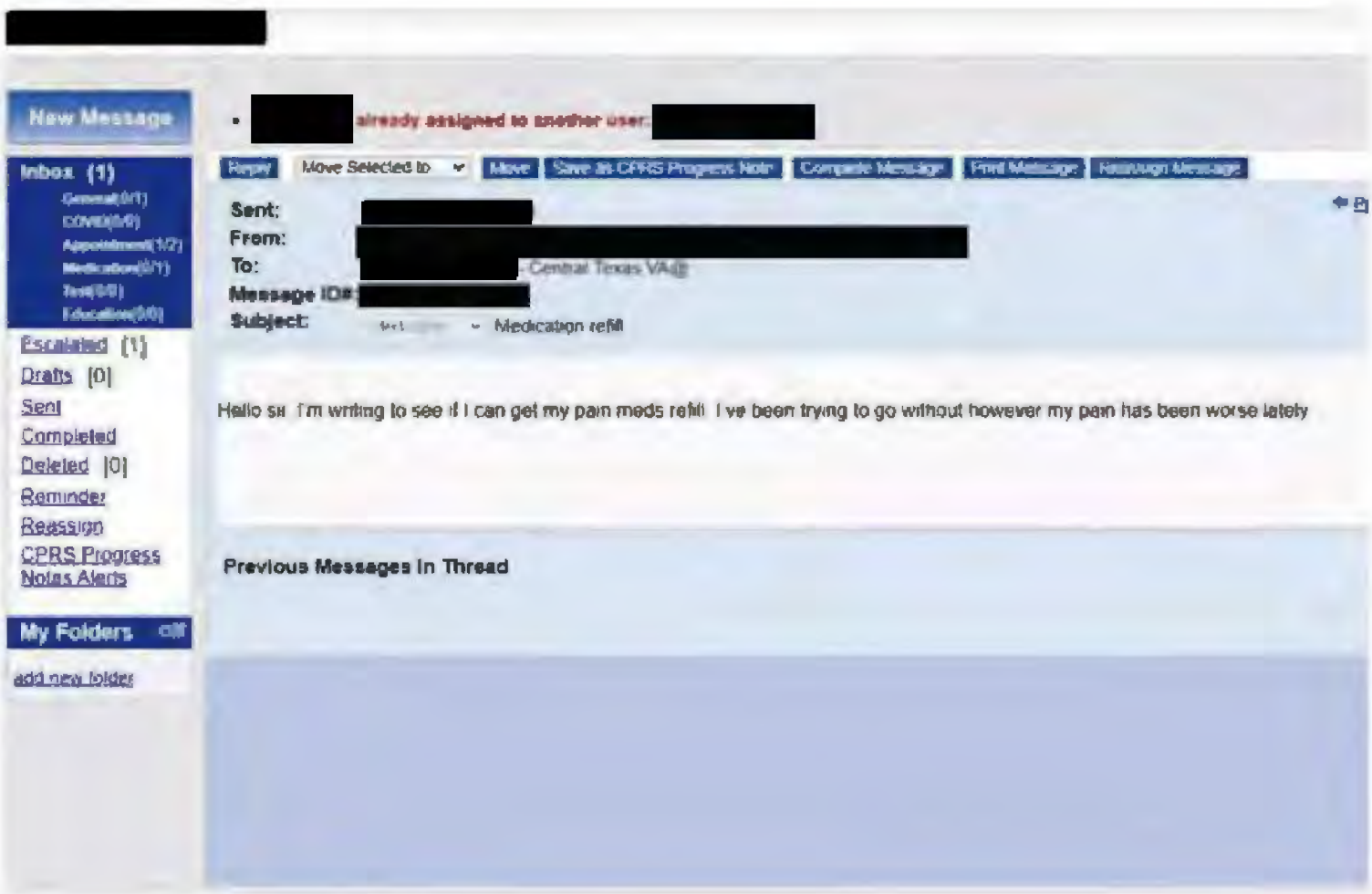
Isn't that what has happened here?

Isn't this a risk to the veterans?

[redacted] [redacted] risk of dying because of series of actions/events regarding the Whole Health Service which have unfolded here at CTVHCS?

Sincerely,

[redacted]



From: [redacted]
Sent: Friday, November 19, 2021 1:22 AM
To: [redacted]
Subject: [redacted] Notification - Escalated Message(s)

The following [redacted] for the Triage group: Pain Management - Central Texas VA@ have been escalated.

+ 2 messages Assigned to [redacted]

If the escalated message was originally placed in your Inbox, a copy of it is available to view in the Escalated folder.

To read the message(s) in the Escalated folder, please access [redacted]. This is an automated, system generated message that cannot be turned off. Please do not reply to this message.

Go to [redacted]

[redacted]

From: [redacted]
Sent: Monday, November 15, 2021 2:13 PM
To: [redacted]
Subject: OMI — Diagnosing (or not) and Treating (or not) OUD

Hello OMI team,

More messages…

Sincerely,

[redacted]

//

Re: **<REDACTED>** <REDACTED>

//

Sent: [redacted]
From: <REDACTED>
To: Pain Management - Central Texas VA@
Message ID#: [redacted]
Subject: General Inquiry

Yes I can not refill them untill he signs off on it

Previous Messages in Thread

-----Original Message-----
Sent: [redacted]
From: [redacted]
To: <REDACTED>
Subject: General Inquiry

I understand.

My understanding is that he continues to have sporadic access to messages, and that he will be available on 11/18/2021 should you request to speak to him regarding your query.

Be well,

[redacted]

-----Original Message-----
Sent [redacted]
From: [redacted]
To: <REDACTED>
Subject: General Inquiry

Hello sir,

Your message has been assigned to [redacted] for his review. [redacted] is currently on leave, but my understanding is that he continues to have sporadic access to messages. My understanding is he will be available on [redacted] should you request to speak to him regarding your query.
From my review of your chart, I suspect your are referencing the medication Buprenorphine that [redacted] has been prescribing you. If true, then it looks like you should have refills available.

Be well,

[redacted]

[redacted]

From: [redacted]
Sent: Monday, November 15, 2021 2:13 PM
To: [redacted]
Subject: OMI -- Diagnosing (or not) and Treating (or not) OUD -- FW: on leave

Hello OMI team,

As long as the veteran says the Suboxone was for pain, even if he was diagnosed previously as suffering of Opioid Dependence, then it must not be Opioid Dependence/OUD, correct?

Is it correct?

Is it the Whole Health Service's job to [redacted] "know if there are any prescriptions that will be due in this time frame so that we can prepare them in advance."

Sincerely,

[redacted]

//

Re: **<REDACTED>** <REDACTED>

//

Sent: [redacted]
From: <REDACTED>
To: Pain Management - Central Texas VA@
Message ID#: [redacted]
Subject: Medication refill

Hello sir, I'm writing to see if I can get my pain meds refill. I've been trying to go without however my pain has been worse lately.

From: [redacted]
Sent: Wednesday, November 3, 2021 3:53 PM
To: CTX Whole Health Service <CTXWholeHealthService@va.gov>
Cc: [redacted]
Subject: on leave

I will be on leave from 11/8 to 11/20, though I will attend the stand down on 11/18/21.

I will have sporadic access to messages.

Please let me know if there are any prescriptions that will be due in this time frame so that we can prepare them in advance.

With appreciation,

[redacted]

[redacted]
Clinical Director, Whole Health and Integrated Health Service
Central Texas VA Healthcare System

[redacted]

Reference 23

[redacted]

From: [redacted]
Sent: Friday, November 19, 2021 4:30 PM
To: [redacted]
Subject: OSC investigation --- Patient Care under Whole Health

Hello [redacted]

Re:

[redacted] [redacted] [redacted]

I was asked on 10/15/2021 if this veteran could be placed on my schedule. He was supposed to see [redacted], who called out sick today and on Monday (Mondays and Fridays are his clinic ½-days).

Then, the veteran was simply put on my schedule.

Best I can tell, the veteran simply wanted his chiropractic care resumed. From my review of the chart, it was denied a couple of times, seemingly with good reason by the reviewer. The most recent discontinuation made less sense to me. Either way, I am not sure that the logic flowed in putting this veteran's appointment with [redacted] onto my schedule. On evaluation, I recommended to defer chiropractic, to which the veteran agreed. Please review the following CPRS notes re: Whole Health involvement. I am sending you additional communication regarding chat transcripts on the matter.

Key questions:

- Was a Whole Health clinical evaluation /consult even requested?
- What exactly are these "evaluations" as evidenced by the charted notes? What is the purpose and the outcome of these billed and coded follow-ups?
- Why was the most recent evaluation billed/coded twice for 21-30 minutes; does it make sense on review of the note's content?

- Just the two unrequested telephone/VVC consults/visits in, [redacted] has decided the pain is "likely myofascial." …Why is everything myofascial?
- Should I have seen the patient without a new consultation request to pain management?
- If I follow up in place of [redacted] to [redacted] seemingly unrequested consultation, is that ok? What type of evaluation should I have done in such a scenario?
- **Did all of this improve the efficiency of care for the Veteran and was it patient-centered?**

Sincerely,

[redacted]

From CPRS below…

//

[redacted]

LOCAL TITLE: WHS INTEGRATED MEDICINE TELEPHONE NOTE
STANDARD TITLE: INTEGRATIVE HEALTH NOTE
DATE OF NOTE: [redacted] ENTRY DATE: [redacted]
AUTHOR: [redacted] EXP COSIGNER:
URGENCY: STATUS: COMPLETED

Received message - patient wanted to discuss community care for chiropractic.

Called patient.

He reports that he has low back pain - muscles tighten, has stiffness.

He attributes this to degenerative changes noted on imaging.

He was seeing a chiropractor - had [redacted] This was helping. Provider recommended more treatment. Pain has gotten worse in the interim.

He recently had a [redacted] fracture. This had been a contraindication to chiropractic treatment. He reports that this has healed.

He has been to introduction to whole health.

Request for reauthorization for CITC was entered by his PCP. However, the records from community provider are not available in VISTA.

Will schedule him to see me to discuss treatment options. He will request that his records be sent again.

/es/ [redacted]
Chief of Whole Health Service
Signed: [redacted]

Related to: Service Connected Condition
Diagnoses:
Low back pain, unspecified (ICD-10-CM M54.50) (Primary)

Procedures:
PHONE E/M 21-30 MIN (2 times)

//

[redacted]

LOCAL TITLE: WHS INTEGRATED MEDICINE TELEPHONE NOTE
STANDARD TITLE: INTEGRATIVE HEALTH NOTE
DATE OF NOTE: [redacted] ENTRY DATE: [redacted]
AUTHOR: [redacted] EXP COSIGNER:
URGENCY: STATUS: COMPLETED

Received message regarding chiropractic care.

Called patient, confirmed ID by full name and SSN.

Veteran reports that he has [redacted] with community care chiropractor.

The chiropractor recommended additional visits.

The veteran believes that the VA should comply with the community care recommendations.

He did not have time to discuss this any further today. Will call again.

/es/ [redacted]
Chief of Whole Health Service
Signed: [redacted]

Related to: Service Connected Condition
Diagnoses:
Low Back Pain (SCT 279039007) - Low back pain (ICD-10-CM M54.5) (Primary)

Procedures:
PHONE E/M 11-20 MIN

//

[redacted]

LOCAL TITLE: WHS INTEGRATED MEDICINE NOTE
STANDARD TITLE: INTEGRATIVE HEALTH NOTE
DATE OF NOTE: [redacted] ENTRY DATE: [redacted]
AUTHOR: [redacted] EXP COSIGNER:
URGENCY: STATUS: COMPLETED

Patient had been seen by [redacted] for chiropractic care for chronic back pain, but [redacted] has resigned. Patient is requesting follow up.

Confirmed ID by name and SSN.

He reports that back pain started while he was in [redacted], but he started having stiffness in his back around [redacted]. His work required [redacted]

He does not have sciatica, numbness, tingling, weakness.

Pprolonged standing or sitting makes it worse.

He tosses and turns at night - cannot lie flat comfortably.

He has difficulty standing up straight when he first gets out of bed.

He has had physical therapy. Recommended stretches, warming up prior to exercise.

He was also prescribed NSAIDs.

He has remained very active. He is mindful of his diet.

Past medical history:
[redacted]

Military:
[redacted]

MRR1 - Med Reconciliation
INCLUDED IN THIS LIST: Alphabetical list of active outpatient prescriptions dispensed from this VA (local) and dispensed from another VA or DoD facility (remote) as well as inpatient orders (local pending and active), local clinic medications, locally documented non-VA medications, and local prescriptions that have expired or been discontinued in the past 90 days.

Non-VA Meds Last Documented On: Jun 23, 2020
****

NOTE The display of VA prescriptions dispensed from another VA or DoD facility (remote) is limited to active outpatient prescription entries matched to National Drug File at the originating site and may not include some items such as investigational drugs, compounds, etc.

NOT INCLUDED IN THIS LIST: Medications self-entered by the patient into personal health records (i.e. My HealtheVet) are NOT included in this list. Non-VA medications documented outside this VA, remote inpatient orders (regardless of status) and remote clinic medications are NOT included in this list. The patient and provider must always discuss medications the patient is taking, regardless of where the medication was dispensed or obtained.

OUTPT AMMONIUM LACTATE 12% LOTION (Status = Active)
APPLY SMALL AMOUNT EXTERNALLY DAILY APPLY TO FEET DAILY (REPLACES LACTIC ACID 5% LOTION)
Rx# 8993060A Last Released: 2/27/20 Qty/Days Supply: 240/30
Rx Expiration Date: 2/25/21 Refills Remaining: 6

Non-VA CHOLECALCIF 25MCG (D3-1,000UNIT) TAB
TAKE ONE TABLET BY MOUTH TWICE A DAY Medication prescribed by Non-VA provider.

Non-VA FLUTICASONE NASAL INH (50MCG, 120 DOSES)
USE 1 SPRAY IN EACH NOSTRIL DAILY Medication prescribed by Non-VA provider.

Non-VA HYOSCYAMINE TAB
TAKE BY MOUTH Medication prescribed by Non-VA provider.

Non-VA INSULIN ASPART (NOVOLOG) * HI ALERT * INJ
INJECT SUBCUTANEOUSLY AS NEEDED Medication prescribed by Non-VA provider.

Non-VA INSULIN GLARGINE (LANTUS) 100UNT/ML 10ML
INJECT 20 UNITS SUBCUTANEOUSLY EVERY MORNING Medication prescribed by Non-VA provider.

Non-VA INSULIN GLARGINE (LANTUS) 100UNT/ML 10ML
INJECT 20 UNITS SUBCUTANEOUSLY AT BEDTIME Medication prescribed by Non-VA provider.

OUTPT MOISTURIZING CREAM (Status = Active)
APPLY EUCERIN EXTERNALLY DAILY FOR DRY SKIN
Rx# 7443517C Last Released: 2/28/20 Qty/Days Supply: 454/30
Rx Expiration Date: 2/25/21 Refills Remaining: 1

Non-VA MONTELUKAST 10MG TAB
TAKE ONE TABLET BY MOUTH EVERY EVENING Patient wants to buy from Non-VA pharmacy. Medication prescribed by Non-VA provider.

Non-VA MULTIVITAMIN/MINERALS THERAPEUT CAP/TAB
TAKE ONE TABLET BY MOUTH DAILY Medication prescribed by Non-VA provider.

OUTPT MYCOPHENOLIC ACID(MYFORTIC) 360MG EC TAB (Status = Active)
TAKE TWO TABLETS BY MOUTH TWICE A DAY FOR LIVER TRANSPLANT###
Rx# 9294341 Last Released: 10/20/20 Qty/Days Supply: 360/90
Rx Expiration Date: 2/4/21 Refills Remaining: 0

Non-VA PREDNISONE 5MG TAB
TAKE ONE TABLET BY MOUTH DAILY Medication prescribed by Non-VA provider.

OUTPT SODIUM FLUORIDE 1.1% ORAL CREAM (Status = Active)
APPLY SMALL AMOUNT BY MOUTH AT BEDTIME TO PREVENT CAVITIES
Rx# 8987587A Last Released: 7/8/20 Qty/Days Supply: 153/90
Rx Expiration Date: 6/4/21 Refills Remaining: 3

OUTPT TACROLIMUS 1MG CAP (Status = Active)
TAKE TWO CAPSULES BY MOUTH EVERY MORNING AND TAKE ONE CAPSULE EVERY EVENING FOR POST TRANSPLANT CARE
Rx# 9323923 Last Released: 11/12/20 Qty/Days Supply: 270/90
Rx Expiration Date: 2/20/21 Refills Remaining: 0

Non-VA VITAMIN E CAPSULE 400 UNITS
TAKE 400 UNITS (1 CAPSULE) BY MOUTH DAILY Medication prescribed by Non-VA provider.

Non-VA ZZALBUTEROL HFA (CFC-FREE) INHL,ORAL
INHALE BY MOUTH

SUPPLIES

OUTPT GLUCOSE SENSOR FREESTYLE LIBRE 14 DAY (Status = Discontinued)
1 SENSOR EVERY 14 DAYS FOR MONITORING BLOOD SUGAR
Rx# 9574437 Last Released: 12/7/20 Qty/Days Supply: 6/90
Rx Expiration Date: 8/5/21 Refills Remaining: 0

OUTPT GLUCOSE SENSOR FREESTYLE LIBRE 14 DAY (Status = Active/Suspended)
1 SENSOR EVERY 14 DAYS FOR MONITORING BLOOD SUGAR
Rx# 9749900 Last Released: Qty/Days Supply: 6/90
Rx Expiration Date: 12/11/21 Refills Remaining: 1

IMPRESSION/PLAN:
1. back pain, likely myofascial
2. diabetes mellitus
3. s/p [redacted]

Patient had been approved for chiropractic care by [redacted]

He would like to go to [redacted] chiropractic in [redacted]

Explained Whole Health initiative, Personal Health Inventory and Mission, Aspiration and Purpose. Suggested Intro to Whole Health class.

Patient is interested in attending this.

/es/ [redacted]
Chief of Whole Health Service
Signed: [redacted]

Related to: Service Connected Condition
Diagnoses:
Low Back Pain (SCT 279039007) - Low back pain (ICD-10-CM M54.5) (Primary)

Procedures:
Expanded Problem Focused

//

[redacted]

LOCAL TITLE: MD TELEPHONE NOTE
STANDARD TITLE: PHYSICIAN TELEPHONE ENCOUNTER NOTE
DATE OF NOTE: [redacted] ENTRY DATE: [redacted]
AUTHOR: [redacted] EXP COSIGNER:

URGENCY: STATUS: COMPLETED

Received message - patient had gone to PMRS hoping to schedule followup for chiropractic care and was told that it was not available. Patient went to director's office.

Called patient. Explained that [redacted] had resigned, and that we may need to refer him to the community.

He has had chiropractic care in the past.

Will schedule for VVC appointment for [redacted].

/es/ [redacted]
Chief of Whole Health Service
Signed: [redacted]

Related to: Service Connected Condition
Diagnoses:
Low Back Pain (SCT 279039007) - Low back pain (ICD-10-CM M54.5) (Primary)

Procedures:
PHONE E/M 11-20 MIN

[redacted]

From: [redacted]
Sent: Monday, October 4, 2021 4:28 PM
To: [redacted]
Subject: OSC investigation — self-consultation

Hello [redacted]

As I have indicated to you previously, I have submitted several JPSR reports in regards to what I perceived as increased risk to the veteran, stemming from the changes that have been made here at CTVHCS.

What follows below is a self-consult that has occurred, best I can tell, *without my having been able to identify any elevated risk*.

I could not identify the reason or request for the consultation, or any medical-decision making to justify the billing/coding of the encounter.

Sincerely,

[redacted]

//

[redacted]

LOCAL TITLE: WHS INTEGRATED MEDICINE TELEPHONE NOTE
STANDARD TITLE: INTEGRATIVE HEALTH NOTE
DATE OF NOTE: [redacted] ENTRY DATE: [redacted]
AUTHOR: [redacted] EXP COSIGNER:
URGENCY: STATUS: COMPLETED

Received call regarding community care request.

Called patient back.

He reports that he has chroinc back and neck pain.

He had been seen by a pain specialist in the community for [redacted]

In [redacted] he had epidural steroid injection and adverse reaction - could not breathe. He was hospitalized for 4 days. He was not intubated. He reports that he was diagnosed with CHF - LVH on chest x-ray. He was treated with diuretics. However, there was a concern that he had anaphylaxis.

He had medial branch block and RFA in April 2020, and again in October 2020.

He was scheduled to do this again on [redacted] on the right and on [redacted] for the left side. He had planned on cancelling [redacted] appointment because the right side feels better.

He received a call from the community care provider's office - [redacted] - to inform him that his authorization had expired. He called hi PCP to request reauthorization.

I informed him that, because there are available appointments at the VA, he would have to be seen here.

He reports that he is reluctant to come to the VA for care because he has experienced delayed diagnosis in the past.

He had a [redacted]. He does not have a history of alcohol use disorder or viral hepatitides. His [redacted] and had alcohol-related health issues. For about 3 years prior he was given the diagnosis of [redacted], presumably due to pancytopenia, without having any testing to confirm this. After his liver tranplant, his blood counts normalized.

He has not experienced rejection at all.

He also had a [redacted] in service - required [redacted] [redacted].

He developed a [redacted]. VA providers recommended surgery, which he declined.

He had physical therapy in the private sector instead. It is still painful, but it is tolerable.

He also reports that he had an episode of [redacted]. He went to the VA ED, waited for 5 1/2 hours, and never saw a doctor. He left to go to another ED, was admitted for 3 days.

He has been followed [redacted] had PT for balance.

He also had a [redacted] removed from [redacted]. He reports that the pathology showed abnormal cells. The pathology slides were sent [redacted] B[redacted]. He reports that no diagnose was given.

He also had [redacted]

He is willing to see the VA pain provider.

/es/ [redacted]
Chief of Whole Health Service
Signed: [redacted]

Related to: Service Connected Condition
Diagnoses:
Low Back Pain (ICD-10-CM M54.5) (Primary)

Procedures:
PHONE E/M 11-20 MIN

//

From the Consult tab / Consult request:

Current PC Provider: [redacted]
Current PC Team: [redacted]
Current Pat. Status: Outpatient
UCID: [redacted]
Primary Eligibility: SC LESS THAN 50%(VERIFIED)
Patient Type: SC VETERAN
OEF/OIF: NO

Service Connection/Rated Disabilities
SC Percent: 10%
Rated Disabilities: LOSS OF GREAT TOE (10%)
SEPTUM, NASAL, DEVIATION OF (0%)

Order Information
To Service: TEM WHS OUTPT PAIN MANAGEMENT
Attention: [redacted]
From Service: WAC EVENT
Requesting Provider: [redacted]
Service is to be rendered on an OUTPATIENT basis
Place: Consultant's choice
Urgency: Routine
Clinically Ind. Date: Jan 07, 2021
DST ID:
Orderable Item: TEM WHS OUTPT PAIN MANAGEMENT
Consult: Consult Request
Provisional Diagnosis: Low Back Pain(ICD-10-CM M54.5)
Reason For Request:
INTERVENTIONAL PAIN MANAGEMENT CONSULTATION GUIDELINES:
This consultation request is for Interventional Pain
Management Procedures.

1. Reason for Request: Where is the primary location of the patient's worst pain for the consultant to address?

   - Back Pain Yes
   - Neck Pain No
   - Other No (please specify):

2. Controlled Substances:
   - Does the patient understand that the Interventional Pain Clinic offers procedures for the management of chronic pain and does not prescribe chronic controlled substances in the management of chronic pain? Yes

3. Interventional Pain Management Procedures:
   - Does the patient desire to receive interventional pain management injections for the management of Chronic Pain? Yes

4. Imaging:
   - The patient needs to have advanced imaging of the area involved within
   the last two years. MRI is usually the preferred advanced imaging for the spine.
   If MRI is contraindicated then obtain CT scan of the involved area. If

the patient had prior surgery to the spine then please request MRI with
and without contrast if the renal function allows it. The official imaging report must be reviewed by pain management before the consultation can be accepted. Please specify where the official imaging
report is found:
(Choice of only one is accepted; may not choose more than one)
VISTA Imaging

5. Blood Thinners:
- Is the patient receiving any blood thinners such as Coumadin, aspirin, clopidogrel, TSOACs (apixaban, dabigatran, or rivaroxaban) etc. No
- If the patient is on blood thinners, can the patient discontinue that
medication for about 7 days WITHOUT ANY BRIDGING medication and without
significant risk of developing stroke, cardiovascular insult, or any
other problem for which the patient is receiving that medication to prevent. Not applicable

6. Laboratory investigations:
- Is the patient Diabetic? Yes
- If YES, then the HGB A1C within the last three months of the date of
the consultation needs to be less than 8.
- Please indicate the VALUE and the DATE of the last HGB A1C:

Collection DT	Specimen	Test Name	Result	Units	Ref Range
08/28/2020 08:03	BLOOD	GLYCOHEMOGLOBIN	7.0 H	%	4.8 - 6.0

7. The Interventional Pain Management Clinic requires responses to the following questions regarding various modalities that may have been used in the management of pain in this patient's pain:
a) Has the patient tried Physical Therapy or exercise within the last year? Yes
b) Has the patient tried Acetaminophen and/or NSAIDs within the last year? Yes
c) Has the patient tried Gabapentin and /or Duloxetine if neuropathic pain was suspected?
No
d) Has the patient tried the TENS Unit be tried within the last year?
Yes
e) Has the patient tried Cognitive Behavioral Therapy (CBT) or Pain Psychology within the last year?
No

8. Comments:

Please evaluate Veteran for CITC Pain management for Nerve ablation... continuity of care request.

If care is available in VA-- Veteran is agreeable to get it here.

**********NOTES**********

ALL FIELDS MUST BE FILLED OUT for the consultation to go through, just like the MRI template. The consultation will not go through if one field is not answered.

****

Inter-facility Information
This is not an inter-facility consult request.

Status: COMPLETE
Last Action: COMPLETE/UPDATE

Facility
Activity Date/Time/Zone Responsible Person Entered By

CPRS RELEASED ORDER 01/07/21 16:31 [redacted] [redacted]
PRINTED TO 01/07/21 16:31
CTX-PTPMRS3 (BIG)
FORWARDED FROM 01/08/21 08:38 [redacted] [redacted]
TEM WHS OUTPT PAIN MANAGEMENT
Forwarded to CC-Pain per requesting provider seemingly for continuity of care.

FORWARDED FROM 01/08/21 13:29 [redacted] [redacted]
COMMUNITY CARE-PAIN
Per CITC Chief, we should attempt to schedule within VA. If unable then fwd to community.

PRINTED TO 01/08/21 13:29
CTX-PTPMRS3 (BIG)
RECEIVED 01/08/21 15:20 [redacted]
Please schedule this patient in the Pain Management Consultation Clinic following the updated guidelines for the Mission Act and the current COVID-19 scheduling modifications. Please inform the patient that the initial visit to this Pain Clinic is a consultation appointment that may be carried out as a VA Video encounter. There will be no procedure performed during the initial consultation. If the patient is interested in the Austin VA for consultation and procedures in Austin, you may forward this consultation to the "Austin Surg Pain Management Clinic."

-You may discontinue this consultation after failed outreach attempts and/or after reaching the appropriate number of “Cancellations by Patient” or “No Shows” as per policy.

SCHEDULED [redacted]
PD011121

COMPLETE/UPDATE [redacted]
Note# 77464887

Note: TIME ZONE is local if not indicated

[redacted]

From: [redacted]
Sent: Tuesday, October 5, 2021 8:33 AM
To: [redacted]
Subject: OSC investigation — veteran affected

Hello [redacted]

Re:

[redacted]

This veteran's MHV message had been assigned to me previously.

I checked the chart in order to review so I could respond to the query, and I found that [redacted] had seen the patient.

I thought the veteran's message seemed odd, in that [redacted] tends not to promise veterans medications --- as the veteran's message seems to have conveyed.

When I reviewed further to try to make sense of that, I discovered that [redacted] had seen the veteran; I initially did not realize this, as his note titles do not take on **Bold-type appearance** with my "VIEW" Notes setting for "**Pain**" notes.

So, apparently, [redacted] had seen the patient; he apparently told the patient that he would be continuing his medication (seemingly, tramadol), and then he simply did not prescribe it.

As I had been in the chart with the purpose of responding to a secure message that had been assigned to me in the first place, I thought I would pass what I found on for investigation (I ended up reassigning the message to [redacted].

Now, why is [redacted] seeing the veteran in the first place? Per [redacted] note: "Received message. Patient wanted to continue to be seen in the community for pain management."
And per [redacted] note: He was supposed to have epidural in the community but this was cancelled because community care was not reauthorized.

I am not sure if [redacted] not sending this veteran the medication discussed was intentional or not; some possibilities follow:

- Maybe this is a technique to get veterans off of opioids.
- Maybe the medication is not actually due yet.
- Maybe he simply forgot.
- Maybe this is a pattern of [redacted], stating he is going to send veterans controlled substances that he discusses with them, only to not do it, perhaps with the forethought to defer it to the Pain Management section physicians or other providers without their agreement, when the veteran shows up for a follow-up appointment. That way, if the veteran gets mad/complains/becomes hostile/violent to themselves or to other providers, the providers will feel coerced to enact [redacted] plan/preference for management, or receive complaints, discipline, or other harm.

To be clear, this is happening in the first place because:

- Tthe veteran's community care consult "was not reauthorized" --- in line with the instructions to our section to process consult requests.
- Somehow, "Per [redacted] note: "Received message. Patient wanted to continue to be seen in the community for pain management" becomes treated by [redacted] as a consult request to himself, apparently.
- [redacted] simply doesn't follow through with his own treatment plan.

Please see the below chart excerpts and [redacted] message:

//

[redacted] TEM WHS CIH PAIN PHY1

//

Sent: [redacted]
From: [redacted]
To: Pain Management - Central Texas VA@
Message ID#: [redacted]
Subject: Follow Up Appt-Aug 30th

I am scheduled to have a follow up appointment on [redacted] but I do not see the point of driving an hour to [redacted] from my house. I haven't received any treatments or any new medications despite being told I would be given new medications from the VA for pain management. I have several appointments that I have not gotten reimbursed for travel pay so I see no need to add one more trip to that number. If you think this appointment is actually worth anything, please call me about it; otherwise I will just cancel it and be done with what the VA refers to as "Pain Management".

//

LOCAL TITLE: WHS INTEGRATED MEDICINE NOTE
STANDARD TITLE: INTEGRATIVE HEALTH NOTE
DATE OF NOTE: [redacted] ENTRY DATE: [redacted]
AUTHOR: [redacted] EXP COSIGNER:
URGENCY: STATUS: COMPLETED

Patient reports chronic back pain.

Confirmed ID by full name and SSN.

He had a back injury during PT in [redacted]
[redacted]
popping sensation, shooting pain sensation, to knee possibly
back issues since then
had an IM injection

tried to continue working, [redacted]
symptoms were getting worse

NTC in [redacted], slipped, fell out. rain.
on back, wearing full gear
5-6 ft.
knocked wind out of him.
evac - to hospital. ruled out fracture.
bedrest for 1 week. muscle relaxer, NSAIDs

pain got worse.
als started having pain in upper back
between [redacted]
neck pain
full spine MRI
DJD
was seeing chiropractor at [redacted] before training injury
was helping
once every 2 weeks

TENS

started getting
epidural injections after [redacted]
[redacted]
RFA - worse pain

Had RFA again in the last year, which did help for a short time, 3 months.

He also has numbness and tingling in his right hand, index finger and thumb. He

has been diagnosed with [redacted] He has braces but he has not been using them.

Medications:
tramadol 50mg tid prn.
takes 1 daily usually

Military: [redacted]

[redacted]

remote

Physical exam:
General: no acute distress
MSK: tenderness of paraspinal muscles, gluteus medius, piriformis, psoas. tight hamstrings.
Neuro: reflexes 2+, symmetric

Reviewed imaging, labs.

impression/plan:

1. myofascial pain
2. carpal tunnel syndrome

Continue tramadol.

Recommended using braces at night.

Follow up within 30 days.

/es/ [redacted]
Chief of Whole Health Service
Signed: [redacted]

ESTABLISHED PATIENT Mod Complex MDM or 30-39 min Related to: Service Connected Condition, Combat Veteran Related
Diagnoses:
Low back pain (SCT 279039007) - Low back pain (ICD-10-CM M54.5) (Primary)

//

LOCAL TITLE: WHS INTEGRATED MEDICINE TELEPHONE NOTE
STANDARD TITLE: INTEGRATIVE HEALTH NOTE
DATE OF NOTE: [redacted] ENTRY DATE: [redacted]
AUTHOR: [redacted] EXP COSIGNER:
URGENCY: STATUS: COMPLETED

Received message. Patient wanted to continue to be seen in the community for pain management.

He has a history of chronic neck and back pain.

He reports that he was being prescribed tramadol, in addition to having injections, RFA.

This regimen has been effective. He was supposed to have epidural in the community but this was cancelled because community care was not reauthorized.

He was seen in the VA pain clinic. Medications were not addressed.

He reports that he has to drive about [redacted] to get to the VA. He also is concerned that he cannot be seen in a timely way if he has an urgent issue.

He also reports that he has been diagnosed with [redacted]. He was informed that he should have an MRI for his cervical spine. He is claustrophobic - requests that he be sent to community care for MRI under sedation.

I will review available records, see patient in the clinic. Will continue his prescription at this time.

/es/ [redacted]
Chief of Whole Health Service
Signed: [redacted]

Procedures:
PHONE E/M 21-30 MIN (2 times)

//

Reference 24

[redacted]

From: [redacted]
Sent: Wednesday, February 24, 2021 3:24 PM
To: [redacted]
Cc: [redacted]
Subject: PMT

Dear colleagues,

Given that we are still negotiating the Service Agreement, I have decided that we must suspend the Pain Management Team's clinical role.

We can continue to meet to discuss strategy for implementation of Stepped Care for Pain Management and OUD.

As for patient care, we can continue to see them in our individual clinics and coordinate amongst ourselves when necessary.

With appreciation,

[redacted]

[redacted]
Clinical Director, Whole Health and Integrated Health Service
Central Texas VA Healthcare System

[redacted]

Reference 25

VHA Directive 1232 - Consult Processes and Procedures

Reference 26

Attachment 6 / OMI report TRIM 2021-C-29, pages 39-40, January 25, 2022.

Reference 27

From: [redacted]
To: [redacted]
Subject: RE: PATS-R: Pain consult
Date: Wednesday, December 15, 2021 2:25:32 PM

I reviewed her records. Please schedule for VVC for me on [redacted] at [redacted].

Thank you

[redacted]

From: [redacted]
Sent: 15 December 2021 14:08
To: [redacted]
Subject: PATS-R: Pain consult

Veteran: [redacted]

Whole Health - Pain Management - Temple - Patient states that she need help getting an appointment with Community Care for Pain Management. Patient states she been waiting to be seen by pain management since September when her Neurosurgery provider did a request for service. Patient state she was never offered community care referral on 9/7/21 when 12/23/21 appointment was scheduled and then later cancelled and moved to 12/17/21. Patient had to cancel the 12/17/21 appointment due to conflicting schedules and this time she was told she was not eligible to be referred to community and will have to wait till March 2022 to be seen.

There is a note from Pt Advocate stating he spoke with Vet and explained the Mission Care Act in detail.

Please contact Veteran to discuss her scheduling options.

Info needed for PATS-R system:

Dates of attempts and of contact with Vet
Resolution
Description of Vet's satisfaction with the resolution/plan

Thanks

[redacted]
Whole Health Clinical Care Supervisor
Central Texas Veterans Health Care System
[redacted]

[redacted]
Whole Health Hub (sharepoint.com)

VISN 17 Self-care calendar

From: [redacted]
To:
Subject: OSC investigation -- veteran affected
Date: Tuesday, October 5, 2021 8:33:00 AM

Hello [redacted]

Re:

[redacted]

This veteran's MHV message had been assigned to me previously.

I checked the chart in order to review so I could respond to the query, and I found that [redacted] had seen the patient.

I thought the veteran's message seemed odd, in that [redacted] **tends not** to promise veterans medications as the veteran's message seems to have conveyed.

When I reviewed further to try to make sense of that, I discovered that [redacted] **had seen the** veteran; I initially did not realize this, as his note titles do not take on **Bold-type appearance** with my "VIEW" Notes setting for **"Pain"** notes.

So, apparently, [redacted] had seen the patient; he apparently told the patient that he would be continuing his medication (seemingly, tramadol), and then he simply did not prescribe it.

As I had been in the chart with the purpose of responding to a secure message that had been assigned to me in the first place, I thought I would pass what I found on for investigation (I ended up reassigning the message to [redacted]).

Now, why is [redacted] seeing the veteran in the first place? Per [redacted] note: "Received message. Patient wanted to continue to be seen in the community for pain management." And per [redacted] note: He was supposed to have epidural in the community but this was cancelled because community care was not reauthorized.

I am not sure if [redacted] not sending this veteran the medication discussed was intentional or not; some possibilities follow.

- Maybe this is a technique to get veterans off of opioids.
- Maybe the medication is not actually due yet.
- Maybe he simply forgot.
- Maybe this is a pattern of [redacted], stating he is going to send veterans controlled substances that he discusses with them, only to not do it, perhaps with the forethought

to defer it to the Pain Management section physicians or other providers without their agreement, when the veteran shows up for a follow-up appointment. That way, if the veteran gets mad/complains/becomes hostile/violent to themselves or to other providers, the providers will feel coerced to enact [redacted] plan/preference for management, or receive complaints, discipline, or other harm.

To be clear, this is happening in the first place because:

- Tthe veteran's community care consult "was not reauthorized" — in line with the instructions to our section to process consult requests.
- Somehow, "Per [redacted] s note: "Received message. Patient wanted to continue to be seen in the community for pain management" becomes treated by [redacted] as a consult request to himself, apparently.
- [redacted] simply doesn't follow through with his own treatment plan.

Please see the below chart excerpts and the MHV message:

//

[redacted] TEM WHS CIH PAIN PHY1

//

Sent: [redacted]
[redacted] [redacted]
[redacted] [redacted] VA@
Message ID#: [redacted]
Subject: Follow Up Appt-Aug 30th

I am scheduled to have a follow up appointment on [redacted] but I do not see the point of driving an hour to Temple from my house. I haven't received any treatments or any new medications despite being told I would be given new medications from the VA for pain management. I have several appointments that I have not gotten reimbursed for travel pay so I see no need to add one more trip to that number. If you think this appointment is actually worth anything, please call me about it; otherwise I will just cancel it and be done with what the VA refers to as "Pain Management".

//

LOCAL TITLE: WHS INTEGRATED MEDICINE NOTE
STANDARD TITLE: INTEGRATIVE HEALTH NOTE
DATE OF NOTE: ENTRY DATE: [redacted]
AUTHOR: [redacted] EXP COSIGNER:
URGENCY: STATUS:
COMPLETED

Patient reports chronic back pain.

Confirmed ID by full name and SSN.

He had a back injury during PT in [redacted]
free weights - deadlift
popping sensation, shooting pain sensation, to knee possibly
back issues since then
had an IM injection

tried to continue working, full gear, marches
symptoms were getting worse

NTC in [redacted] 2015
fell when climbing [redacted], slipped, fell out. rain.
on back, wearing full gear
5-6 ft.
knocked wind out of him.
evac - to hospital. ruled out fracture.
bedrest for 1 week. muscle relaxer, NSAIDs

pain got worse.
als started having pain in upper back
between [redacted]
neck pain
full spine MRI
DJD
was seeing chiropractor at [redacted] before training injury
was helping
once every 2 weeks

TENS

started getting
epidural injections after 2nd injury - [redacted]
2015-18
RFA - worse pain

Had RFA again in the last year, which did help for a short time, 3 months.

He also has numbness and tingling in his right hand, index finger and thumb. He
has been diagnosed with [redacted]. He has braces but he has not been using them.

Medications:
tramadol 50mg tid prn.
takes 1 daily usually

Military: [redacted]
[redacted]
Data entry
[redacted]
remote

Physical exam:

General: no acute distress
MSK: tenderness of paraspinal muscles, gluteus medius, piriformis, psoas. tight
hamstrings.
Neuro: reflexes 2+, symmetric

Reviewed imaging, labs.

impression/plan:

1. myofascial pain
2. carpal tunnel syndrome

Continue tramadol.

Recommended using braces at night.

Follow up within 30 days.

/es/ [redacted]
Chief [redacted] Service
Signed: [redacted]

ESTABLISHED PATIENT Mod Complex MDM or 30-39 min Related to: Service Connected Condition, Combat Veteran Related
Diagnoses:
Low back pain (SCT 279039007) - Low back pain (ICD-10-CM M54.5) (Primary)

//

LOCAL TITLE: WHS INTEGRATED MEDICINE TELEPHONE NOTE
STANDARD TITLE: INTEGRATIVE HEALTH NOTE
DATE OF NOTE: ENTRY DATE: [redacted] [redacted]
AUTHOR: [redacted] EXP COSIGNER:
URGENCY: STATUS:
COMPLETED

Received message. Patient wanted to continue to be seen in the community for pain management.

He has a history of chronic neck and back pain.

He reports that he was being prescribed tramadol, in addition to having injections, RFA.

This regimen has been effective. He was supposed to have epidural in the community but this was cancelled because community care was not reauthorized.

He was seen in the VA pain clinic. Medications were not addressed.

He reports that he has to drive about [redacted] to get to the VA. He also is concerned that he cannot be seen in a timely way if he has an urgent issue.

He also reports that he has been diagnosed with [redacted]. He was
informed that he should have an MRI for his cervical spine. He is claustrophobic
- requests that he be sent to community care for MRI under sedation.

I will review available records, see patient in the clinic. Will continue his prescription at this time.

/es/ [redacted]
Chief [redacted] Service
Signed: [redacted]

Procedures:

PHONE E/M 21-30 MIN (2 times)

//

From: [redacted]
To:

Subject: HIMS Guidance
Date: Thursday, September 10, 2020 2:09:32 PM

I could not respond to the last message from [redacted] as it was locked. However, this is my response and it has not changed.

Thanks.

Good Afternoon All,

First of all, I would like to say, I am not and shall not seek or need an apology for anything. I would like for you to understand what I thought I was asked to do.
A) Review four cases and comment on the coding of these cases.
B) Respond on those cases
C) I was also asked if it was okay for another provider to reach out to the veteran prior to the IDT team conference meeting.

In that, it was explained (in writing) that the PMT Team Conference was rather an IDT team in nature and it was the intent to treat it like a team.

A)
As a coder, this was somewhat confusing because to be a true team conference – in the coding realm for IDT- all providers on the team **"In order to even qualify for correct code assignment of Medical Team Conference, CPT explicitly states that "reporting participants shall have performed face-to-face (or the PHE equivalent) evaluations or treatments of the patient, independent of any team conference, within the previous 60 days." As this reads, each participating provider should have had some contact with the patient prior to the conference, or it can't be coded as a conference. As such, the provider should "see" the patient prior to any conference and establish that relationship, recording the visit with whatever code fits the modality of care (i.e. audio only, VVC, or F2F)"**

Additionally, HIMS does not decide at all what is billable - That is the job of CPAC and the FRM. In none of my positions as a coder, have I ever been told or asked my opinions on billing. In Private Sector, Billing is determined by the business office and HIMS is not a part of that operation.

A. **Continued...**

PMT clinic of **07/07/2020**:
1. 08:00 **AM:** [redacted]
2. 09:00 AM
3. 10:00 AM:
4. 11:00 AM:

PMT clinic of 08/04/2020:
1. 08:00 AM: [redacted]
2. 09:00 AM
3. 10:00 AM:
4. 11:00 AM:

The above cases were reviewed. Please see our findings below:
1. If these were intended to be Consultations with [redacted] the Primary Care

Provider asking for his opinion and advise should be listed by name, address and phone number. While CPRS shows a request for a consult from various PharmD providers for the above patients, in each case, the documentation is addressed to an unlisted Primary Care Provider.

2. Documentation for a Consultation needs to satisfy all three of the elements – History, Exam and Medical Decision Making.
   a. During COVID 19 the exam portion has been exempted.
   b. History is documented as: Chief Complaint, History of Present Illness, Review of Systems, Past, Family and Social History. As previously stated, the documentation for all the above cases was excellent.
   c. Medical Decision Making was documented as:
      i. Previous Medical Records were reviewed.
      ii. Data reviewed was mentioned and met the criteria.
      iii. Number of Diagnoses and Management Options was met
3. In each of the above 07/07/2020 cases, the patient was contacted by [redacted] prior to the Conference Meeting. Patients had no prior contact from the conference participants for the 08/04/2020 cases.
4. During each conference it was attempted to contact the patient via phone. There was at least one time the phone call to the patient was not successful. A consultation CPT code 99243 was billed by [redacted] for each of the above cases. With no verbal or face to face contact with the patient it is difficult for the documentation to support a consultation CPT code.

B)
I answered the question, "Is it okay for a provider to reach out prior to the Team Meeting?" – my response was Yes. If the provider is performing services within their scope of practice and documents each service, they are able to see and treat patients.

C)
If there is no consultation process for the Whole Health Service, [redacted] would be able to see and treat patients as an active member of the PMT Conference Team. As per the guidelines below, each specialty can bill for their part of the team meeting. Each provider would need to document what they contributed to the treatment plan in order to take advantage of this billing opportunity.

With the above stated -

I did review your cases, and this is why I asked about the conference meetings and your "Team Approach". Your notes are well written, but the documentation states the purpose of the service was to provide a consultation service. That leads me to believe that you were wanting these cases to be more of a consult-based response rather than a "team approach". In order to be a Team Conference, all members must have firsthand knowledge of the patient and the patient must have knowledge of each of the providers on the team.

If you decide to use the consult approach, CPT codes 99241-99245 would apply. Is that your intent? From reading the documentation, it appears that one person asked the questions, that same person authored the note and it is receipt acknowledged by the remaining participants. That does not constitute a team conference service, CPT code 99367 – 99368.

In conclusion, we are not finding the supporting documentation to code a consultation or a team conference CPT code. The above services do not meet the documentation criteria for either code series. However, according to the VHA Pain Management Directive 2009-053 the PMT Conference Meeting is an integral part of how patients are treated for pain management. This is a mandate from the VA itself. The facility/organization is giving the directive that this team approach with a "Consultation" type of service is how pain management operates. In this case, we would ask each provider to perform services if medically necessary, document that service individually and bill according to the service that is rendered. During the PMT Team Conference the members come together for peer review, studying and discussing this case with the group and to resolve any roadblocks by utilizing each member's experience. This would **not** be a billable service but would instead be used to expedite the care of the patient.

[redacted]

[redacted]

Health Information Management Section/MAS
Central Texas Veterans Health Care System

[redacted]

Effective Communication begins with all of us!

Suicide Prevention is Everyone's Business

From: [redacted]
To:
Cc:
Subject: RE: HIMS Guidance Needed
Date: Thursday, September 3, 2020 11:17:24 AM

Hi;

Please write out your concerns/questions, but cease from any further emails about this for now. We can schedule a meeting to discuss those when [redacted] returns. I'm not completely following what the problem is, but let's de-escalate the perception below, so please refrain from answering any further emails on this thread. Thanks

From: [redacted]
Sent: Thursday, September 3, 2020 11:11 AM
To: [redacted]
Cc: [redacted]
Subject: FW: HIMS Guidance Needed
Importance: High

I agree with [redacted] Please cease [redacted] is on leave now through Sep 8th. I am adding [redacted] the Deputy Assoc Chief of Staff for Surgical Service, to this email.

Thank you,

[redacted]
Administrative Officer, Surgical Service
Central Texas Veterans Health Care System
[redacted]

From: [redacted]
Sent: Thursday, September 3, 2020 10:39 AM
To: [redacted]
Subject: FW: HIMS Guidance Needed

This is truly getting out of hand. The tone is extremely disrespectful of [redacted] expertise.

I would like someone to ask [redacted] to desist from continuing this exchange.

As for the PMT being "highly effective", I would say that this has not been the feedback that I have heard from members of the PMT, patients, ambulatory care providers and leadership, or the veterans' experience service, insofar as pain management is concerned.

PMT may have been effective in decreasing opioid prescribing, but that does not mean that veterans are not obtaining opioids illicitly, or that their pain is adequately treated.

Respectfully,

[redacted]

From: [redacted]
Sent: Thursday, September 3, 2020 10:30 AM
To: [redacted]
Cc: [redacted]
Subject: Re: HIMS Guidance Needed

Hello [redacted]

I have to say that I feel your replies and comments do not seem to incorporate the CPT coding wording, the queries presented to you, or an adequate understanding of the peculiarities of IDT.

According to the CPT excerpt on Medical Team conferences, please be aware of:

"Individuals should not report 99366-99368 when their participation in the medical team conference is part of a facility or organizational service contractually provided by the organization or facility."

Our PMT, as the other PMTs at VA centers across the country, exist because they are mandated by CARA legislation. The PMT by its very nature is different than the "usual" IDTs you reference.

HIMS cannot take a stance that it does not determine what is billable citing "other factors" while simultaneously suggesting an alteration of approach. HIMS directly comments on matters related to coding which plays into billing. Consistency of coding plays into billing. These issues necessitate comment from HIMS. Comments on "good" care or "effective" care are not really relevant here. Our PMT has been *highly* effective.

Nearly all of my other queries have additionally gone unanswered.

I noticed that [redacted] asked you "Is the question can PMT members contact the patient before the PMT meeting?" at 2:07pm.

I see she wrote you again at 1:00pm.

May I ask, what was your reply in between (to the question posed at 2.07pm)?

It helps to understand the context of what [redacted] was trying to answer.

The questions you had asked at the end of the day yesterday were important ones to ask in order to begin to understand all of the questions at play here. But I cannot help but feel you had already decided your approach to response on these matters prior to asking the important questions you ended up asking.

We really need clarification here and all of these questions answered — exactly because our PMT is dedicated to continuing to provide the excellent care that we do.

[redacted] [redacted]

Be well,

[redacted]

Get Outlook for iOS

From: [redacted]
Sent: Thursday, September 3, 2020 8:47:32 AM
To: [redacted]
Cc: [redacted]
Subject: RE. HIMS Guidance Needed

Thank you so much for that answer.

[redacted] [redacted]

This spars another question, if all the participates in the team have not seen the patient or have first hand knowledge of the patient, how can we really conduct a collaborative and effective treatment plan. is the patient always (phone, video, person) or their representative , present?

Usually, IDT teams consist of disciplines that have a full knowledge of patient needs, expectations and goals. The team is known by the patient, in most cases, and is very effective in the care of the patient.

The documentation of the team is very individualized and very beneficial to the care rendered and treatment needs, expectations and goals of the providers.

So with this new information, you all might want to explore another option for this team.

[redacted]

[redacted]
Health Information Management Section/MAS
Central Texas Veterans Health Care System
[redacted]

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From: [redacted]
Sent: Wednesday, September 2, 2020 3:49 PM
To: [redacted]
Cc: [redacted]
Subject: Re: HIMS Guidance Needed

Hello [redacted]

Is the PMT team considered IDT in nature. —

Yes.

if it is have all of the providers on the team seen the patient within 60 days of IDT team date?

No.

It is possible that 1 or 2 of the team's providers may have seen the veteran beforehand, if they had had a prior relationship "randomly" (e.g. a consult is independently requested of me, and the veteran sees me in interventional pain, and subsequently, the veteran is identified/referred for IDT).

If IDT in nature, do all the participate have first line knowledge of the patient in the respect of their discipline?

No.

I am reading your question above to mean "Have all of the providers already been individually requested to see the veteran in consultation, and have those visits already occurred and care been independently established with all providers on the team prior to the IDT meeting?"

[redacted]

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From: [redacted]
Sent: Wednesday, September 2, 2020 3:26 PM
To: [redacted]
Cc:
Subject: RE: HIMS Guidance Needed

Asking for clarification on a few items:

On the PMT Team –

Questions:

Is the PMT team considered IDT in nature, if it is have all of the providers on the team seen the patient within 60 days of IDT team code?

If IDT in nature, do all the participants have first hand knowledge of the patient in the review of their discipline?

[redacted]

[redacted]
Health Information Management Section/MAS
Central Texas Veterans Health Care System
[redacted]

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From: [redacted]
Sent: Wednesday, September 2, 2020 12:09 PM
To: [redacted]
Cc: [redacted]
Subject: RE: IDMS Guidance Needed

Thank you [redacted]

Please send all the email below as presented with the attachment that I included in the first email. Also, please include me on the correspondence as they may need further clarification and may have questions I may answer regarding the team function and operation.

Sincerely,
[redacted]

From: [redacted]
Sent: Wednesday, September 2, 2020 12:03 PM
To: [redacted]
Cc: [redacted]
Subject: RE: HIMS Guidance Needed

I will send this off for an "official response" to the National Office, as your requested, it will take some time, but hopefully we can receive an answer back quickly so this can be resolved.

[redacted]
Health Information Management Section/MAS
Central Texas Veterans Health Care System
[redacted]

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From: [redacted]
Sent: Wednesday, September 2, 2020 11:50 AM
To: [redacted]

[redacted]
Cc: [redacted]
Subject: RE: HIMS Guidance Needed
Importance: High

I agree with [redacted] comments. I do not believe that our inquiry into this topic has been satisfactorily addressed. All we are seeking are the facts and good guidance regarding this issue. [redacted] please guide us as to whom we may escalate these questions, or should we refer this to an outside expert?

Sincerely,
[redacted]

From: [redacted]
Sent: Wednesday, September 2, 2020 11:30 AM
To: [redacted]
Cc: [redacted]
Subject: Re: HIMS Guidance Needed

Hello [redacted]

I brought up several specific questions and concerns in my prior emails.

I do not feel that most of them have been addressed.

Please indicate to me to whom I can escalate my remaining questions and concerns.

Thank you,

[redacted]

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From: [redacted]
Sent: Wednesday, September 2, 2020 11:25:19 AM
To: [redacted]
[redacted]
Cc: [redacted]
Subject: RE: HIMS Guidance Needed

This was answered in the last email.

[redacted]

[redacted]
Health Information Management Section/MAS
Central Texas Veterans Health Care System
[redacted]

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From: [redacted]
Sent: Wednesday, September 2, 2020 11:18 AM
To: [redacted]
Raj
[redacted]
Cc: [redacted]

Subject: Re: HIMS Guidance Needed

Hello [redacted]

So it looks like we could very much use clarification between what constitutes:

"consult with the patient individually, prior to a team meeting, without having been requested individually to do so"

And

"reach out to the patient and talk to them."

From my review of the prior-to-team meeting provider "consults/talking-to-patients" encounters that are being specifically discussed right now, the interaction looks far more like an "unrequested individual consult" than a "talking-to."

It may be helpful for HIMS to review specific prior instances of this to determine more clearly.

I unfortunately do not have veteran names/last4s right now to share from prior. but maybe we could get you some veteran charts to review.

If you can also speak to the other issues brought up, I would very much appreciate it.

Thank you for your attention in this.

[redacted]

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From: [redacted]
Sent: Wednesday, September 2, 2020 11:06 AM
To: [redacted]
Cc: [redacted]
Subject: RE: HIMS Guidance Needed

Hi [redacted]

I want to make sure I understand what you are saying.

Are you saying:

(1) You can consult with the patient individually, prior to a team meeting, without having been requested individually to do so (individual request for consultation was not made)? **No, I stated that you can reach out to the patient and talk to them, *but if you do this is Historical and NOT billable or coded.***

Or

(2) You can have a non-clinician perform an objective, predefined intake (not evaluation, not management, not rapport-building) prior to a requested team meeting that has been requested

If #1, then I would like you to speak specifically to the possibility of differential billing.

If in other scenarios, the degree of interaction undertaken during such a telephone call desired would be otherwise billable, then we MUST bill and code the interaction. If we don't, then it is discriminatory to bill (regardless of the "currency") some veterans, while not billing others for the same service provided because it suits our purpose(s).

If so, we cannot have such an interaction without an individual consult, anymore than I can walk into an inpatient room and perform a consultation without being requested.

On a side note, just as it would be considered fraudulent to overbill/overcode, it is also fraudulent to underbill/undercode.

Please address all of these issues. When I have encountered the same question in similar scenarios in the past, we had not been able to proceed in such a fashion...

It is important to view this from all angles, and we want to be certain.

[redacted]

[redacted]

[redacted]

Health Information Management Section/MAS [redacted]
Central Texas Veterans Health Care System

[redacted]

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From: [redacted]
Sent: Wednesday, September 2, 2020 10:58 AM
To: [redacted]
Cc: [redacted]
Subject: Re: HIMS Guidance Needed

Hi [redacted]

I want to make sure I understand what you are saying.

Are you saying:

(1) You can consult with the patient individually, prior to a team meeting, without having been requested individually to do so (individual request for consultation was not made)?

Or

(2) You can have a non-clinician perform an objective, predefined intake (not evaluation, not management, not rapport-building) prior to a requested team meeting that has been requested.

If #1, then I would like you to speak specifically to the possibility of differential billing.

If in other scenarios, the degree of interaction undertaken during such a telephone call desired would be otherwise billable, then we MUST bill and code the interaction. If we don't, then it is discriminatory to bill (regardless of the "currency") some veterans, while not billing others for the same service provided because it suits our purpose(s).

If so, we cannot have such an interaction without an individual consult, anymore than I can walk into an inpatient room and perform a consultation without being requested.

On a side note, just as it would be considered fraudulent to overbill/overcode, it is also fraudulent to underbill/undercode.

Please address all of these issues. When I have encountered the same question in similar scenarios in the past, we had not been able to proceed in such a fashion...

It is important to view this from all angles, and we want to be certain.

[redacted]

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From: [redacted]
Sent: Wednesday, September 2, 2020 10:37:24 AM
To: [redacted]
Cc: [redacted]
Subject: RE: HIMS Guidance Needed

Thank you [redacted] this would be correct. The information captured before hand, if any, should be non count and NOT be codable.

[redacted]

[redacted]
Health Information Management Section/MAS
Central Texas Veterans Health Care System
[redacted]

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From: [redacted]
Sent: Wednesday, September 2, 2020 10:09 AM
To: [redacted]
Cc: [redacted]
Subject: RE: HIMS Guidance Needed

It seems like this could be addressed as a non-count telephone visit. It is helpful to collect information from a patient before the meeting, both to compare the patient's narrative to the medical record, and to establish rapport.

Respectfully,

[redacted]

From: [redacted]
Sent: Wednesday, September 2, 2020 10:05 AM
To: [redacted]
Cc: [redacted]
Subject: HIMS Guidance Needed
Importance: High

[redacted] (HIMS),

I understand that some of the Pain management Team (PMT) members desire to contact the patients before the PMT meeting. I cannot endorse or deny that. I am no expert on billing or CPT coding, therefore, I have relayed this responsibility to our experts at Health Information Management Service (HIMS) to recommend. Currently

my understanding is as follows.

1. If you already have an established relation with the patient, then you have to see the patient within the last 60 days before the PMT meeting through the independent consultation process that is issued to your clinic and not through the PMT group consultation.

1. If you do not already have an established relation with the patient through another consultation that is specifically issued to your clinic and that is independent of the PMT group consultation, then you ought to see the patient within the PMT meeting only and not before or after the meeting. You may, however, see the patient after the meeting if you are specifically consulted to do so depending on the recommendations of the PMT and the approval of the patient to such a consultation.

I attach to this email an excerpt from the 2019 AMA CPT Guidebook on "Medical Team Conferences."
Please give us your final decision on this matter. We need definite guidance in this area.

Sincerely,
[redacted]

From: [redacted]
To:
Cc:
Subject: FW: IDT Team Conference Question/clarification
Date: Thursday, September 3, 2020 8:56:25 AM
Importance: High

Good Morning Team –

As I promised, here is the information from HIMS National. If you will remember, I had to ask you some questions yesterday about the process and the PMT in nature.

See the response below.

[redacted]

[redacted]
Health Information Management Section/MAS
Central Texas Veterans Health Care System
[redacted]

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From: [redacted]
Sent: Wednesday, September 2, 2020 4:00 PM
To: [redacted]
Subject: RE: IDT Team Conference Question/clarification

First, HIM does not determine what is billable. That is dependant on other factors besides coding.

In order to even qualify for correct code assignment of Medical Team Conference, CPT explicitly states that "reporting participants shall have performed face-to-face (or the PHE equivalent) evaluations or treatments of the patient, independent of any team conference, within the previous 60 days." As this reads, each participating provider should have had some contact with the patient prior to the conference, or it can't be coded as a conference. As such, the provider should "see" the patient prior to any conference and establish that relationship, recording the visit with whatever code fits the modality of care (i.e. audio only, VVC, or F2F)

From [redacted]
Sent: Wednesday, September 2, 2020 2:07 PM
To: [redacted]

Subject: RE: IDT Team Conference Question/clarification

I'm not sure I understand exactly what your question is? Is the question can PMT members contact the patient before the PMT meeting?

From: [redacted]
Sent: Wednesday, September 2, 2020 12:09 PM
To: [redacted]
Subject: IDT Team Conference Question/clarification
Importance: High

At Central Texas, I have a couple of questions.

Can members of an "IDT" (our case the Pain management Team (PMT)) contact the patient prior to the meeting for informational and rapport building? If so could that or would that be a codable and "potential workload" option?

AMA CPT 2020 requires on Medical Team Conference:

1. If you already have an established relation with the patient, then you have to see the patient within the last 60 days before the PMT meeting through the independent consultation process that is issued to your clinic and not through the PMT group consultation.

1. If you do not already have an established relation with the patient through another consultation that is specifically issued to your clinic and that is independent of the PMT group consultation, then you ought to see the patient within the PMT meeting only and not before or after the meeting. You may, however, see the patient after the meeting if you are specifically consulted to do so depending on the recommendations of the PMT and the approval of the patient to such a consultation.

Some more question, have spared from this as well. Can you please address these below, separately.

(1) You can consult with the patient individually, prior to a team meeting, without having been requested individually to do so (Individual request for consultation was not made)? (can you gather any information at all from the patient and document it – or do you have to rely on the medical record as a sole source)

Or

(2) You can have a non-clinician perform an objective, predefined intake (not evaluation, not management, not rapport-building) prior to a requested team meeting that has been requested.

If #1, then I would like you to speak specifically to the possibility of differential billing.

If in other scenarios, the degree of interaction undertaken during such a telephone call desired would be otherwise billable, then we MUST bill and code the interaction. If we don't, then it is discriminatory to bill (regardless of the "currency") some veterans, while not billing others for the same service provided because it suits our purpose(s).

If so, we cannot have such an interaction without an individual consult, anymore than one can walk into an inpatient room and perform a consultation without being requested.

On a side note, just as it would be considered fraudulent to overbill/overcode, it is also fraudulent to underbill/undercode.

Please address all of these issues; it is important to view this from all angles, and we want to be certain.

[redacted]

[redacted]

[redacted]

Health Information Management Section/MAS
Central Texas Veterans Health Care System

[redacted]

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[redacted]

From: [redacted]
To: [redacted]
Subject: HIMS Guidance
Date: Thursday, September 10, 2020 2:09:32 PM

I could not respond to the last message from [redacted] as it was locked. However, this is my response and it has not changed.

Thanks.

Good Afternoon All,

First of all, I would like to say, I am not and shall not seek or need an apology for anything. I would like for you to understand what I thought I was asked to do.
A) Review four cases and comment on the coding of these cases.
B) Respond on those cases
C) I was also asked if it was okay for another provider to reach out to the veteran prior to the IDT team conference meeting.

In that, it was explained (in writing) that the PMT Team Conference was rather an IDT team in nature and it was the intent to treat it like a team.

A)
As a coder, this was somewhat confusing because to be a true team conference – in the coding realm for IDT- all providers on the team **"In order to even qualify for correct code assignment of Medical Team Conference, CPT explicitly states that "reporting participants shall have performed face-to-face (or the PHE equivalent) evaluations or treatments of the patient, independent of any team conference, within the previous 60 days." As this reads, each participating provider should have had some contact with the patient prior to the conference, or it can't be coded as a conference. As such, the provider should "see" the patient prior to any conference and establish that relationship, recording the visit with whatever code fits the modality of care (i.e. audio only, VVC, or F2F)"**

Additionally, HIMS does not decide at all what is billable - That is the job of CPAC and the FRM. In none of my positions as a coder, have I ever been told or asked my opinions on billing. In Private Sector, Billing is determined by the business office and HIMS is not a part of that operation.

A. **Continued...**

PMT clinic of **07/07/2020**:
1. 08:00 **AM**:
2. 09:00 AM
3. 10:00 AM:
4. 11:00 AM:

[redacted]

PMT clinic of **08/04/2020**:
1. 08:00 **AM**:
2. 09:00 AM
3. 10:00 AM:
4. 11:00 AM:

[redacted]

The above cases were reviewed. Please see our findings below:
1. If these were intended to be Consultations with [redacted], the Primary Care

Provider asking for his opinion and advise should be listed by name, address and phone number. While CPRS shows a request for a consult from various PharmD providers for the above patients, in each case, the documentation is addressed to an unlisted Primary Care Provider.

2. Documentation for a Consultation needs to satisfy all three of the elements – History, Exam and Medical Decision Making.
    a. During COVID 19 the exam portion has been exempted.
    b. History is documented as: Chief Complaint, History of Present Illness, Review of Systems, Past, Family and Social History. As previously stated, the documentation for all the above cases was excellent.
    c. Medical Decision Making was documented as:
        i. Previous Medical Records were reviewed.
        ii. Data reviewed was mentioned and met the criteria.
        iii. Number of Diagnoses and Management Options was met
3. In each of the above 07/07/2020 cases, the patient was contacted by [redacted] prior to the Conference Meeting. Patients had no prior contact from the conference participants for the 08/04/2020 cases.
4. During each conference it was attempted to contact the patient via phone. There was at least one time the phone call to the patient was not successful. A consultation CPT code 99243 was billed by [redacted] for each of the above cases. With no verbal or face to face contact with the patient it is difficult for the documentation to support a consultation CPT code.

B)
I answered the question, "Is it okay for a provider to reach out prior to the Team Meeting?" – my response was Yes. If the provider is performing services within their scope of practice and documents each service, they are able to see and treat patients.

C)
If there is no consultation process for the Whole Health Service, [redacted] would be able to see and treat patients as an active member of the PMT Conference Team. As per the guidelines below, each specialty can bill for their part of the team meeting. Each provider would need to document what they contributed to the treatment plan in order to take advantage of this billing opportunity.

With the above stated -

I did review your cases, and this is why I asked about the conference meetings and your "Team Approach". Your notes are well written, but the documentation states the purpose of the service was to provide a consultation service. That leads me to believe that you were wanting these cases to be more of a consult-based response rather than a "team approach". In order to be a Team Conference, all members must have firsthand knowledge of the patient and the patient must have knowledge of each of the providers on the team.

If you decide to use the consult approach, CPT codes 99241-99245 would apply. Is that your intent? From reading the documentation, it appears that one person asked the questions, that same person authored the note and it is receipt acknowledged by the remaining participants. That does not constitute a team conference service, CPT code 99367 – 99368.

In conclusion, we are not finding the supporting documentation to code a consultation or a team conference CPT code. The above services do not meet the documentation criteria for either code series. However, according to the VHA Pain Management Directive 2009-053 the PMT Conference Meeting is an integral part of how patients are treated for pain management. This is a mandate from the VA itself. The facility/organization is giving the directive that this team approach with a "Consultation" type of service is how pain management operates. In this case, we would ask each provider to perform services if medically necessary, document that service individually and bill according to the service that is rendered. During the PMT Team Conference the members come together for peer review, studying and discussing this case with the group and to resolve any roadblocks by utilizing each member's experience. This would **not** be a billable service but would instead be used to expedite the care of the patient.

[redacted]

[redacted]

Health Information Management Section/MAS

Central Texas Veterans Health Care System

[redacted]

Effective Communication begins with [redacted]

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From: [redacted]
To:
Cc:
Subject: RE: HIMS Guidance Needed
Date: Thursday, September 3, 2020 11:17:24 AM

Hi;

Please write out your concerns/questions, but cease from any further emails about this for now. We can schedule a meeting to discuss those when [redacted] returns. I'm not completely following what the problem is, but let's de-escalate the perception below, so please refrain from answering any further emails on this thread. Thanks

From: [redacted]
Sent: Thursday, September 3, 2020 11:11 AM
To: [redacted]
Cc [redacted]
Subject: FW: HIMS Guidance Needed
Importance: High

I agree with [redacted] Please cease. [redacted] is on leave now through Sep 8th. I am adding [redacted], the Deputy Assoc Chief of Staff for Surgical Service, to this email.

Thank you,

[redacted]
Administrative Officer, Surgical Service
Central Texas Veterans Health Care System
Temple, TX
[redacted]

From: [redacted]
Sent: Thursday, September 3, 2020 10:39 AM
To: [redacted]
Subject: FW: HIMS Guidance Needed

This is truly getting out of hand. The tone is extremely disrespectful of [redacted] expertise.

I would like someone to ask [redacted] to desist from continuing this exchange.

As for the PMT being "highly effective", I would say that this has not been the feedback that I have heard from members of the PMT, patients, ambulatory care providers and leadership, or the veterans' experience service, insofar as pain management is concerned.

PMT may have been effective in decreasing opioid prescribing, but that does not mean that veterans are not obtaining opioids illicitly, or that their pain is adequately treated.

Respectfully,

[redacted]

From: [redacted]
Sent: Thursday, September 3, 2020 10:30 AM
To: [redacted]
Cc: [redacted]
Subject: Re: HIMS Guidance Needed

Hello [redacted]

I have to say that I feel your replies and comments do not seem to incorporate the CPT coding wording, the queries presented to you, or an adequate understanding of the peculiarities of IDT.

According to the CPT excerpt on Medical Team conferences, please be aware of:

"Individuals should not report 99366-99368 when their participation in the medical team conference is part of a facility or organizational service contractually provided by the organization or facility."

Our PMT, as the other PMTs at VA centers across the country, exist because they are mandated by CARA legislation. The PMT by its very nature is different than the "usual" IDTs you reference.

HIMS cannot take a stance that it does not determine what is billable citing "other factors" while simultaneously suggesting an alteration of approach. HIMS directly comments on matters related to coding which plays into billing. Consistency of coding plays into billing. These issues necessitate comment from HIMS. Comments on "good" care or "effective" care are not really relevant here. Our PMT has been *highly* effective.

Nearly all of my other queries have additionally gone unanswered.

I noticed that [redacted] asked you "Is the question can PMT members contact the patient before the PMT meeting?" at 2:07pm.

I see she wrote you again at 4:00pm.

May I ask, what was your reply in between (to the question posed at 2:07pm)?

It helps to understand the context of what [redacted] was trying to answer.

The questions you had asked at the end of the day yesterday were important ones to ask in order to begin to understand all of the questions at play here. But I cannot help but feel you had already decided your approach to response on these matters prior to asking the important questions you ended up asking.

We really need clarification here and all of these questions answered - - exactly because our PMT is dedicated to continuing to provide the excellent care that we do.

Be well.

[redacted]

Get Outlook for iOS

From: [redacted]
Sent: Thursday, September 3, 2020 @ 47:32 AM
To: [redacted]
Cc: [redacted]
Subject: RE: HIMS Guidance Needed

Thank you so much for that answer.

This spurs another question, if all the participates in the team have not seen the patient or have first hand knowledge of the patient, how can we really conduct a collaborative and effective treatment plan. Is the patient always (phone, video, person) or their representative, present?

Usually, IDT teams consist of disciplines that have a full knowledge of patient needs, expectations and goals. The team is known by the patient, in most cases, and is very effective in the care of the patient.

The documentation of the team is very individualized and very beneficial to the care rendered and treatment needs, expectations and goals of the providers.

So with this new information, you all might want to explore another option for this team.

[redacted]

[redacted]
Health Information Management Section/MAS
Central Texas Veterans Health Care System
[redacted]

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From: [redacted]
Sent: Wednesday, September 2, 2020 3:49 PM
To: [redacted]
Cc: [redacted]
Subject: Re: HIMS Guidance Needed

Hello [redacted]

Is the PMT team considered IDT in nature, —

Yes.

if it is have all of the providers on the team seen the patient within 60 days of IDT team date?

No.

It is possible that 1 or 2 of the team's providers may have seen the veteran beforehand, if they had had a prior relationship "randomly" (e.g. a consult is independently requested of me, and the veteran sees me in interventional pain, and subsequently, the veteran is identified/referred for IDT).

If IDT in nature, do all the participate have first line knowledge of the patient in the respect of their discipline?

No.

I am reading your question above to mean "Have all of the providers already been individually requested to see the veteran in consultation, and have those visits already occurred and care been independently established with all providers on the team prior to the IDT meeting?"

[redacted]

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From: [redacted]
Sent: Wednesday, September 2, 2020 3:26 PM
To: [redacted]
Cc: [redacted]
Subject: RE: HIMS Guidance Needed

Asking for clarification on a few items:

On the PMT Team –

Questions:

Is the PMT team considered IDT in nature, if it is have all of the providers on the team seen the patient within 60 days of IDT team date?

If IDT in nature, do all the participate have first line knowledge of the patient in the respect of their discipline?

[redacted]

[redacted]
Health Information Management Section/MAS
Central Texas Veterans Health Care System
[redacted]

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From: [redacted]
Sent: Wednesday, September 2, 2020 12:09 PM
To: [redacted]
Cc: [redacted]
Subject: RE: HIMS Guidance Needed

Thank you [redacted]

Please send all the email below as presented with the attachment that I included in the first emai. Also, please include me on the correspondence as they may need further clarification and may have questions I may answer regarding the team function and operation.

Sincerely,
[redacted]

From: [redacted]
Sent: Wednesday, September 2, 2020 12:03 PM
To: [redacted]
Cc: [redacted]
Subject: RE: HIMS Guidance Needed

I will send this off for an "official response" to the National Office, as your requested. It will take some time, but hopefully we can receive an answer back quickly so this can be resolved.

[redacted]

[redacted]
Health Information Management Section/IMAS
Central Texas Veterans Health Care System
[redacted]

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From: [redacted]
Sent: Wednesday, September 2, 2020 11:50 AM
To: [redacted]

[redacted]
Cc: [redacted]
Subject: RE: HIMS Guidance Needed
Importance: High

I agree with [redacted] comments. I do not believe that our inquiry into this topic has been satisfactorily addressed. All we are seeking are the facts and good guidance regarding this issue [redacted] please guide us as to whom we may escalate these questions, or should we refer this to an outside expert?

Sincerely,
[redacted]

From: [redacted]
Sent: Wednesday, September 2, 2020 11:30 AM
To: [redacted]
Cc: [redacted]
Subject: Re: HIMS Guidance Needed

Hello [redacted]

I brought up several specific questions and concerns in my prior emails.

I do not feel that most of them have been addressed.

Please indicate to me to whom I can escalate my remaining questions and concerns.

Thank you,

[redacted]

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From: [redacted]
Sent: Wednesday, September 2, 2020 11:25:06 AM
To: [redacted]
Cc: [redacted]
Subject: RE: HIMS Guidance Needed

[redacted]

[redacted]
Health Information Management Section/IRMS
Central Texas Veterans Health Care System
[redacted]

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From: [redacted]
Sent: Wednesday, September 2, 2020 11:18 AM
To: [redacted]
Cc: [redacted]

Subject: Re: HIMS Guidance Needed

Hello [redacted]

So it looks like we could very much use clarification between what constitutes:

"consult with the patient individually, prior to a team meeting, without having been requested individually to do so"

And

"reach out to the patient and talk to them."

From my review of the prior-to-team meeting provider "consults/talking-to-patients" encounters that are being specifically discussed right now, the interaction looks far more like an "unrequested individual consult" than a "talking-to."

It may be helpful for HIMS to review specific prior instances of this to determine more clearly.

I unfortunately do not have veteran names/last4s right now to share from prior, but maybe we could get you some veteran charts to review.

If you can also speak to the other issues brought up, I would very much appreciate it.

Thank you for your attention in this.

[redacted]

Get Outlook for iOS

From: [redacted]
Sent: Wednesday, September 2, 2020 11:06 AM
To: [redacted]
Cc: [redacted]
Subject: RE: HIMS Guidance Needed

Hi [redacted]

I want to make sure I understand what you are saying.

Are you saying:

(1) You can consult with the patient individually, prior to a team meeting, without having been requested individually to do so (individual request for consultation was not made)? **No, I stated that you can reach out to the patient and talk to them, *but if you do this is Historical and NOT billable or coded.***

Or

(2) You can have a non-clinician perform an objective, predefined intake (not evaluation, not management, not rapport-building) prior to a requested team meeting that has been requested.

If #1, then I would like you to speak specifically to the possibility of differential billing.

If in other scenarios, the degree of interaction undertaken during such a telephone call desired would be otherwise billable, then we MUST bill and code the interaction. If we don't, then it is discriminatory to bill (regardless of the "currency") some veterans, while not billing others for the same service provided because it suits our purpose(s).

If so, we cannot have such an interaction without an individual consult, anymore than I can walk into an inpatient room and perform a consultation without being requested.

On a side note, just as it would be considered fraudulent to overbill/overcode, it is also fraudulent to underbill/undercode.

Please address all of these issues. When I have encountered the same question in similar scenarios in the past, we had not been able to proceed in such a fashion...

It is important to view this from all angles, and we want to be certain.

[redacted]

[redacted]

[redacted]

Health Information Management Section/MAS
Central Texas Veterans Health Care System

[redacted]

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From: [redacted]
Sent: Wednesday, September 2, 2020 10:58 AM
To: [redacted]
Cc: [redacted]
Subject: Re: HIMS Guidance Needed

Hi [redacted]

I want to make sure I understand what you are saying.

Are you saying:

(1) You can consult with the patient individually, prior to a team meeting, without having been requested individually to do so (individual request for consultation was not made)?

Or

(2) You can have a non-clinician perform an objective, predefined intake (not evaluation, not management, not rapport-building) prior to a requested team meeting that has been requested.

If #1, then I would like you to speak specifically to the possibility of differential billing.

If in other scenarios, the degree of interaction undertaken during such a telephone call desired would be otherwise billable, then we MUST bill and code the interaction. If we don't, then it is discriminatory to bill (regardless of the "currency") some veterans, while not billing others for the same service provided because it suits our purpose(s).

If so, we cannot have such an interaction without an individual consult, anymore than I can walk into an inpatient room and perform a consultation without being requested.

On a side note, just as it would be considered fraudulent to overbill/overcode, it is also fraudulent to underbill/undercode.

Please address all of these issues. When I have encountered the same question in similar scenarios in the past, we had not been able to proceed in such a fashion..

It is important to view this from all angles, and we want to be certain.

[redacted]

Get Outlook for iOS

From: [redacted]
Sent: Wednesday, September 2, 2020 10:37:24 AM
To: [redacted]
Cc: [redacted]
Subject: RE: HIMS Guidance Needed

Thank you [redacted] this would be correct. The information captured before hand, if any, should be non count and NOT be codable.

[redacted]

[redacted]
Health Information Management Section/MAS
Central Texas Veterans Health Care System
[redacted]

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From: [redacted]
Sent: Wednesday, September 2, 2020 10:09 AM
To: [redacted]
Cc: [redacted]
Subject: RE: HIMS Guidance Needed

It seems like this could be addressed as a non-count telephone visit. It is helpful to collect information from a patient before the meeting, both to compare the patient's narrative to the medical record, and to establish rapport.

Respectfully,

[redacted]

From: [redacted]
Sent: Wednesday, September 2, 2020 10:05 AM
To: [redacted]
Cc: [redacted]
Subject: HIMS Guidance Needed
Importance: High

[redacted] (HIMS),

I understand that some of the Pain management Team (PMT) members desire to contact the patients before the PMT meeting. I cannot endorse or deny that. I am no expert on billing or CPT coding; therefore, I have relayed this responsibility to our experts at Health Information Management Service (HIMS) to recommend. Currently

my understanding is as follows:

1. If you already have an established relation with the patient, then you have to see the patient within the last 60 days before the PMT meeting through the independent consultation process that is issued to your clinic and not through the PMT group consultation.

1. If you do not already have an established relation with the patient through another consultation that is specifically issued to your clinic and that is independent of the PMT group consultation, then you ought to see the patient within the PMT meeting only and not before or after the meeting. You may, however, see the patient after the meeting if you are specifically consulted to do so depending on the recommendations of the PMT and the approval of the patient to such a consultation.

I attach to this email an excerpt from the 2019 AMA CPT Guidebook on "Medical Team Conferences."
Please give us your final decision on this matter. We need definite guidance in this area.

Sincerely,
[redacted]

From: [redacted]
To: [redacted]
Cc: [redacted]
Subject: FW: IDT Team Conference Question/clarification
Date: Thursday, September 3, 2020 8:56:25 AM
Importance: High

Good Morning Team –

As I promised, here is the information from HIMS National. If you will remember, I had to ask you some questions yesterday about the process and the PMT in nature.

See the response belaw….

[redacted]

[redacted]
Health Information Management Section/MAS
Central Texas Veterans Health Care System
[redacted]

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From: [redacted]
Sent: Wednesday, September 2, 2020 4:00 PM
To: [redacted]
Subject: RE: IDT Team Conference Question/clarification

First, HIM does not determine what is billable. That is dependent on other factors besides coding.

In order to even qualify for correct code assignment of Medical Team Conference, CPT explicitly states that "reporting participants shall have performed face-to-face (or the PHE equivalent) evaluations or treatments of the patient, independent of any team conference, within the previous 60 days." As this reads, each participating provider should have had some contact with the patient prior to the conference, or it can't be coded as a conference. As such, the provider should "see" the patient prior to any conference and establish that relationship, recording the visit with whatever code fits the modality of care (i.e. audio only, VVC, or F2F)

From: [redacted]
Sent: Wednesday, September 2, 2020 2:07 PM
To: [redacted]

Subject: RE: IDT Team Conference Question/clarification

I'm not sure I understand exactly what your question is? Is the question can PMT members contact the patient before the PMT meeting?

From: [redacted]
Sent: Wednesday, September 2, 2020 12:09 PM
To: [redacted]
Subject: IDT Team Conference Question/clarification
Importance: High

At Central Texas, I have a couple of questions.

Can members of an "IDT" (our case the Pain management Team (PMT)) contact the patient prior to the meeting for informational and rapport building? If so could that or would that be a codable and "potential workload" option?

AMA CPT 2020 requires on Medical Team Conference:

1. If you already have an established relation with the patient, then you have to see the patient within the last 60 days before the PMT meeting through the independent consultation process that is issued to your clinic and not through the PMT group consultation.

1. If you do not already have an established relation with the patient through another consultation that is specifically issued to your clinic and that is independent of the PMT group consultation, then you ought to see the patient within the PMT meeting only and not before or after the meeting. You may, however, see the patient after the meeting if you are specifically consulted to do so depending on the recommendations of the PMT and the approval of the patient to such a consultation.

Some more question, have spared from this as well. Can you please address these below, separately.

(1) You can consult with the patient individually, prior to a team meeting, without having been requested individually to do so (individual request for consultation was not made)? (can you gather any information at all from the patient and document it – or do you have to rely on the medical record as a sole source)

Or

(2) You can have a non-clinician perform an objective, predefined intake (not evaluation, not management, not rapport-building) prior to a requested team meeting that has been requested.

If #1, then I would like you to speak specifically to the possibility of differential billing.

If in other scenarios, the degree of interaction undertaken during such a telephone call desired would be otherwise billable, then we MUST bill and code the interaction. If we don't, then it is discriminatory to bill (regardless of the "currency") some veterans, while not billing others for the same service provided because it suits our purpose(s).

If so, we cannot have such an interaction without an individual consult, anymore than one can walk into an inpatient room and perform a consultation without being requested.

On a side note, just as it would be considered fraudulent to overbill/overcode, it is also fraudulent to underbill/undercode.

Please address all of these issues; it is important to view this from all angles, and we want to be certain.

[redacted]

[redacted]

Health Information Management Section/MAS
Central Texas Veterans Health Care System

[redacted]

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[redacted]

From: [redacted]
Sent: Thursday, November 5, 2020 12:36 PM
To: [redacted]
Subject: VA OIG 2021-02792

- **Please provide the name and last 4 of SSN of the patient example you described in page 2 of letter attached to your complaint, which described a Veteran switched to Suboxone:**

<REDACTED>
*** Please note the patient was switched to Suboxone by an outside provider, prior to [redacted] getting to him; the disturbing thing regarding [redacted] self-initiated consult of the veteran prior to the team meeting is that he recommended likely to increase the suboxone, in spite of the fact that the veteran complained of potential side effects that could very well be attributable to the medication that he indicated only noticing after the medication was initiated in the first place PRIOR to any other evaluation being completed to investigate / risk assess the safety of increasing it.

- Please provider at least one additional example of an adverse patient outcome, related to the reorganization of clinical practice (include name and last 4 SSN of patient)

<REDACTED>
I do not know if the following ended in a bad outcome. I do know that this veteran, who was scheduled for an interdisciplinary team meeting / phone call with the pain management team, was called during the team's meeting and he indicated that right at that moment, he was actively in the ER being evaluated for acute chest pain and shortness of breath. The moment I heard that, I spoke up, trying to get the phone call to end right away, so the veteran could be evaluated by the ER for his acute, potentially life-threatening presentation in peace, but [redacted] spoke to him for at least another 10 minutes, citing that the veteran said he was told by someone his EKG was normal and he was ok to speak. I tried messaging the whole team, hoping [redacted] would take notice and understand that we should not want to add any additional stress to the veteran because if something was happening from a cardiovascular standpoint, the veteran could experience a worse outcome (this is in spite of the veteran self-reporting a normal EKG and certainly in spite of his saying he could speak --- many people with acute chest pain do not want it to be something bad/serious; many veterans are polite and deferential to physicians who insist on talking to them; we are charged with looking out for them, not supposed to be the other way around ...). I cannot say a bad outcome occurred as I was not there in the ER for his in-person ER evaluation; I was only there for our team phone call to the veteran via MS Teams. I can say that if he experienced a worse outcome because of this, he potentially would [redacted]

- **Please provide 2 patient examples of [redacted] improper self-consultations, which are in violation of 5 U.S.C. 2302 (b)(8) (provide name and last 4 SSN of each patient and documentation of the consults and billing).**

<REDACTED>
In this case, [redacted] self-consulted the veteran prior to the IDT Team meeting, left a note on the chart PRIOR to the team meeting; I am under the impression that he may have initially billed for the encounter, but later potentially converted it to a non-billed encounter.

<REDACTED>
In this case, [redacted] self-consulted the veteran prior to the IDT Team meeting, admitted that he spoke to the veteran before the team meeting during the team meeting, BUT did not leave a note on the chart prior to the team meeting in spite of having spoken to the patient.

I have additional examples of his various self-consultation behavior, which at least (meaning, to the knowledge that I have) falls under the categories:

(1) Performing self-consultations and billing for them, at least initially, and he may have reversed the billing charges later, which has financial/support/clinical ramifications, and is fraudulent behavior, I believe.
    - he indicated his intent to change them to non-billable encounters after this issue was raised with Coding; he then attempted to shut down the exchange with Coding intended to educate and to clarify the rules for the team.
(2) Performing self-consultations and not billing for them, which is differential billing/treatment of behavior, and has financial/support/clinical ramifications, and is fraudulent behavior, I believe.
(3) Performing self-consultations and not billing for them and not even leaving a note PRIOR to the team meetings, which is differential billing/treatment of behavior, and has financial/support/clinical ramifications, and is fraudulent behavior, and it becomes impossible to even confirm the depth of.
    - he started doing this when all of the clinicians on the team also stated outright that they would need individual consult requests from established providers prior to seeing a patient in individual consultation, I believe.

[redacted]

From: [redacted]
Sent: Thursday, June 11, 2020 3:49 PM
To: [redacted]
Cc:
Subject: CARA-PMT Cases for 07/07/2020

Importance: High

Follow Up Flag: Follow up
Flag Status: Flagged

[redacted],
Please schedule the following listed patients for 60 minutes each in the "**TEM SUR PAIN IDT-X**" Clinic on 07/07/2020, at the following times:

[redacted] Consultation Present
Consultation Present
Consultation Present
Consultation Present

Please confirm this scheduling ASAP.

[redacted], kindly call these patients and brief them on the procedure and function of the PMT clinic and confirm to me the completion of this action. Because of the COVID-19 issue, please let them know that communication with them be on the telephone.

Communication between the members of the pain management team will be conducted on a [redacted]

Sincerely,
[redacted]

[redacted]

From: [redacted]
Sent: Friday, July 17, 2020 12:55 PM
To: [redacted]
Cc:
Subject: CARA PMT Cases for 08/04/2020

Importance: High

[redacted],
Please schedule the following listed patients for 60 minutes each in the "**TEM SUR PAIN IDT-X**" Clinic on 08/04/2020, at the following times:

[redacted] Consultation Present.
Consultation Present.
Consultation Present.
Consultation Present.

Please confirm this scheduling ASAP.

[redacted], kindly call these patients and brief them on the procedure and function of the PMT clinic and confirm to me the completion of this action. Because of the COVID-19 issue, please let them know that communication with them be on the telephone.

Communication between the members of the pain management team will be conducted on a [redacted]

Sincerely,
[redacted]

[redacted]

From: [redacted]
Sent: Wednesday, September 2, 2020 9:59 AM
To: [redacted]
Cc:
Subject: CARA-PMT Cases for 10/06/2020

Importance: High

[redacted],
Please schedule the following listed patients for 60 minutes each in the "**TEM VVC SUR PAIN IDT-X**" Clinic on 10/06/2020, at the following times:

[redacted] Consultation Present
Consultation Present
Consultation Present
Consultation Present

Please confirm this scheduling ASAP.

[redacted]
Please distribute VVC connection emails to the following PMT team participants:

1. [redacted], Social Worker.
2. [redacted], Social Worker.
3. [redacted]., Behavioral Medicine Specialist.
4. [redacted] Pain Medicine Pharmacist.
5. [redacted] Pain Medicine Pharmacist.
6. [redacted] Addiction Medicine Specialist.
7. [redacted] PMRS, Rehabilitation Specialist
8. [redacted] Director of Complementary Integrated Health (Whole Health)
9. [redacted] Pain Medicine Specialist
10. [redacted] Pain Medicine Specialist.

[redacted] kindly call these patients and brief them on the procedure and function of the PMT clinic and confirm to me the completion of this action. Because of the COVID-19 issue, please let them know that communication with them be on the on the VA Video Connect (VVC) or telephonic if the prior dysfunctions or is not available.

To All:
Communication between the members of the pain management team will be conducted on a [redacted]

Communication between the members of the pain management team and the patient will be conducted on VA Video Connect (VVC) that will be established for every patient. The link to VVC will be sent to all members to join in talking with the patient. If this fails, then communication with the patient will be conducted on the telephone.

Sincerely,
[redacted]

[redacted].

From: [redacted]
Sent: Friday, October 2, 2020 9:11 AM
To: [redacted]
Cc:
Subject: RE: CARA-PMT Cases for 11/03/2020
Attachments: VA Video Connect (VVC) Appointment has been scheduled for 10/06/2020 08:00 CDT

Here is an updated VVC appointment. Please remove the 830 A VVC appointment. The appointment will start at 8AM.

We will have time between 10 AM and 11 AM to discuss changes to how PMT operates to be in compliance with CARA requirements and E&M/CPT coding.

Respectfully,

[redacted]

From: [redacted]
Sent: Tuesday, September 22, 2020 11:23 AM
To: [redacted]
Cc: [redacted]
Subject: CARA-PMT Cases for 11/03/2020
Importance: High

[redacted],
Please schedule the following listed patients for 60 minutes each in the "**TEM VVC SUR PAIN IDT-X**" Clinic on 11/03/2020, at the following times:

[redacted] Consultation Present
Consultation Present
Consultation Present
Consultation Present

As we are no longer utilizing the "TEM VVC SUR PAIN IDT-X" clinic at this time, please block the 4 slots in this clinic for 10/06/2020 and for 11/03/2020.

Please confirm this scheduling action ASAP.

[redacted], kindly call these patients and brief them on the procedure and function of the PMT clinic and confirm to us the completion of this action. Because of the COVID-19 issue, please let them know that communication with them be on VVC or telephonic as backup.

[redacted], kindly communicate with the PCPs of these patients and invite them for the meetings.

Communication between the members of the pain management team will be conducted on a [redacted]

Communication between members of the team and the patient will be on VVC, or telephonic if VVC cannot be established.

Sincerely,
[redacted]

[redacted]

From: [redacted]
Sent: Monday, November 23, 2020 4:36 PM
To: [redacted]
Cc: [redacted]
Subject: December 2020 CARA-Mandated PMT Patients

Good Afternoon,

Thank you everyone for your continued assistance. Please see the list of December PMT patients highlighted in green.

[redacted]
Please schedule the following listed patients for 60 minutes each in the "**TEM VVC SUR PAIN IDT-X**" Clinic on 12/01/2020, at the following times:

[redacted] Consultation Present
Consultation Present
Consultation Present
Consultation Present

Please confirm this scheduling ASAP.

[redacted],
Please distribute VVC connection emails to the following PMT team participants:

1. [redacted], Social Worker.
2. [redacted], Social Worker.
3. [redacted] Behavioral Medicine Specialist.
4. [redacted] Pain Medicine Pharmacist.
5. [redacted], Substance Use Disorder Pharmacist.
6. [redacted] Addiction Medicine Specialist.
7. [redacted], PMRS, Rehabilitation Specialist
8. [redacted] Director of Complementary Integrated Health (Whole Health)
9. [redacted], Pain Medicine Specialist
10. [redacted], Pain Medicine Specialist.

[redacted] kindly call these patients and brief them on the procedure and function of the PMT clinic and confirm to me the completion of this action. Because of the COVID-19 issue, please let them know that communication with them be on the on the VA Video Connect (VVC) or telephonic if the prior dysfunctions or is not available.

Respectfully,
[redacted]

[redacted]
Clinical Pharmacy Specialist- Pain Management
[redacted]

[redacted]

From: [redacted]
Sent: [redacted]
To: [redacted]
Cc:
Subject: January 2020 CVVC-Mandated PMT Patients

Good morning,

Please see the list of January PMT patients highlighted in green.

[redacted],
Please schedule the following listed patients for 60 minutes each in the "TEM VVC SUR PAIN IDT-X" Clinic on 01/05/2021, at the following times:

[redacted]

[redacted]
Please distribute VVC connection emails to the following PMT team participants:

1. [redacted], Social Worker,
2. [redacted] Social Worker,
3. [redacted] Behavioral Medicine Specialist,
4. [redacted] Pain Medicine Pharmacist,
5. [redacted], Substance Use Disorder Pharmacist,
6. [redacted], Addiction Medicine Specialist,
7. [redacted] PMRS, Rehabilitation Specialist
8. [redacted] Director of Complementary Integrated Health (Whole Health)
9. [redacted] Pain Medicine Specialist
10. [redacted] Pain Medicine Specialist,

Thank you,
[redacted]
Clinical Pharmacy Specialist, CRVA-SUD
[redacted]

[redacted]

From: [redacted]
Sent: [redacted]
To: [redacted]
Subject: [redacted]

In lieu of a clinical meeting, we will meet tomorrow morning to discuss the proposed changes for PMT and the Service Agreement.

Thank you!

[redacted]

[redacted]
Clinical Director, Whole Health and Integrated Health Service
Central Texas VA Healthcare System

[redacted]

[redacted]

From: [redacted]
Sent: Wednesday, February 24, 2021 3:24 PM
To: [redacted]
Cc: [redacted]
Subject: PMT

Dear colleagues,

Given that we are still negotiating the Service Agreement, I have decided that we must suspend the Pain Management Team's clinical role.

We can continue to meet to discuss strategy for implementation of Stepped Care for Pain Management and OUD.

As for patient care, we can continue to see them in our individual clinics and coordinate amongst ourselves when necessary.

With appreciation,

[redacted]

[redacted]
Clinical Director, Whole Health and Integrated Health Service
Central Texas VA Healthcare System

[redacted]

Reference 30

VHA Directive 1230 - Outpatient Scheduling Processes and Procedures, July 15, 2016, amended January 7, 2021.

Reference 31

§17.108, Specialty care outpatient visits.

The Central Texas Veterans Health Care System
Charter of the Comprehensive Addiction and Recovery Act Mandated
Pain Management Team

1. **Preamble**: This charter outlines the process of the Comprehensive Addiction and Recovery Act (CARA) mandated Pain Management Team (PMT) at the Central Texas Veterans Health Care System (CTVHCS).

2. **Membership**: This is an interdisciplinary Pain Management Team that is composed of the following expert providers or their assigned surrogates.
   a) Pain Medicine Expert.
   b) Addiction Medicine Expert.
   c) Rehabilitation Medicine Expert.
   d) Behavioral Medicine Expert.
   e) Pain Management Pharmacy Expert.
   f) Ambulatory Care Chief and Pain Champion.
   g) Social Worker.
   h) Case Manager.

3. **Purpose**: The purpose of the Pain Management Team is to meet the requirements of the Comprehensive Addiction and Recovery Act.

4. **Function**: The function of the Pain Management Team is,
   a) To facilitate the delivery of effective and safe pain management modalities to our Veterans.
   b) To assure that Veterans who suffer pain are provided a continuum of care in accordance with the Stepped Care Model for Pain Management and in line with the National Leadership Council (NLC) recommendations and requirements.
   c) To evaluate and follow-up, as needed, patients with complex pain conditions.
   d) To process pain consultation for medication management and to prescribe pain medication, if needed.

e) To review patients with high risk opioid prescriptions and to provide recommendations to clinical providers, in concordance with the published VHA OSI requirements for OSI teams, the CTVHCS Pain Assessment and Management Policy, and the CTVHCS Opioid Use Policy.

5. **Elements**: The PMT will endorse and assure the following elements:
   a) The availability of e-consultation.
   b) The availability of immediate consultation for assistance with prescriptions.
   c) The availability of pain consultation by Telehealth.
   d) The inclusion of Complementary and Integrative Medicine (CIM) on the PMT.
   e) The inclusion of 0.25 PACT Pain Champion.
   f) The inclusion of interventional Pain Care.
   g) The availability of inpatient Pain Consultation
   h) Interdisciplinary Pain Management Case Review Forum.
   i) The Coordination of Care and the Distribution of Responsibilities:
      i. The PMT serves as an advisory body.
      ii. The patient's PCP maintains the primary responsibility of following through on the PMT's advice as this relates to the prescription of medication and referrals to other specialties as indicated.
      iii. The primary care provider (PCP) of the involved Veteran will remain actively involved in the management of his or her Veteran throughout the pain management process.
   j) Compliance with the Stepped-Care Model of Pain Management or a corrective plan of action. The CARA-mandated Stepped-Care Model of Pain Management involves the following steps:
      i. Patient/ family education and self-care.
      ii. Primary Care involvement within the Patient Aligned Care Team (PACT)
      iii. Secondary Consultations to involved specialties including Multidisciplinary Pain Medicine Specialty Teams.
      iv. Tertiary referral to Interdisciplinary Pain Centers with advanced Pain Medicine diagnostics and interventions.

k) Availability of e-consultation and a formalized referral pathway to the PMT:
   i. An e-consultation process to access the services of the CARA mandated PMT is to be implemented in the CPRS.
   ii. Face-to-face consultations and consultations through tele-health will also be available to the PMT as needed and as would be appropriate.

l) Availability of immediate consultation for assistance with prescriptions:
   i. Immediate telephonic consultation is to be made available to all providers who are treating pain. The telephone numbers will be listed under the Consultations Guidelines to the Pain Management Team in the CPRS.
   ii. The pain management team experts may suggest various pain management modalities through prescriptions or others.
   iii. However, it is the patient's PCP or Primary Care surrogate who should approve the pain management plan and write the prescriptions.
   iv. The Patient's Primary Care Provider (PCP) will remain involved with the care of the patient throughout the Stepped Care Model of Pain Management.

m) Pain consultation by Telehealth: Telehealth systems will be utilized to communicate with providers and with patients as would be deemed appropriate and necessary.

n) Inclusion of Complementary and Integrative Medicine (CIM) on Pain Team: That is included as part of the function of the Rehabilitation Medicine expert on the team.

o) The inclusion of 0.25 PACT Pain Champion: The Ambulatory Care Chief on the team will assume this role or may assign an interested party or a surrogate for this role. The 0.25 PACT Pain Champion may be a Physician, a Nurse Practitioner, or a Pharmacist with expertise and experience in Pain Management.

p) Interventional Pain Care: That is included as part of the function of the Pain Medicine expert on the team.

q) Inpatient Pain Consultation: Consultations to the PMT will be available to Inpatients and outpatients alike.

r) Interdisciplinary Pain Management Case Review Forum: The CARA mandated PMT will,

i. Meet at a designated place that is determined by the members of the team.
ii. Meet at least monthly, for about 2-4 hours, depending on patient demand.
iii. Review and discuss all consultations that were accepted to the PMT.

s) The CARA-mandated PMT will review and discuss all consultations that were accepted to the PMT.

i. PMT meetings will be divided into hourly intervals.
ii. During each hour, one pain case will be reviewed and the patient interviewed if available.
    1. All members of the PMT will be requested to review the scheduled cases and prepare for the discussion prior to the meetings.
    2. Patients and their PCP will be invited to join the meetings in person or through Telehealth Systems.
iii. If either the patient or the PCP could not be available for the encounter, the meeting, chart review, discussion, and decision will proceed in absentia.
iv. Following each patient encounter, a note will be generated by the members of the PMT and documented in the CPRS. This note will be directed to the patient's PCP for fulfillment and implementation.

6. Authority and Limitations:

a) The authority of the PMT is given by the office of the Director.
b) The function of the PMT is limited to an expert consultative service. The PMT will offer direction, guidance, education, and advice to the Veteran's PCP in regards to the available medications and non-medication resources in the management of the patient's pain.

7. Review/Rescission & Reissue:

a) This Charter will be reviewed biennially by the Committee.
b) Any revisions should be approved by the Clinical Executive Council or the office of the Chief of Staff.

8. Requirements for Decision-Making:

a) All members of the PMT or their assigned surrogates are expected to be present during all meetings.
b) It is the responsibility of each member on the team to assign a surrogate in case of absence.
c) If there are missing members during the meeting, the meeting will proceed on time with the members who are available.

9. Parent:

a) The PMT will report to the Pain Oversight Committee (POC).

10. Communication:

a) Official communication between the PMT and the responsible PCP will be made through notes in the patient's medical records.
b) Communication may also be done through encrypted outlook email, telephone calls, or during face-to-face meetings with the responsible PCP.

11. Chairperson:

a) The Chairperson of the PMT is the Pain Management Expert and the Point of Contact regarding pain management for this Medical Center.

12. Member Roles and Responsibilities:

a) Members and their surrogates should be compliant with the requirements specified in the White House Memorandum "Addressing Prescription Drug Abuse and Heroin Use"; i.e. completion of the Talent Management System (TMS) training course #31108 or future successor training for Opioid Safety.
b) Members are expected to attend all the PMT meetings regularly and to assign surrogates in case of their absence.
c) Members are expected to review the assigned consultations before the scheduled PMT meeting.
d) Members are expected to actively participate in the PMT meetings by sharing their expertise and resources to the best of their knowledge.

13. Use of Alternates:

a) It is expected that members of the PMT will attend the meetings. Alternates or surrogates may attend in instances when the primary member is unavailable.
b) Alternates should be pre-approved and accepted to the PMT by the PMT Chairperson prior to attendance.
c) It is expected that Alternates have reviewed the assigned cases and are fully aware of the issues addressed by the PMT. Alternates should possess the same 'content expertise' as the primary member.
d) Alternates will act on behalf of the primary member and will be required to participate in the meeting and vote as needed.
e) Decisions and Votes made by Alternates are binding and are not subject to recant by the primary member unless there is evidence of serious problems and risk to the patient.

14. Effective Date and Revisions:

a) This charter is effective when approved by the Clinical Executive Council under the signature of the Chief of Staff.
b) There is no expiration date to this charter.
c) Revisions of this charter may be initiated by the Pain Management Team or by the Pain Oversight Committee but should be approved by the Clinical Executive Council or the Office of the Chief of Staff.
d) Termination or revisions to this charter can be accomplished only by approval of the Clinical Executive Council or the Office of the Chief of Staff.

15. References:

a) 05222017-Memo-CARA Requirements from Section 911(c) PMT Facility Report.
b) 7791174-Memo-Opioid Safety Initiative Attch B1.
c) 7791174-SEC. 901. SHORT TITLE. Subtitle A, Opioid Therapy and Pain Mgmt
d) NLC_PMT_guidance
e) OSI and Pain Mgt [redacted] 4.27.17

f) STEPPED CARE MODEL FOR PM

g) VHA Directive 2009-053, Pain Management;

16. **History of Charter Revisions**:

a) The original Charter was approved by the CEC on July 18, 2017

b) This first revision of this Charter was approved by the CEC on _____

10/17/2019

X [redacted]

Chairperson, The Pain Management Team

[redacted]

[redacted]

CEC Chair

Reference 33

JCAHO alert *Sentinel Event Alert,* Issue 5, September 12, 2017.

[redacted]

From: [redacted]
Sent: Friday, March 26, 2021 11:02 AM
To: [redacted]
Subject: RE: [PRIVATE]

[redacted]

The template creates a direct obstacle to Veterans getting pain management care by consult. The specific issues with the template are: 1) the consult requests are now 'screened' by non-physician coaches, 2) the non-physician makes an evaluation as to whether appropriate non-interventional approaches have been implemented, and 3) Veterans are forced to complete an Intro to Whole Health before getting pain management care (regardless of whether a PMT physician believes this complementary approach is appropriate).

I believe the above bureaucratic steps prevent Veterans from getting the care required under the regulations. I believe it also inserts a non-physician 'coach' into a substitute role for that of a physician. I do not believe this is consistent with regulations or the appropriate professional standards of care."

I have offered Whole Health to the bulk of my patients: Many are not interested, and many are expressly uninterested in it noting that they have tried it previously.

[redacted]

From: [redacted]
Sent: Thursday, March 25, 2021 4:34 PM
To: [redacted]
Subject: RE: [PRIVATE]

Thank you for providing this. Please share your insights on what parts of this template are not up to par and why. Thanks in advance.

From: [redacted]
Sent: Thursday, March 25, 2021 2:29 PM
To: [redacted]
Subject: [PRIVATE]

Hello [redacted],

Please see below consult template, changed by [redacted], **now viewable by providers requesting pain management consultation**:

Patient care continues to be affected negatively in real time by these changes.

I question the legality of this as per my initial statement of concerns, as had been requested by you; [redacted] has now enacted this and to my knowledge, **there is now no other way to consult us**.

Sincerely,

[redacted]

Reason For Request:
Pain Management Specialty Clinic Consult

For urgent concerns about opioid safety, please call ext. 57300, in addition to entering the order as STAT. Please do not stop opioids abruptly because this can increase the risk of suicide and overdose. Pain clinic providers with the support of Clinical Pharmacy will develop a risk mitigation plan and address concerns immediately.

The Following criteria must be met. If the answer to any of these questions are No , do not enter consult until they are met.

Yes 1. Initial measures such as non-opioid medications, Physical Therapy, and other non-interventional approaches have already been implemented.

Yes 2. Veteran has been informed that this service includes management of medications, as well as interventional procedures (such as epidural injection and radiofrequency ablation) when appropriate.

Yes 3. Veteran has been informed that after an initial evaluation, consultation with other members of the Pain Management Team, including Behavioral Medicine Psychologist, Physical Medicine and Rehabilitation Physician, Addiction Medicine Specialist, Clinical Pharmacist, Integrative Medicine Specialist, and others, may be recommended. This interdisciplinary team would develop an individualized, integrative treatment plan with the Veteran.

Yes 4. Veteran has been informed that Primary Care Provider will resume medication management when it is recommended by the members of the Interdisciplinary Pain Management Team with the understanding that the PMT will be available for ongoing consultation and management as necessary.

No 5. For neck and back pain, advanced imaging (CT or MRI) of affected area has been updated if older than 2 years. (MRI is preferable,

but if contraindicated, CT should be done. MRI with contrast is indicated if patient has had surgery for the condition.)

Images and report must be available in the electronic medical record. Please indicate where they can be found:
a. CPRS
b. JLV
c. Vista Imaging

Yes 6. A current H&P has been documented in the past 60 days for a diagnosed chronic pain condition that can be managed in an outpatient setting: (The provider will rule out emergent and urgent conditions.)
a.history (mechanism of injury, precise location of pain, provoking and palliating factors, quality of pain, radiation, severity, chronicity, associated symptoms, risk factors)
b.vital signs
c.focused neurologic exam (reflexes, motor and sensory)
d.focused musculoskeletal exam (including range of motion, inspection and palpation)
e.appropriate orthopedic testing (Spurling, straight leg raise, FADER, etc.)

Yes 7. Veteran has been informed that they must take Introduction to Whole Health before they will be scheduled. Please place consult for Intro to Whole Health if patient has not yet completed this class. This is intended to optimize response to treatment patients achieve the best results from practitioner-delivered care when they also learn and practice self-management approaches.

Reference 35 & 36

[redacted]

From: [redacted]
Sent: Monday, October 4, 2021 4:26 PM
To: [redacted]
Subject: OSC investigation --- A template that had been put into place and then reversed...

Hello [redacted],

Please see below consult template, which had been put in place previously and then changed "back" by [redacted]; the below had been **viewable by providers requesting pain management consultation** for some time:

Patient care has been affected negatively in real time by these changes.

I questionned the legality of this as per my initial statement of concerns; [redacted] had enacted this and to my knowledge, **there had been no other way to consult us.**

The template created a direct obstacle to Veterans getting pain management care by consult. The specific issues with the template are: 1) the consult requests are now 'screened' by non-physician coaches, 2) the non-physician makes an evaluation as to whether appropriate non-interventional approaches have been implemented, and 3) Veterans are forced to complete an Intro to Whole Health before getting pain management care (regardless of whether a PMT physician believes this complementary approach is appropriate).

I believe the above bureaucratic steps prevented Veterans from getting the care required under the regulations. I believe it also inserts a non-physician 'coach' into a substitute role for that of a physician. I do not believe this is consistent with regulations or the appropriate professional standards of care."

I have offered Whole Health to the bulk of my patients: Many are not interested, and many are expressly uninterested in it noting that they have tried it previously.

My understanding is the template was again changed following complaints from Primary Care.

Sincerely,

[redacted]

Reason For Request:
Pain Management Specialty Clinic Consult

For urgent concerns about opioid safety, please call ext. 57300, in addition to entering the order as STAT. Please do not stop opioids abruptly because this can increase the risk of suicide and overdose. Pain clinic providers with the support of Clinical Pharmacy will develop a risk mitigation plan and address concerns immediately.

The Following criteria must be met. If the answer to any of these questions are No , do not enter consult until they are met.

Yes 1. Initial measures such as non-opioid medications, Physical Therapy, and other non-interventional approaches have already been implemented.

Yes 2. Veteran has been informed that this service includes management of medications, as well as interventional procedures (such as epidural injection and radiofrequency ablation) when appropriate.

Yes 3. Veteran has been informed that after an initial evaluation, consultation with other members of the Pain Management Team, including Behavioral Medicine Psychologist, Physical Medicine and Rehabilitation Physician, Addiction Medicine Specialist, Clinical Pharmacist, Integrative Medicine Specialist, and others, may be recommended. This interdisciplinary team would develop an individualized, integrative treatment plan with the Veteran.

Yes 4. Veteran has been informed that Primary Care Provider will resume medication management when it is recommended by the members of the Interdisciplinary Pain Management Team with the understanding that the PMT will be available for ongoing consultation and management as necessary.

No 5. For neck and back pain, advanced imaging (CT or MRI) of affected area has been updated if older than 2 years. (MRI is preferable, but if contraindicated, CT should be done. MRI with contrast is indicated if patient has had surgery for the condition.)

Images and report must be available in the electronic medical record. Please indicate where they can be found:
a. CPRS
b. JLV
c. Vista Imaging

Yes 6. A current H&P has been documented in the past 60 days for a diagnosed chronic pain condition that can be managed in an outpatient setting: (The provider will rule out emergent and urgent conditions.)

a.history (mechanism of injury, precise location of pain, provoking and palliating factors, quality of pain, radiation, severity, chronicity, associated symptoms, risk factors)
b.vital signs
c.focused neurologic exam (reflexes, motor and sensory)
d.focused musculoskeletal exam (including range of motion, inspection and palpation)
e.appropriate orthopedic testing (Spurling, straight leg raise, FADER, etc.)

Yes 7. Veteran has been informed that they must take Introduction to Whole Health before they will be scheduled. Please place consult for Intro to Whole Health if patient has not yet completed this class. This is intended to optimize response to treatment patients achieve the best results from practitioner-delivered care when they also learn and practice self-management approaches.

From: [redacted]
To: [redacted]
Subject: RE: [SECURE] - PATIENT CONFIDENTIAL
Date: Monday, August 2, 2021 8:42:20 AM
Attachments: image001.jpg

Unfortunately we have 1000+ pending consults for Intro to WH. Our new AMSA starts next week and I have other staff working the backlog but we had some as old as April. I will send this to our AMSAs to see if they can contact him to get him in but know that any other patients will be in the same boat as him. Hopefully we will see some improvements in the coming months when we have more staff to work these orders.

[redacted]
Whole Health Program Manager [redacted]
Central Texas Veterans Healthcare System
[redacted]

"People are fed by the Food Industry, which pays no attention to health, and are healed by the Health Industry, which pays no attention to food." - [redacted]
"Let food be thy medicine and medicine be thy food"--[redacted]

From: [redacted]
Sent: Friday, July 30, 2021 12:33 PM
To: [redacted]
Subject: [SECURE] - PATIENT CONFIDENTIAL

Hello [redacted]

Re:

[redacted]

Intro class consult pending action.

Who can I inform to try to move this forward?

Thanks,

[redacted]

Reference 37

VAOIG-21-03525-148 - Failure to Follow a Consult Process

[redacted]

From: [redacted]
Sent: Monday, January 10, 2022 4:20 PM
To: [redacted]
Subject: OSC --- FW: Whole Health --- Intro Class --- Changes to Processing

Hello [redacted],

Please see message.

[redacted]

From: [redacted]
Sent: Monday, January 10, 2022 4:00 PM
To: [redacted]
Subject: Whole Health --- Intro Class — Changes to Processing

To whom it may concern:

It appears that changes have occurred:

- "Whole Health is NOT a prerequisite for" the traditional and complementary treatments offered.
- Explicit statement that Whole Health Coaches cannot evaluate and/or medically clear patients OR submit consults for the traditional and complementary treatments offered.

Sincerely,

[redacted]

//

Re:

[redacted] [redacted] [redacted]

//

<EXCERPT>

Veteran only wants pain management and acupuncture care at this time.

As written this consult only pertains to scheduling an appointment with a Whole Health Coach.

Intro to Whole Health is NOT a prerequisite for chiropractic care and/or pain management and/or acupuncture therapeutic treatment.

Whole Health Coaches cannot evaluate and/or medically clear patients or submit consults for chiropractic care and/or pain management and/or acupuncture therapeutic treatment.

//

<FULL>

Current PC Provider: [redacted]
Current PC Team: W AMB PACT GOLD 1 *WH*
Current Pat. Status: Outpatient
UCID: [redacted]
Primary Eligibility: SERVICE CONNECTED 50% to 100%(VERIFIED)
Patient Type: SC VETERAN
OEF/OIF: NO

Service Connection/Rated Disabilities
SC Percent: 70%
Rated Disabilities: LUMBOSACRAL OR CERVICAL STRAIN (20%)
LUMBOSACRAL OR CERVICAL STRAIN (20%)
TINNITUS (10%)
LIMITED MOTION OF ANKLE (10%)
PARALYSIS OF SCIATIC NERVE (10%)
PARALYSIS OF SCIATIC NERVE (10%)
IMPAIRED HEARING (10%)
LIMITED MOTION OF ANKLE (10%)
SEPTUM, NASAL, DEVIATION OF (0%)
LARYNGITIS,CHRONIC (0%)

Order Information
To Service: TEM WHS OUTPT INTRO TO WHOLE HEALTH
From Service: TEM WHS PAIN PROC2
Requesting Provider: [redacted]
Service is to be rendered on an OUTPATIENT basis
Place: Consultant's choice
Urgency: Routine
Clinically Ind. Date: Jan 10, 2022
DST ID:
Orderable Item: TEM WHS OUTPT INTRO TO WHOLE HEALTH
Consult: Consult Request
Provisional Diagnosis: Illness, unspecified(ICD-10-CM R69.)
Reason For Request:
**If you are requesting consult to the Whole Health Integrated Pain Management program for your patient to receive Acupuncture, Chiropractic or Pain Management clinic services, in addition to this Intro to Whole Health consult you must also complete the whole health integrated pain manage consult specific for the one service you are requesting. If the Veteran has already attended Intro to Whole Health, exit out of this

consult and proceed as indicated.**

REASON FOR REQUEST

Acupuncture

All patients involved in Whole Health should attend a one hour Introduction to Whole Health Class (Orientation) and a minimum of one WH Coaching session. Introduction to WH is offered in multiple modalities to accommodate patient needs.

Is this a STAT consult?

Inter-facility Information
This is not an inter-facility consult request.

Status: CANCELLED
Last Action: CANCELLED
Significant Findings: Unknown

Facility
Activity | Date/Time/Zone | Responsible Person | Entered By

CPRS RELEASED ORDER 01/10/22 11:53 [redacted] [redacted]
SIG FINDING UPDATE 01/10/22 12:47
As written this consult only pertains to scheduling an appointment with a Whole Health Coach.

Intro to Whole Health is NOT a prerequisite for chiropractic care and/or pain management and/or acupuncture therapeutic treatment.

Whole Health Coaches cannot evaluate and/or medically clear patients or submit consults for chiropractic care and/or pain management and/or acupuncture therapeutic treatment.

RECEIVED 01/10/22 12:47 [redacted] [redacted]
CCE-CC Eligibility Status: NO ELIGIBILITY FOUND

CVA-Accept new consult, received during COVID-19 Pandemic
ME-May discontinue if Veteran fails to respond to mandated scheduling effort.
CUR-CTB User Role: Scheduler

ADDED COMMENT 01/10/22 12:49 [redacted] [redacted]
CCE-CC Eligibility Status: NO ELIGIBILITY FOUND

C1-First call to Veteran: Left voicemail
L1-Unable to schedule letter sent by mail to Veteran.
CUR-CTB User Role: Scheduler

CANCELLED 01/10/22 13:06 [redacted] [redacted]
Veteran declined to participate in the Intro to Whole Health coaching orientation session(s) at this time.

Veteran only wants pain management and acupuncture care at this time.

As written this consult only pertains to scheduling an appointment with a Whole Health Coach.

Intro to Whole Health is NOT a prerequisite for chiropractic care and/or pain management and/or acupuncture therapeutic treatment.

Whole Health Coaches cannot evaluate and/or medically clear patients or submit consults for chiropractic care and/or pain management and/or

acupuncture therapeutic treatment.

Note: TIME ZONE is local if not indicated

Significant Findings: Unknown

No local TIU results or Medicine results available for this consult

==========

========== END ==========

[redacted]

From: [redacted]
Sent: Monday, November 30, 2020 1:16 PM
To: [redacted]
Cc:
Subject: pain school curriculum
Attachments: Anatomy of pain updated.pptx

Dear colleagues,

I hope everyone had a restful holiday!

We are working very hard to try to create an integrated, interdisciplinary approach to pain management that can meet the demand for services using the limited resources we have, while reducing the volume of referrals to the community. Based on discussions I have had with team members, and with pain management and Whole Health leaders in other facilities as well as with [redacted] I believe the best way to do this will be to create a single point of entry for referrals for pain management. This is critical for us to ensure that we deliver a consistent message to veterans and referring providers, that effective pain management requires patients to learn self-management skills.

To this end, all referrals for CIH and pain clinic will start with referral to Intro to Whole Health, where veterans will initiate the Personal Health Inventory. Ideally, they will go on to do individual coaching or at least the Taking Charge of my Health and my Life class. From there, they will choose which pathway they wish to start on. They cannot do everything at once – they can choose acupuncture, chiropractic, or pain clinic. They can certainly go to the other services later. (Other programs can be done in parallel, however, including yoga, KT, CBT for chronic pain, etc.)

We have already set this up for [redacted] acupuncture clinic – patients will attend her Traditional East Asian Medicine (TEAMS) class before having an individual evaluation. This class will include training in self acupressure as well as Qigong. After this, they will be scheduled for group acupuncture clinics.

I would like for the pain specialists and the chiropractors to work on doing something similar for their sections. I have already spoken with some of you about this.

I am sharing the slides that I have used for Pain School in Pittsburgh and in Salisbury. This will serve as the basis for the Palestine Whole Health PACT Pain School, but it can also be used for the other sections in our service. Regardless, they will need to be updated for content and clarity - I welcome any input from anyone.

Also, we have selected a Nurse Practitioner for our service, and she has accepted our tentative offer. Part of her duties will involve integrative pain management. There are several possibilities, including leading the pain school, running an Opioid Review clinic, or a running a SCOUTT clinic. We can discuss this further as a team.

With appreciation,

[redacted]

[redacted]
Clinical Director, Whole Health and Integrated Health Service
Central Texas VA Healthcare System

[redacted]

From: [redacted]
Sent: Thursday, April 15, 2021 11:20 AM
To: [redacted]
Subject: FW: Pain management consults and intro to WH consults

... again, I am not the only one thinking these thoughts...

From: [redacted]
Sent: Tuesday, March 30, 2021 2:59 PM
To: [redacted]
Cc: [redacted]
Subject: RE: Pain management consults and intro to WH consults

Hi All,

I'm just thinking out loud here.

Was this email meant to be sent to PCPs? Isn't it still the responsibility of the PCPs and haven't we been preaching to them that they are still the responsible entity for placing the consults to whole health and pain clinic? If we review a consult for Pain Clinic and notice that the Intro to Whole Health consult wasn't placed, then what? Are we supposed to place a consult that the patient doesn't know about, most likely a program they have no information about, hasn't agreed to participate in and they are going to receive a phone call from our schedulers and have no idea what it is for or the reasoning behind it.

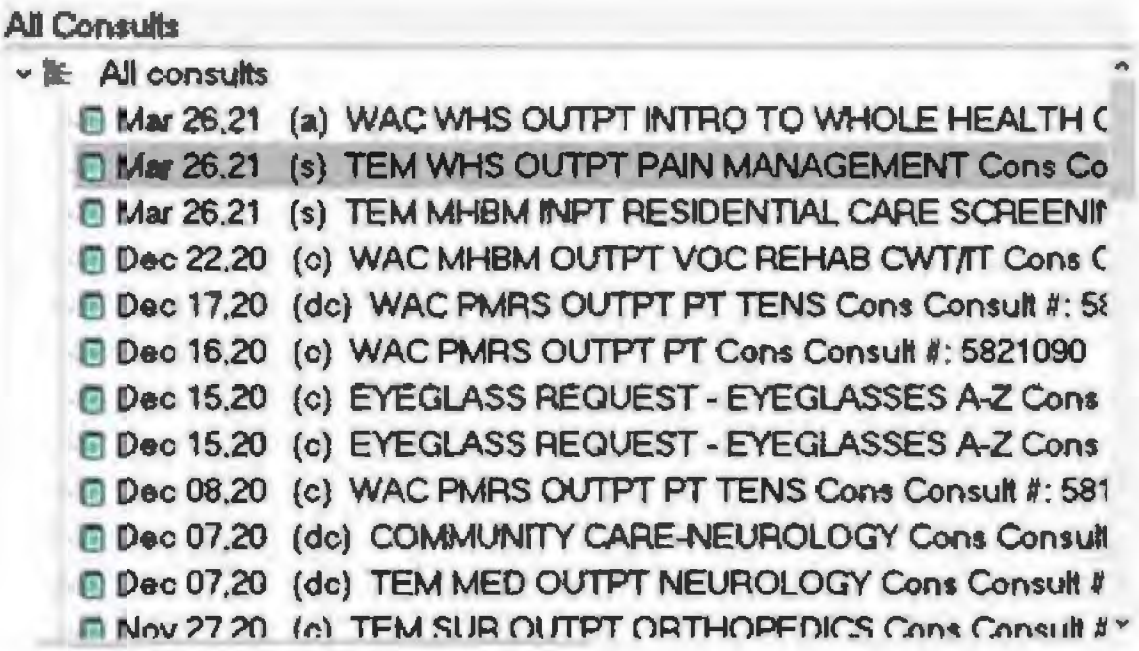
Or are you saying that once the veteran is seen in the Pain Clinic during a tele, VVC or face to face initial consult visit we explain what whole health is, how it will benefit them towards wellness and decreased chronic pain, encourage it / require it , and at least then they are informed by someone before they are scheduled.

Or that this needs to be communicated to the PACT providers?

Thank you,
[redacted]

From: [redacted]
Sent: Tuesday, March 30, 2021 9:38 AM
To: [redacted]
Cc: [redacted]
Subject: Pain management consults and intro to WH consults
Importance: High

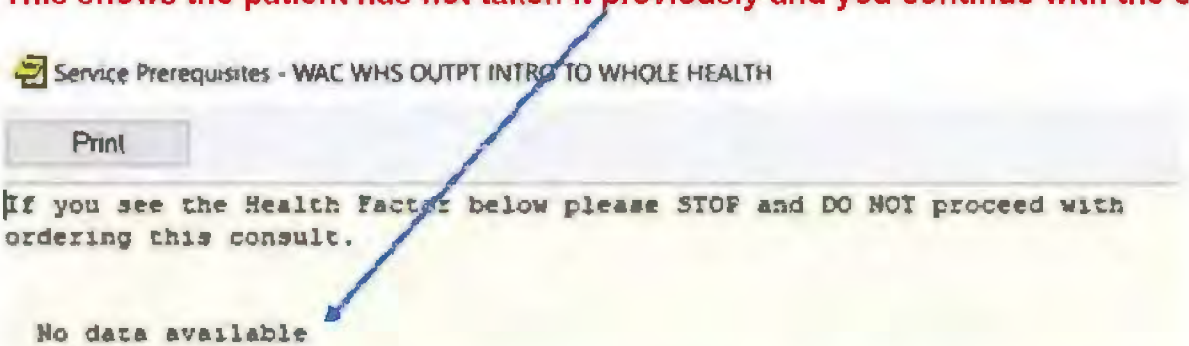
Good morning---I know [redacted] has communicated to [redacted] that you all will need to be sure that the when you receive the pain management consults that you double check that the patient has the consult for Introduction to Whole Health placed as well. Some doctors are doing it, others are missing the second step. The picture below shows a patient that has both requirements entered correctly for pain consult and the consult for Intro to Whole Health.



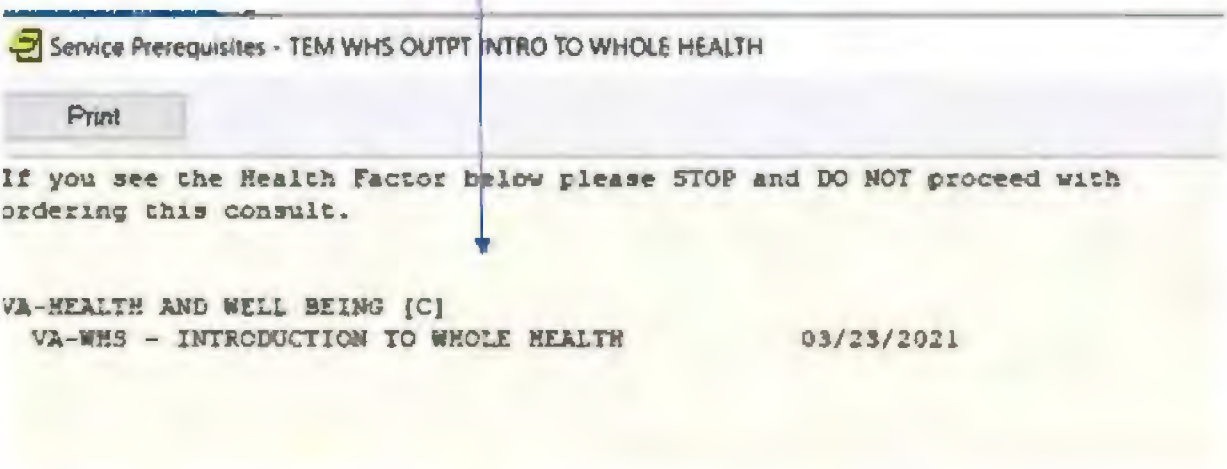
If there is no consult for Intro to Whole Health you will need to place it by going to orders tab, choose Whole Health consults:

Next choose the location the consult came from, if it came from a CBOC choose the closest parent station (Temple/Austin/Waco)

This shows the patient has not taken it previously and you continue with the consult.



If you enter the consult and this pops up, the patient has taken the course in the past (likely before it was a consult). <u>No need to re-enter again.</u>



My AMSAs in WH will schedule the Intro to WH consults and the pain AMSAs will continue to schedule the consults for pain clinics/procedures.

We are working out a plan to combine intro to WH and the intro to pain session so that pts have a one stop class to get both before being scheduled into pain clinics. When we finish this curriculum and it's ready to go live I will f/u to this email on your next steps. If you have questions or need assistance please let me know.

[redacted]
Whole Health Program Manager [redacted]
Central Texas Veterans Healthcare System
[redacted]

"People are fed by the Food Industry, which pays no attention to health, and are healed by the Health Industry, which pays no attention to food." - [redacted].
"Let food be thy medicine and medicine be thy food" -- [redacted]

[redacted]

From: [redacted]
Sent: Tuesday, March 30, 2021 8:52 AM
To: [redacted]
Subject: Re: Pain management consults and recs to WH providers

[redacted]

To be clear:

(1) The physicians of the Pain Management section here at CTVHCS do not agree with what has been instituted by [redacted] — also as per my prior letter of concerns and more recent email regarding the issues highlighted.

(2) Multiple other physicians of CTVHCS have expressed disagreement with what has been instituted by [redacted] as well.

[redacted]

[redacted]

From: [redacted]
Sent: Wednesday, March 31, 2021 5:51 PM
To: [redacted]
Subject: FW: Consult to Pain Management

... Veterans are forced to complete an Intro to Whole Health before getting pain management care...

From: [redacted]
Sent: Wednesday, March 31, 2021 3:47 PM
To: [redacted]
Subject: RE: Consult to Pain Management

As long as the Intro class is scheduled, the pain consult can be scheduled. The class should be taken before the pain clinic appointment.

[redacted]

From: [redacted]
Sent: Wednesday, March 31, 2021 3:43 PM
To: [redacted]
Cc: [redacted]
Subject: RE: Consult to Pain Management

This means that the two events, pain clinic scheduling and intro class scheduling are not mutually exclusive, i.e. we may go ahead and schedule the patient in our pain clinics even if the patient has not yet completed the Whole Health intro. Class.

I shall add [redacted] on the email so he may comment, correct, or further clarify.

With appreciation,
[redacted]

From: [redacted]
Sent: Wednesday, March 31, 2021 2:55 PM
To: [redacted]
Subject: RE: Consult to Pain Management

Likewise if you don't mind clarifying. Thanks!

From: [redacted]
Sent: Wednesday, March 31, 2021 2:13 PM
To: [redacted]
Subject: RE: Consult to Pain Management

I do not understand.

What does this mean?

[redacted]

From: [redacted]
Sent: Wednesday, March 31, 2021 1:51 PM
To: [redacted]
Cc: [redacted]
Subject: Consult to Pain Management

Team,

Please note that if patients are scheduled for the Intro class, they may also be scheduled for the Pain clinic.

For questions, call me at [redacted]

Thanks,
[redacted]

From: [redacted]
To:
Subject: [PRIVATE]
Date: Thursday, April 15, 2021 9:56:00 AM

Hello [redacted]

To be clear,

Here is **clear written evidence that other staff at this facility are being instructed** as **per [redacted] recently changed consult processing instructions:**

This veteran is already established with a community care pain doctor. Best I can tell, per [redacted] consult processing instructions, CITC personnel has been instructed that the veteran requires Intro to Whole Health Class **prior** to obtaining (here, continuing, in this case) their pain management treatment.

Re:

Veterans are forced to complete an Intro to Whole Health before getting pain management care (regardless of whether … complementary approach is appropriate).

I believe the above bureaucratic steps prevent Veterans from getting the care required under the regulations… I do not believe this is consistent with regulations or the appropriate professional standards of care.

*** Please scroll all the way down, see highlighted portions ***

//

[redacted] [redacted] [redacted]

Current PC Provider: [redacted]
Current PC Team: TAMB PACT GOLD 5 *WH*
Current Pat. Status: Outpatient
UCID: [redacted]
Primary Eligibility: SERVICE CONNECTED 50% to 100%(VERIFIED)
Patient Type: SC VETERAN

OEF/OIF: NO

Service Connection/Rated Disabilities
SC Percent: 100%
Rated Disabilities: TRAUMATIC BRAIN DISEASE (70%)
SLEEP APNEA SYNDROMES (50%)
MIGRAINE HEADACHES (50%)
HEMORRHOIDS (20%)
HIATAL HERNIA (10%)
ALLERGIC OR VASOMOTOR RHINITIS (10%)
LIMITED FLEXION OF KNEE (10%)
SUPERFICIAL SCARS (10%)
FACIAL SCARS (10%)
LABYRINTHITIS (10%)
LIMITED EXTENSION OF KNEE (0%)
SINUSITIS,MAXILLARY,CHRONIC (0%)
SCARS (0%)
VENTRAL HERNIA (0%)
DEFORMITY OF THE PENIS (0%)

Order Information
To Service: COMMUNITY CARE-PAIN
From Service: TEM PACT GOLD PHY5
Requesting Provider: [redacted]
Service is to be rendered on an OUTPATIENT basis
Place: Consultant's choice
Urgency: Routine
Clinically Ind. Date: May 12, 2021
DST ID:
Orderable Item: COMMUNITY CARE-PAIN
Consult: Consult Request
Provisional Diagnosis: Cervicalgia(ICD-10-CM M54.2)
Reason For Request:
INTERVENTIONAL PAIN MANAGEMENT CONSULTATION GUIDELINES:
This consultation request is for Interventional Pain Management Procedures.

1. Reason for Request: Where is the primary location of the patient's worst pain for the consultant to address?

- Back Pain Yes
- Neck Pain Yes
- Other No (please specify):

2. Controlled Substances:

- Does the patient understand that the Interventional Pain Clinic offers procedures for the management of chronic pain and does not prescribe chronic controlled substances in the management

of chronic pain? Yes

3. Interventional Pain Management Procedures:

- Does the patient desire to receive interventional pain management injections for the management of Chronic Pain? Yes

4. Imaging:

- The patient needs to have advanced imaging of the area involved within the last two years. MRI is usually the preferred advanced imaging for the spine. If MRI is contraindicated then obtain CT scan of the involved area. If the patient had prior surgery to the spine then please request MRI with and without contrast if the renal function allows it. The official imaging report must be reviewed by pain management before the consultation can be accepted. Please specify where the official imaging report is found:

(Choice of only one is accepted; may not choose more than one)

VISTA Imaging

5. Blood Thinners:

- Is the patient receiving any blood thinners such as Coumadin, aspirin, clopidogrel, TSOACs (apixaban, dabigatran, or rivaroxaban) etc. No
- If the patient is on blood thinners, can the patient discontinue that medication for about 7 days WITHOUT ANY BRIDGING medication and without significant risk of developing stroke, cardiovascular insult, or any other problem for which the patient is receiving that medication to prevent. Not applicable

6. Laboratory investigations:

- Is the patient Diabetic? No
- If YES, then the HGB A1C within the last three months of the date of the consultation needs to be less than 8.
- Please indicate the VALUE and the DATE of the last HGB A1C:

Collection DT	Specimen	Test Name	Result	Units	Ref Range
10/22/2020 13:50	BLOOD	GLYCOHEMOGLOBIN	5.7	%	4.8 - 6.0

7. The Interventional Pain Management Clinic requires responses to the following questions regarding various modalities that may have been

used in the management of pain in this patient's pain:
a) Has the patient tried Physical Therapy or exercise within the last year? Yes
b) Has the patient tried Acetaminophen and/or NSAIDs within the last year? Yes
c) Has the patient tried Gabapentin and /or Duloxetine if neuropathic pain was suspected?
Yes
d) Has the patient tried the TENS Unit be tried within the last year?
Yes
e) Has the patient tried Cognitive Behavioral Therapy (CBT) or Pain Psychology within the last year?
Yes
8. Comments:

**********NOTES**********
ALL FIELDS MUST BE FILLED OUT for the consultation to go through, just like the MRI template. The consultation will not go through if one field is not answered.
****

Inter-facility Information
This is not an inter-facility consult request.

Status: ACTIVE
Last Action: RECEIVED

Facility
Activity Date/Time/Zone Responsible Person Entered By

CPRS RELEASED ORDER 04/12/21 12:57 [redacted] [redacted]
PRINTED TO 04/12/21 12:57
CTX-PTPMRS3 (BIG)
ADDED COMMENT 04/12/21 15:03 [redacted]
Per Veteran, awaiting approval for auth cont of care with established community care provider. Veteran does not wish to be seen by VA Pain Clinic, he wants to continue care with established provider, awaiting approval to schedule procedure.

ADDED COMMENT 04/12/21 15:05 [redacted]
[redacted] please enter referral for **the Intro to Whole Health Services, as this is mandated for Veterans who desire pain mgmt.**

RECEIVED 04/13/21 14:55 [redacted]
Please schedule this patient in the Introduction to Whole Health Class

before they will be scheduled in the Pain Management Consultation Clinic. The goal of this class is to provide an orientation to holistic care that is personalized, proactive, and patient-driven, and to emphasize the importance of self-management to achieving optimal treatment outcomes. Please inform the patient that the initial visit to this Pain Clinic is a consultation appointment that may be carried out as a VA Video encounter. There will be no procedure performed during the initial consultation. If the patient is interested in the Austin VA for consultation and procedures in Austin, you may forward this consultation to the "Austin WHS Pain Management Clinic.

-You may discontinue this consultation after failed outreach attempts and/or after reaching the appropriate number of "Cancellations by Patient" or "No Shows" as per policy.

-PLEASE CONTACT ME BY EMAIL OR CALL ME AT 43868 IF YOU HAVE ANY QUESTIONS OR CONCERNS REGARDING THE PROCESSING OF THIS CONSULTATION.

ADDED COMMENT 04/14/21 11:09 [redacted]

DST-DST ID: 403839c5-58e9-4dcd-8e32-0516a4105316
CSC-Consult stop code: 420
CSN-Clinical Service: PAIN CLINIC
CST-Consult service type: SPECIALTY CARE
DSW-DST Workflow: NEW PT
CCE-CC Eligibility Status: NO ELIGIBILITY FOUND

#COI# WAIT TIME CID:05/12/21

FORWARDED FROM 04/14/21 11:09 [redacted]
TEM WHS OUTPT PAIN MANAGEMENT
RECEIVED 04/14/21 13:36 [redacted]

SEOC - VHA Office of Community Care----------

VHA Office of Community Care - Standardized Episode of Care
Pain Management Comprehensive

CAT-SEOC CoC: PAIN MANAGEMENT
SEOC ID: MSC_PAIN MANAGEMENT COMPREHENSIVE_1.2.6_PRCT
Description: This authorization covers services associated with the specialty(s) identified for this episode of care, including all medical care listed below relevant to the referred care specified on the consult order. Medication Management including any opioid therapy should be consistent with VA/DOD clinical practice guidelines. This episode of care

does not include intrathecal drug delivery (IDD) or neuromodulation device care. Separate approval is required for IDD or neuromodulation device initiation and care.
Duration: 180 days

Procedural Overview:
1. Initial outpatient evaluation and treatment for the referred condition indicated on the consult order, including any restrictions for or against treatment options
2. Diagnostic imaging relevant to the referred condition on the consult order
3. Diagnostic studies relevant to the referred condition on the consult order including but not limited to: EMG/NCV
4. Labs including necessary drug screens and pathology relevant to the referred condition on the consult order
5. Injections including but not limited to: Medial branch blocks, epidural injections, facet injections, trigger point injections, genicular injections, joint injections
6. Procedures including but not limited to: radiofrequency ablation, vertebroplasty and spinal decompression
7. Anesthesia consultation related to a procedure
8. Pre-operative medical and cardiac clearance as indicated, to include H+P/labs, EKG, CXR, echo
9. Inpatient or observation admission for procedure, if indicated.
** Notify the referring VA of admission status to initiate and facilitate care coordination and discharge planning.
10. Inpatient admission or observation status for complications from the procedure
** Notify the referring VA of admission status to initiate and facilitate care coordination and discharge planning.
11. Follow-up visits for this episode of care
12. Physical Therapy: as indicated up to 15 visits as related to the referred condition on the consult order; Notify VA to request additional visits with supporting medical documentation
13. Occupational Therapy: as indicated up to 15 visits as related to the referred condition on the consult order; Notify VA to request additional visits with supporting medical documentation

*Please visit the VHA Storefront www.va.gov/COMMUNITYCARE/providers/index.asp for additional resources and requirements pertaining to the following
* Pharmacy prescribing requirements
* Durable Medical Equipment (DME), Prosthetics, and Orthotics prescribing requirements
* Precertification (PRCT) process requirements

* Request for Services (RFS) requirements
* DME, prosthetics and orthotics will be reviewed by the VA for provision.

SEO----------

SEV-Community Care Eligibility: Wait Time
CVA-Accept new consult, received during COVID-19 Pandemic

Scheduling prioritized during COVID-19 Pandemic
CV1-COVID-19 Priority 1
  Schedule appointment despite COVID-19 restrictions
As an alternative to a face-to-face appointment:
  TEL-Telephone Appointment may be offered to the Veteran
  THL-Telehealth Appointment may be offered to the Veteran
CAP-Community Care Approved, Program:
  Authorized/Pre-authorized Referral - 1703
ME-May discontinue if Veteran cancels/no-shows twice or fails to respond
to mandated scheduling effort.
CCH-Community Care Appt Scheduling to be handled by: Community provider
schedules directly with Veteran
Admin Screening for Care Coordination
SCD-Screening Code: 005-77-TC-A-85
  CAN Score: 85
Admin Screening=Moderate
Clinical Screening for Care Coordination
TCD-Clinical Triage Code: 040-77-TC-A
  Significant Comorbidities: no Significant Psychosocial Issues: no ADL
Support Needed: no

Clinical Triage Care Coordination: Moderate
Clinical Triage: Complete

After the appointment has been scheduled, the integrated team should
proceed to coordinate are based on the Veteran's needs.
Moderate care coordination may include:
-assistance with navigation
-scheduling
-post-appointment follow-up
-monitoring and coordination of preventative services

Recommended frequency of contact: monthly to quarterly

ICR-Initiate Community Care Referral

Community Care Coordinator:
Community Care Contact Number:

Note: TIME ZONE is local if not indicated

No local TIU results or Medicine results available for this consult
========== END ==========

From: [redacted]
To:
Subject: [redacted] — veteran affected
Date: Monday, October 4, 2021 4:26:00 PM

[redacted]

This is an **example of just one veteran** whose care has been affected by the consult template that [redacted], in his administrative role over Whole Health, had been allowed to enact with effects on:

1. Services, and ease of procurement of services, available to the veteran

2. Clinical availability and function of the Pain Management section

On the basis of [redacted] template, we had been instructed to discontinue the consult request if any answers are "no" to the template; as such, this veteran's consult request has been discontinued:

[redacted]

No 7. Veteran has been informed that they must take Introduction to Whole Health before they will be scheduled. Please place consult for Intro to Whole Health if patient has not yet completed this class. This is intended to optimize response to treatment patients achieve the best results from practitioner-delivered care when they also learn and practice self-management approaches.

[redacted]

From: [redacted]
To: [redacted]
Subject: [redacted]
Date: Monday, October 4, 2021 4:27:00 PM

Hello [redacted]

--- veteran affected

//////////////////////////////////

Here is a veteran that, best I can tell, that per [redacted] recently changed consult processing instructions, I myself had entered an Intro to Whole Health Class order for.

I had never even seen this patient.

[redacted]

//////////////////////////////////

Here is a veteran that, best I can tell, that per [redacted] recently changed consult processing instructions, I myself have just entered an Intro to Whole Health Class order for.

This veteran is already established with a community care pain doctor, and qualifies per drive time.

Best I can tell, per [redacted] recently consult processing instructions, the veteran required Intro to Whole Health Class also.

I also had never even seen this patient.

[redacted]

//////////////////////////////////

From: [redacted]
To: [redacted]
Cc:
Subject: pain school curriculum
Date: Monday, November 30, 2020 1:16:04 PM
Attachments: Anatomy of pain updated.pptx

Dear colleagues,
I hope everyone had a restful holiday!
We are working very hard to try to create an integrated, interdisciplinary approach to pain management that can meet the demand for services using the limited resources we have, while reducing the volume of referrals to the community. Based on discussions I have had with team members, and with pain management and Whole Health leaders in other facilities as well as with [redacted], I believe the best way to do this will be to create a single point of entry for referrals for pain management. This is critical for us to ensure that we deliver a consistent message to veterans and referring providers, that effective pain management requires patients to learn self-management skills.
To this end, all referrals for CIH and pain clinic will start with referral to Intro to Whole Health, where veterans will initiate the Personal Health Inventory. Ideally, they will go on to do individual coaching or at least the Taking Charge of my Health and my Life class. From there, they will choose which pathway they wish to start on. They cannot do everything at once – they can choose acupuncture, chiropractic, or pain clinic. They can certainly go to the other services later. (Other programs can be done in parallel, however, including yoga, KT, CBT for chronic pain, etc.)
We have already set this up for [redacted] acupuncture clinic – patients will attend her Traditional East Asian Medicine (TEAMS) class before having an individual evaluation. This class will include training in self acupressure as well as Qigong. After this, they will be scheduled for group acupuncture clinics.
I would like for the pain specialists and the chiropractors to work on doing something similar for their sections. I have already spoken with some of you about this.
I am sharing the slides that I have used for Pain School in Pittsburgh and in Salisbury. This will serve as the basis for the Palestine Whole Health PACT Pain School, but it can also be used for the other sections in our service. Regardless, they will need to be updated for content and clarity – I welcome any input from anyone.
Also, we have selected a Nurse Practitioner for our service, and she has accepted our tentative offer. Part of her duties will involve integrative pain management. There are several possibilities, including leading the pain school, running an Opioid Review clinic, or a running a SCOUTT clinic. We can discuss this further as a team.
With appreciation,

[redacted]
Clinical Director, Whole Health and Integrated Health Service

Central Texas VA Healthcare System

From: [redacted]
To: [redacted]
Subject: USC investigation — Communications/documents
Date: Monday, October 4, 2021 4:22:00 PM
Attachments: Communication- Updating the OHR- 10202021.pdf
Communication- OUD- 10172021.pdf
Communication- OpenPhone Bans- 12212020.pdf
Communication- SOP- Subcommittee- 10212021.pdf
Communication- Whistleblowers- 11302020.pdf
Communication- Community arts- continuity- 10192021.pdf
Communication- miscellaneous- 09282021.pdf
Communication- DTC Local- Policy- 3112021.pdf
Communication- Changing- versus- the- agreement- 01272021.pdf
Communications- Waiver- 01282021.pdf
[redacted]- CTVHCS- Dan- Phillipson.pdf

Hello [redacted]

The attached documents should contain the communications you requested.

Please let me know what else you would like from me.

[redacted]

From: [redacted]
To: [redacted]
Subject: Per request
Date: Monday, March 15, 2021 10:03:00 AM
Attachments: [redacted]_PerformancePay_12302020.pdf
[redacted]_Copy_with_Rebuttal_Response_LetterofCounseling[redacted]_01082021.pdf
[redacted]_Copy_Also[redacted]_LetterofCounseling_12182020.pdf
Communications_Updating_the_OPP_10202020.pdf
Communications_OUD_10172020.pdf
Communications_OpioidPrescribing_12212020.pdf
Communications_SOP_Subcommittee_[illegible]2020.pdf
Communications_WH[illegible]Care_11302020.pdf
Communications_CommunityCare_continuity_01082021.pdf
Communications_miscellaneous_01092021.pdf
Communications_CIIT_Local_Policy_3112021.pdf
Communications_Changing_service_line_agreement_01122021.pdf
Communications_System_01082021.pdf

Hello [redacted]

Please see the attachments, included as per my best understanding of your requests from our interview on March 12th, 2021.

You may have to get my job description from [redacted]; I could only find my Core Privileges, which I can send to you if you like.

[redacted]

From: [redacted]
To:
Subject: OSC investigation — veteran affected
Date: Monday, October 4, 2021 4:28:00 PM

Hello [redacted],

Here is **clear written evidence that other staff at this facility are being instructed** as **per [redacted] recently changed consult processing instructions:**

This veteran is already established with a community care pain doctor. Best I can tell, per [redacted] consult processing instructions, CITC personnel has been instructed that the veteran requires Intro to Whole Health Class **prior** to obtaining (here, continuing, in this case) their pain management treatment.

*** Please scroll all the way down, see highlighted portions ***

//

[redacted] [redacted] [redacted]

Current PC Provider: [redacted]
Current PC Team: T AMB PACT GOLD 5 *WH*
Current Pat. Status: Outpatient
UCID: [redacted]
Primary Eligibility: SERVICE CONNECTED 50% to 100%(VERIFIED)
Patient Type: SC VETERAN
OEF/OIF: NO

Service Connection/Rated Disabilities
SC Percent: 100%
Rated Disabilities: TRAUMATIC BRAIN DISEASE (70%)
SLEEP APNEA SYNDROMES (50%)
MIGRAINE HEADACHES (50%)
HEMORRHOIDS (20%)
HIATAL HERNIA (10%)
ALLERGIC OR VASOMOTOR RHINITIS (10%)
LIMITED FLEXION OF KNEE (10%)
SUPERFICIAL SCARS (10%)
FACIAL SCARS (10%)
LABYRINTHITIS (10%)

LIMITED EXTENSION OF KNEE (0%)
SINUSITIS,MAXILLARY,CHRONIC (0%)
SCARS (0%)
VENTRAL HERNIA (0%)
DEFORMITY OF THE PENIS (0%)

Order Information
To Service: COMMUNITY CARE-PAIN
From Service: TEM PACT GOLD PHY5
Requesting Provider: [redacted]
Service is to be rendered on an OUTPATIENT basis
Place: Consultant's choice
Urgency: Routine
Clinically Ind. Date: May 12, 2021
DST ID:
Orderable Item: COMMUNITY CARE-PAIN
Consult: Consult Request
Provisional Diagnosis: Cervicalgia(ICD-10-CM M54.2)
Reason For Request:
INTERVENTIONAL PAIN MANAGEMENT CONSULTATION GUIDELINES:
This consultation request is for Interventional Pain Management Procedures.

1. Reason for Request: Where is the primary location of the patient's worst pain for the consultant to address?

- Back Pain Yes
- Neck Pain Yes
- Other No (please specify):

2. Controlled Substances:
- Does the patient understand that the Interventional Pain Clinic offers procedures for the management of chronic pain and does not prescribe chronic controlled substances in the management of chronic pain? Yes

3. Interventional Pain Management Procedures:
- Does the patient desire to receive interventional pain management injections for the management of Chronic Pain? Yes

4. Imaging:
- The patient needs to have advanced imaging of the area involved within the last two years. MRI is usually the preferred advanced imaging for the spine.

If MRI is contraindicated then obtain CT scan of the involved area.

If
the patient had prior surgery to the spine then please request MRI
with
and without contrast if the renal function allows it. The official
imaging report must be reviewed by pain management before the
consultation can be accepted. Please specify where the official
imaging
report is found:
(Choice of only one is accepted; may not choose more than one)
VISTA Imaging

5. Blood Thinners:
- Is the patient receiving any blood thinners such as Coumadin,
aspirin, clopidogrel, TSOACs (apixaban, dabigatran, or
rivaroxaban)
etc. No
- If the patient is on blood thinners, can the patient discontinue
that
medication for about 7 days WITHOUT ANY BRIDGING medication and
without
significant risk of developing stroke, cardiovascular insult, or
any
other problem for which the patient is receiving that medication to
prevent. Not applicable

6. Laboratory investigations:
- Is the patient Diabetic? No
- If YES, then the HGB A1C within the last three months of the date
of
the consultation needs to be less than 8.
- Please indicate the VALUE and the DATE of the last HGB A1C:

Collection DT	Specimen	Test Name	Result	Units	Ref Range
10/22/2020 13:50	BLOOD	GLYCOHEMOGLOBIN	5.7	%	4.8 - 6.0

7. The Interventional Pain Management Clinic requires responses to the
following questions regarding various modalities that may have been
used in the management of pain in this patient's pain:
a) Has the patient tried Physical Therapy or exercise within the last
year? Yes
b) Has the patient tried Acetaminophen and/or NSAIDs within the last
year? Yes
c) Has the patient tried Gabapentin and /or Duloxetine if

neuropathic pain was suspected?
Yes
d) Has the patient tried the TENS Unit be tried within the last year?
Yes
e) Has the patient tried Cognitive Behavioral Therapy (CBT) or Pain Psychology within the last year?
Yes

8. Comments:

**********NOTES**********

ALL FIELDS MUST BE FILLED OUT for the consultation to go through, just like the MRI template. The consultation will not go through if one field is not answered.

****

Inter-facility Information
This is not an inter-facility consult request.

Status: ACTIVE
Last Action: RECEIVED

Facility
Activity Date/Time/Zone Responsible Person Entered By

CPRS RELEASED ORDER 04/12/21 12:57 [redacted] [redacted]
PRINTED TO 04/12/21 12:57
CTX-PTPMRS3 (BIG)
ADDED COMMENT 04/12/21 15:03 [redacted]
Per Veteran, awaiting approval for auth cont of care with established community care provider. Veteran does not wish to be seen by VA Pain Clinic, he wants to continue care with established provider, awaiting approval to schedule procedure.

ADDED COMMENT 04/12/21 15:05 [redacted]
[redacted] please enter referral for **the Intro to Whole Health Services, as this is mandated for Veterans who desire pain mgmt.**

RECEIVED 04/13/21 14:55 [redacted]
Please schedule this patient in the Introduction to Whole Health Class before they will be scheduled in the Pain Management Consultation Clinic.

The goal of this class is to provide an orientation to holistic care that is personalized, proactive, and patient-driven, and to emphasize the importance of self-management to achieving optimal treatment outcomes. Please inform the patient that the initial visit to this Pain Clinic is a consultation appointment that may be carried out as a VA Video encounter. There will be no procedure performed during the initial consultation. If the patient is interested in the Austin VA for consultation and procedures in Austin, you may forward this consultation to the "Austin WHS Pain Management Clinic.

-You may discontinue this consultation after failed outreach attempts and/or after reaching the appropriate number of "Cancellations by Patient" or "No Shows" as per policy.

-PLEASE CONTACT ME BY EMAIL OR CALL ME AT 43868 IF YOU HAVE ANY QUESTIONS OR CONCERNS REGARDING THE PROCESSING OF THIS CONSULTATION.

ADDED COMMENT 04/14/21 11:09 [redacted]

DST-DST ID: 403839c5-58e9-4dcd-8e32-0516a4105316
CSC-Consult stop code: 420
CSN-Clinical Service: PAIN CLINIC
CST-Consult service type: SPECIALTY CARE
DSW-DST Workflow: NEW PT
CCE-CC Eligibility Status: NO ELIGIBILITY FOUND

#COI# WAIT TIME CID:05/12/21

FORWARDED FROM 04/14/21 11:09 [redacted]
TEM WHS OUTPT PAIN MANAGEMENT
RECEIVED 04/14/21 13:36 [redacted]

SEOC - VHA Office of Community Care----------

VHA Office of Community Care - Standardized Episode of Care
Pain Management Comprehensive

CAT-SEOC CoC: PAIN MANAGEMENT
SEOC ID: MSC_PAIN MANAGEMENT COMPREHENSIVE_1.2.6_PRCT
Description: This authorization covers services associated with the specialty(s) identified for this episode of care, including all medical care listed below relevant to the referred care specified on the consult order. Medication Management including any opioid therapy should be consistent with VA/DOD clinical practice guidelines. This episode of care does not include intrathecal drug delivery (IDD) or neuromodulation device

care. Separate approval is required for IDD or neuromodulation device initiation and care.
Duration: 180 days

Procedural Overview:
1. Initial outpatient evaluation and treatment for the referred condition indicated on the consult order, including any restrictions for or against treatment options
2. Diagnostic imaging relevant to the referred condition on the consult order
3. Diagnostic studies relevant to the referred condition on the consult order including but not limited to: EMG/NCV
4. Labs including necessary drug screens and pathology relevant to the referred condition on the consult order
5. Injections including but not limited to: Medial branch blocks, epidural injections, facet injections, trigger point injections, genicular injections, joint injections
6. Procedures including but not limited to: radiofrequency ablation, vertebroplasty and spinal decompression
7. Anesthesia consultation related to a procedure
8. Pre-operative medical and cardiac clearance as indicated, to include H+P/labs, EKG, CXR, echo
9. Inpatient or observation admission for procedure, if indicated.
** Notify the referring VA of admission status to initiate and facilitate care coordination and discharge planning.
10. Inpatient admission or observation status for complications from the procedure
** Notify the referring VA of admission status to initiate and facilitate care coordination and discharge planning.
11. Follow-up visits for this episode of care
12. Physical Therapy: as indicated up to 15 visits as related to the referred condition on the consult order; Notify VA to request additional visits with supporting medical documentation
13. Occupational Therapy: as indicated up to 15 visits as related to the referred condition on the consult order; Notify VA to request additional visits with supporting medical documentation

*Please visit the VHA Storefront www.va.gov/COMMUNITYCARE/providers/index.asp for additional resources and requirements pertaining to the following
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* Durable Medical Equipment (DME), Prosthetics, and Orthotics prescribing requirements
* Precertification (PRCT) process requirements
* Request for Services (RFS) requirements

* DME, prosthetics and orthotics will be reviewed by the VA for provision.

SEO----------

SEV-Community Care Eligibility: Wait Time
CVA-Accept new consult, received during COVID-19 Pandemic

Scheduling prioritized during COVID-19 Pandemic
CV1-COVID-19 Priority 1
  Schedule appointment despite COVID-19 restrictions
As an alternative to a face-to-face appointment:
  TEL-Telephone Appointment may be offered to the Veteran
  THL-Telehealth Appointment may be offered to the Veteran
CAP-Community Care Approved, Program:
  Authorized/Pre-authorized Referral - 1703
ME-May discontinue if Veteran cancels/no-shows twice or fails to respond
to mandated scheduling effort.
CCH-Community Care Appt Scheduling to be handled by: Community provider
schedules directly with Veteran
Admin Screening for Care Coordination
SCD-Screening Code: 005-77-TC-A-85
  CAN Score: 85
Admin Screening=Moderate
Clinical Screening for Care Coordination
TCD-Clinical Triage Code: 040-77-TC-A
  Significant Comorbidities: no Significant Psychosocial Issues: no ADL
Support Needed: no

Clinical Triage Care Coordination: Moderate
Clinical Triage: Complete

After the appointment has been scheduled, the integrated team should
proceed to coordinate are based on the Veteran's needs.
Moderate care coordination may include:
-assistance with navigation
-scheduling
-post-appointment follow-up
-monitoring and coordination of preventative services

Recommended frequency of contact: monthly to quarterly

ICR-Initiate Community Care Referral
Community Care Coordinator:

Community Care Contact Number:

Note: TIME ZONE is local if not indicated

No local TIU results or Medicine results available for this consult
========== END ==========

From: [redacted]
To: [redacted]
Subject: OSC — FW: Whole Health — Intro Class — Changes to Processing
Date: Monday, January 10, 2022 4:19:00 PM

Hello [redacted]

Please see message.

[redacted]

From: [redacted]
Sent: Monday, January 10, 2022 4:00 PM
To: [redacted]
Subject: Whole Health — Intro Class — Changes to Processing

To whom it may concern

It appears that changes have occurred:

- "Whole Health is NOT a prerequisite for" the traditional and complementary treatments offered.

- Explicit statement that Whole Health Coaches cannot evaluate and/or medically clear patients OR submit consults for the traditional and complementary treatments offered.

Sincerely,

[redacted]

//

Re:

[redacted] [redacted] [redacted]

//

<EXCERPT>

Veteran only wants pain management and acupuncture care at this time.

As written this consult only pertains to scheduling an appointment with a Whole Health Coach.

Intro to Whole Health is NOT a prerequisite for chiropractic care and/or pain management and/or acupuncture therapeutic treatment.

Whole Health Coaches cannot evaluate and/or medically clear patients or submit consults for chiropractic care and/or pain management and/or acupuncture therapeutic treatment.

//

<FULL>

Current PC Provider: [redacted]
Current PC Team: [redacted]
nt Pat. Status: [redacted] 50% to 100%(VERIFIED)
OEF/OIF: NO

Service Connection/Rated Disabilities
SC Percent: 70%
Rated Disabilities: LUMBOSACRAL OR CERVICAL STRAIN (20%)
LUMBOSACRAL OR CERVICAL STRAIN (20%)
TINNITUS (10%)
LIMITED MOTION OF ANKLE (10%)
PARALYSIS OF SCIATIC NERVE (10%)
PARALYSIS OF SCIATIC NERVE (10%)
IMPAIRED HEARING (10%)
LIMITED MOTION OF ANKLE (10%)
SEPTUM, NASAL, DEVIATION OF (0%)
LARYNGITIS,CHRONIC (0%)

Order Information
To Service: TEM WHS OUTPT INTRO TO WHOLE HEALTH
From Service: ROC2
Requesting Provider: [redacted]
Service is to be rende[redacted]TIENT basis
Place: Consultant's choice
Urgency: Routine
Clinically Ind. Date: Jan 10, 2022
DST ID:
Orderable Item: TEM WHS OUTPT INTRO TO WHOLE HEALTH
Consult: Consult Request
Provisional Diagnosis: Illness, unspecified(ICD-10-CM R69.)
Reason For Request:
If you are requesting consult to the Whole Health Integrated Pain Management program for your patient to receive Acupuncture, Chiropractic or Pain Management clinic services, in addition to this Intro to Whole Health consult you must also complete the whole health integrated pain manage consult specific for the one service you are requesting. If the Veteran has already attended Intro to Whole Health, exit out of this consult and proceed as indicated.

REASON FOR REQUEST

Acupuncture

All patients involved in Whole Health should attend a one hour Introduction to Whole Health Class (Orientation) and a minimum of one WH Coaching session. Introduction to WH is offered in multiple modalities to accommodate patient needs.

Is this a STAT consult?

Inter-facility Information
This is not an inter-facility consult request.

Status: CANCELLED
Last Action: CANCELLED
Significant Findings: Unknown

Facility Activity	Date/Time/Zone	Responsible Person	Entered By
CPRS RELEASED ORDER	01/10/22 11:53	[redacted]	[redacted]
[redacted]E	01/10/22 12:47		

As written this consult only pertains to scheduling an appointment with a Whole Health Coach.

Intro to Whole Health is NOT a prerequisite for chiropractic care and/or pain management and/or acupuncture therapeutic treatment.

Whole Health Coaches cannot evaluate and/or medically clear patients or submit consults for chiropractic care and/or pain management and/or acupuncture therapeutic treatment.

01/10/22 12:47 [redacted]

[redacted]y Status: NO ELIGIBILITY FOUND

CVA-Accept new consult, received during COVID-19 Pandemic
ME-May discontinue if Veteran fails to respond to mandated scheduling effort.
CUR-CTB User Role: Scheduler

01/10/22 12:49 [redacted]

[redacted]y Status: NO ELIGIBILITY FOUND

C1-First call to Veteran: Left voicemail
L1-Unable to schedule letter sent by mail to Veteran.
CUR-CTB User Role: Scheduler

[redacted] [redacted] [redacted]
to participate in the Intro to Whole Health coaching orientation session(s) at this time.

Veteran only wants pain management and acupuncture care at this time.

As written this consult only pertains to scheduling an appointment with a Whole Health Coach.

Intro to Whole Health is NOT a prerequisite for chiropractic care and/or pain management and/or acupuncture therapeutic treatment.

Whole Health Coaches cannot evaluate and/or medically clear patients or submit consults for chiropractic care and/or pain management and/or acupuncture therapeutic treatment.

Note: TIME ZONE is local if not indicated

Significant Findings: Unknown

No local TIU results or Medicine results available for this consult
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===
========== END
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From: [redacted]
To:
Subject: OIG Hotline Case --- [redacted] --- "The single consult will channel folks through the Health Coaches. "
Date: Friday, August 6, 2021 8:06:00 AM

On 11/17/2020 at the VISN Pain Stewardship meeting, [redacted] brought up the ICC today re: specifically the Specialty Care ICC

Re: Whole Health and integrating with ICC.

[redacted]: "Whole Health at the VISN has been aligned at the Primary Care ICC".
: "Because it is interdisciplinary, it should have a seat at the table with each of the ICCs"
: "We have aligned the pain section under Whole Health ... I know that's a little unorthodox"

When asked by [redacted], [redacted] responded: "We are headed that way" re: **centralized consult approach between CIH approaches and Pain clinic**. The **single consult will channel folks through the Health Coaches**. We only have 4 on staff. We are posting for several more. I have spoken to several of the pain specialists" re: the centralized approach. Everyone is enthusiastic about that component of it. We also will be working on a shared medical appointment, Pain school curriculum, 4 week series, behavior, nutrition, exercise, pharmacotherapy."

"Everything will be based on collaborative care, team care, **including monitoring patients who are on suboxone or opiates.**"

"By January, we will have this up and running; that's my goal right now."

"already, prior to us even considering Palestine, I was concerned about the team dynamics at other CBOCs that I visited... There were able to field their patients' needs without a lot of walk-ins."

//
//

From: [redacted]
To:
Subject: [redacted]s emails re: Scheduling follow-ups and Community Care
Date: Friday, January 8, 2021 2:31:00 PM
Attachments: Veteran Community Care—Eligibility Fact Sheet.pdf

---

Hello [redacted],

I am not sure how/if to reply to [redacted] recent emails regarding:

1) **Scheduling follow up visits:**

- VVC is only booked in my procedure clinics if the clinics are not filled or not likely to be filled with procedure patients as the procedure clinic day gets closer.
- My clinic is more than just doing injections; there are evaluations that need to be followed up on… I am concerned that some veterans will get lost to follow-up exactly when the risk is highest for them.
- Some veterans, and this is true for all patients, take a few visits to build trust.
- I can conceivably ask for appointments with veterans following requested studies being available, but this takes time, and [redacted] has taken my administrative time… I am already trying to put this change into play, but this will lead to unpredictability in procedure scheduling citing all of the above…

2) Regarding **community care consults** for continuity care being only applicable if patients are immediate post-op, this does not seem to take into account how personal it is for most patients as to who they trust to touch their spine for procedures. The risks by name of the procedures we do are not minor risks; the risks are potentially catastrophic; a lot goes into building the relationship with the patient and ensuring the patients that we will be stewards in their safe care --- and that is also true for the patients in their relationship with interventional pain doctors in the community. I am also not sure that this stance is consistent with VHA stances on the matter… see attached (I searched for this myself after I did not receive it from Community Care upon request … I am not sure if aspects of the attachment are no longer applicable?).

When I spoke to [redacted] and asked him for the actual documents to guide the process of community care referral processing, he eventually agreed that that is a fair request on my part, he indicated he would get back to me with the VHA Policy (and then he mentioned that there is a local facility policy) that guides the Community Care referrals. He then wrote me an email which referenced an "attached explanation and example" for my review--- there was no such attachment to his email; there were no policy documents attached either.

I wrote [redacted] in a reply to his email:

"

Hello sir,

I do not see any attached explanations or examples, maybe the attachments did not take? Also, you had indicated something along the lines of this being a VHA and, then I think you said, local facility mandate/directive; to minimize any possible confusion on my part, please send me those documents are per our discussion.

Thank you,

[redacted]

[redacted] then copied [redacted] in a response to the above and wrote the following in return, which was not informative.

Happy New Year [redacted].

Sir, I will defer further questions to [redacted] as we have discussed this matter. He can clarify further with you.

Thanks.

[redacted]

[redacted]

From: [redacted]
To: [redacted]
Subject: OMI — Consults under Whole Health — Deviations from the Mission Act
Date: Friday, January 7, 2022 8:50:00 AM

Hello OMI team,

Below is another example of a veteran consult request that was processed according to the orders of [redacted], under threat of administrative action (as all the others prior, no change to that) and not as the Mission Act would direct ...

Like all the other consults I have sent your way, I have processed it according to orders from [redacted]. I disagree with the disposition of the consult (like so many consults processed previously and/or shared with you) according to his instructions.

Like the other consults I have sent your way, I disagree with [redacted] administrative insertion into our judgment on these matters.

Sincerely,

[redacted]

//

< EXCERPT >

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CCE-CC Eligibility Status: ELIGIBLE
  VCC-Veteran CC option: OPT-IN
  BVP-Basis for Veteran Preference: Existing relationship with provider
  CSC-Consult stop code: 420
  CSN-Clinical service: Pain Clinic
  CST-Consult service type: Specialty Care
  SEV-CC Eligibility: BMI-Potential for improved continuity of care
    Veteran seen at ADVANCED PAIN CARE in Round Rock by
Dr. Dennis, underwent RFA not done at the VA with significant symptom
relief needing renewal of CC PAIN REFERRAL.  Significant hardship travelling
```

//

Re:

[redacted]

//

< FULL >

Current PC Provider: [redacted]
Current PC Team: [redacted]WH*
[redacted]nt Pat. Status: [redacted]
[redacted]ry Eligibility: [redacted]NECTED 50% to 100%(VERIFIED)
Patient Type: SC VETERAN
OEF/OIF: YES

Service Connection/Rated Disabilities
SC Percent: 100%
Rated Disabilities: POST-TRAUMATIC STRESS DISORDER (100%)
MIGRAINE HEADACHES (50%)
TRAUMATIC BRAIN DISEASE (40%)
HIATAL HERNIA (10%)
HEMORRHOIDS (0%)
LIMITED MOTION OF ANKLE (0%)

Order Information
To Service: TEM WHS OUTPT PAIN MANAGEMENT
From Service:
Requesting Provider: [redacted]
Service is to be render[redacted]asis
Place: Consultant's choice
Urgency: Routine
Clinically Ind. Date: Jan 07, 2022
DST ID: 796fd6ba-dff3-4e69-be6e-875cf61ea33b
Orderable Item: TEM WHS OUTPT PAIN MANAGEMENT
Consult: Consult Request
Provisional Diagnosis: Other Spondylosis with Radiculopathy, Lumbar Region(ICD-10-CM M47.26)
Reason For Request:
1. Reason for Request: Where is the primary location of the patient's worst pain for the consultant to address?
- Back Pain Yes
- Neck Pain No
- Other No (please specify):
2. Interventional Pain Management Procedures:
- Does the patient desire to receive interventional pain management injections for the management of Chronic Pain? Yes
3. Imaging:
- The patient needs to have advanced imaging of the area involved within the last two years. MRI is usually the preferred advanced imaging for the spine.
If MRI is contraindicated then obtain CT scan of the involved area. If the patient had prior surgery to the spine then please request MRI with and without contrast if the renal function allows it. The official imaging report must be reviewed by pain management before the consultation can be accepted. Please specify where the official imaging report is found:
(Choice of only one is accepted; may not choose more than one)
CPRS

4. Blood Thinners:
- Is the patient receiving any blood thinners such as Coumadin, aspirin, clopidogrel, TSOACs (apixaban, dabigatran, or rivaroxaban) etc. No
- If the patient is on blood thinners, can the patient discontinue that medication for about 7 days WITHOUT ANY BRIDGING medication and without significant risk of developing stroke, cardiovascular insult, or any other problem for which the patient is receiving that medication to prevent. Not applicable
5. Laboratory investigations:
- Is the patient Diabetic? No
- If YES, then the HGB A1C within the last three months of the date of the consultation needs to be less than 8 for intervention.
- Please indicate the VALUE and the DATE of the last HGB A1C:

Collection DT	Specimen	Test Name	Result	Units	Ref Range
06/28/2021 07:02	BLOOD	GLYCOHEMOGLOBIN	4.5 L	%	4.8 - 6.0

6. The Interventional Pain Management Clinic requires responses to the following questions regarding various modalities that may have been used in the management of pain in this patient's pain:
a) Has the patient tried Physical Therapy or exercise within the last year? Yes
b) Has the patient tried Acetaminophen and/or NSAIDs within the last year? Yes
c) Has the patient tried Gabapentin and /or Duloxetine if neuropathic pain was suspected? Yes
d) Has the patient tried the TENS Unit be tried within the last year? Yes
e) Has the patient tried Cognitive Behavioral Therapy (CBT) or Pain Psychology within the last year? No
7. Comments:
[redacted] seen at [redacted] by [redacted] underwent RFA not done at the VA with significant symptom relief needing renewal of CC PAIN REFERRAL. Significant hardship travelling to Temple as LBP only allows pt. to drive very limited distance and time

**********NOTES**********
ALL FIELDS MUST BE FILLED OUT for the consultation to go through, just like the MRI template. The consultation will not go through if one field is not answered.
****
Inter-facility Information
This is not an inter-facility consult request.

Status: ACTIVE
Last Action: RECEIVED

Facility Activity	Date/Time/Zone	Responsible Person	Entered By
CPRS RELEASED ORDER	01/07/22 08:39	[redacted]	[redacted]
ADDED COMMENT	01/07/22	[redacted]	[redacted]

(entered) 01/07/22 08:39
CCE-CC Eligibility Status: ELIGIBLE
VCC-Veteran CC option: OPT-IN
BVP-Basis for Veteran Preference: Existing relationship with provider
CSC-Consult stop code: 420
CSN-Clinical service: Pain Clinic
CST-Consult service type: Specialty Care
SEV-CC Eligibility: BMI-Potential for improved continuity of care
Veteran seen at [redacted] underwent RFA not done at the VA with significant symptom relief needing renewal of CC PAIN REFERRAL. Significant hardship travelling
CCE----------
SEOC - VHA Office of Community Care----------
VHA Office of Community Care - Standardized Episode of Care
Pain Management Comprehensive
CAT-SEOC CoC: PAIN MANAGEMENT

SEOC ID: MSC_PAIN MANAGEMENT COMPREHENSIVE_1.2.7_PRCT
Description: This authorization covers services associated with the specialty(s) identified for this episode of care, including all medical care listed below relevant to the referred care specified on the consult order. Note: Medication Management including any opioid therapy should be consistent with VA/DOD clinical practice guidelines. This episode of care does not include intrathecal drug delivery (IDD) or neuromodulation device care. Separate approval is required for IDD or neuromodulation device initiation and care.
Duration: 180 days
Procedural Overview:
1. Initial outpatient evaluation and treatment for the referred condition indicated on the consult order, including any restrictions for or against treatment options
2. Diagnostic imaging relevant to the referred condition on the consult order
3. Diagnostic studies relevant to the referred condition on the consult order including but not limited to: EMG/NCV
4. Labs including necessary drug screens and pathology relevant to the referred condition on the consult order
5. Injections including but not limited to: Medial branch blocks, epidural injections, facet injections, trigger point injections, genicular injections, joint injections
6. Procedures including but not limited to: radiofrequency ablation, vertebroplasty and spinal decompression
7. Anesthesia consultation related to a procedure
8. Pre-procedure medical and basic cardiac clearance, as indicated (including H+P/labs, EKG, CXR, echo)
Note: cardiac testing or evaluation outside of the above CXR, EKG and echo will require an RFS for a cardiology referral
9. Inpatient or observation admission for procedure and/or procedure related complications, if indicated.
Notify the referring VA of admission status to initiate and facilitate care coordination and discharge planning.
10. Follow-up visits as related to the referred condition on the consult order
11. Outpatient Physical Therapy: as indicated up to 15 visits as related to the referred condition on the consult order; Notify VA to request additional visits with supporting medical documentation
12. Outpatient Occupational Therapy: as indicated up to 15 visits as related to the referred condition on the consult order; Notify VA to request additional visits with supporting medical documentation
Please visit the VHA Storefront www.va.gov/COMMUNITYCARE/providers/index.asp for additional resources and requirements pertaining to the following:
Pharmacy prescribing requirements
Durable Medical Equipment (DME), Prosthetics, and Orthotics prescribing requirements
Precertification (PRCT) process requirements
Request for Services (RFS) requirements
SEO----------
CUR-CTB User Role: Provider
COM-Additional Comments:
[redacted]en at [redacted]by [redacted], underwent RFA not done at the VA with significant symptom [redacted]ding renewal of CC PAIN REFERRAL. Significant hardship travelling to Temple as LBP only allows pt. to drive very limited distance and time needing renewal of expired previously approved CC PAIN MX consult for improved continuity of care
COM----------

PRINTED TO 01/07/22 08:39
CTX-PTPMRS3 (BIG)
RECEIVED 01/07/22 08:43 [redacted] [redacted]
M
Please schedule this patient in the Pain Management Consultation Clinic following the updated guidelines for the Mission Act and the current COVID-19 scheduling modifications. Please inform the patient that the

initial visit to this Pain Clinic is a consultation appointment that may be carried out as a VA Video encounter. There will be no procedure performed during the initial consultation. If the patient is interested in the Austin VA for consultation and procedures in Austin, you may forward this consultation to the "Austin Surg Pain Management Clinic.

-You may discontinue this consultation after failed outreach attempts and/or after reaching the appropriate number of Cancellations by Patient or No Shows as per policy.

Note: TIME ZONE is local if not indicated

No local TIU results or Medicine results available for this consult
========== END
==========

From: [redacted]
To: [redacted]
Subject: OMI — Consults under Whole Health — Deviations from the Mission Act
Date: Wednesday, November 10, 2021 10:50:00 AM

Hello OMI team,

Below is another example of a veteran consult request that clarifies the matter very cleanly / Mission Act …

Like all the other consults I have sent your way, I have processed it according to orders from [redacted]

Sincerely,

[redacted]

//

< EXCERPT >

CCE-CC Eligibility Reason: Eligible
PCC-Veteran CC Option: OPC-IN
RVP-Basis for Veteran Preference: Existing relationship with provider
CSC-Consult stop code: 422
CSN-Clinical service: Pain Clinic
CST-Consult service type: Specialty Care
REP-CC Eligibility PMT-Potential for imminent continuity of care
Needs renewal of [redacted]
CCE

//

Re:

[redacted] [redacted] [redacted]

//

< FULL >

Current PC Provider: [redacted]
Current PC Team: 2 *WH*
Current Pat. Status:
UCID:
Primary Eligibility: [redacted]NECTED 50% to 100%(VERIFIED)
Patient Type: SC VETERAN
OEF/OIF: YES

Service Connection/Rated Disabilities
SC Percent: 100%
Rated Disabilities: MAJOR DEPRESSIVE DISORDER (70%)
PARALYSIS OF SCIATIC NERVE (40%)
LUMBOSACRAL OR CERVICAL STRAIN (40%)
PARALYSIS OF SCIATIC NERVE (40%)
SCARS (0%)

Order Information
To Service: TEM WHS OUTPT PAIN MANAGEMENT
From Service:
Requesting Provider: [redacted]
Service is to be render[redacted]ENT basis
Place: Consultant's choice
Urgency: Routine
Clinically Ind. Date: Nov 09, 2021
DST ID: 38889f79-9c6b-4bf4-9d3c-68453770a281
Orderable Item: TEM WHS OUTPT PAIN MANAGEMENT
Consult: Consult Request
Provisional Diagnosis: Vertebrogenic low back pain(ICD-10-CM M54.51)
Reason For Request:
PAIN MANAGEMENT CONSULTATION GUIDELINES:
This consultation request is for Pain Management Procedures.
1. Reason for Request: Where is the primary location of the patient's worst pain for the consultant to address?
- Back Pain Yes
- Neck Pain Yes
- Other No (please specify):
Needs approval please for
renewal of
CITC pain management
for continuity of care

[redacted]

2. Interventional Pain Management Procedures:
- Does the patient desire to receive interventional pain management injections for the management of Chronic Pain? Yes
3. Imaging:
- The patient needs to have advanced imaging of the area involved within the last two years. MRI is usually the preferred advanced imaging for the spine.
If MRI is contraindicated then obtain CT scan of the involved area.
If the patient had prior surgery to the spine then please request MRI with and without contrast if the renal function allows it. The official imaging report must be reviewed by pain management before the consultation can be accepted. Please specify where the official imaging report is found:
(Choice of only one is accepted; may not choose more than one)

CPRS
4. Blood Thinners:
- Is the patient receiving any blood thinners such as Coumadin, aspirin, clopidogrel, TSOACs (apixaban, dabigatran, or rivaroxaban) etc. No
- If the patient is on blood thinners, can the patient discontinue that medication for about 7 days WITHOUT ANY BRIDGING medication and without significant risk of developing stroke, cardiovascular insult, or any other problem for which the patient is receiving that medication to prevent. Not applicable
5. Laboratory investigations:
- Is the patient Diabetic? No
- If YES, then the HGB A1C within the last three months of the date of the consultation needs to be less than 8 for intervention.
- Please indicate the VALUE and the DATE of the last HGB A1C:

Collection DT	Specimen	Test Name	Result	Units	Ref Range
09/05/2019 07:48	BLOOD	GLYCOHEMOGLOBIN	6.0	%	4.8 - 6.0

6. The Interventional Pain Management Clinic requires responses to the following questions regarding various modalities that may have been used in the management of pain in this patient's pain:
a) Has the patient tried Physical Therapy or exercise within the last year? Yes
b) Has the patient tried Acetaminophen and/or NSAIDs within the last year? Yes
c) Has the patient tried Gabapentin and /or Duloxetine if neuropathic pain was suspected? Yes
d) Has the patient tried the TENS Unit be tried within the last year? Yes
e) Has the patient tried Cognitive Behavioral Therapy (CBT) or Pain Psychology within the last year? Yes
7. Comments:
Whole Health

**********NOTES**********
ALL FIELDS MUST BE FILLED OUT for the consultation to go through, just like the MRI template. The consultation will not go through if one field is not answered.
****
Inter-facility Information
This is not an inter-facility consult request.

Status: ACTIVE
Last Action: RECEIVED

Facility Activity	Date/Time/Zone	Responsible Person	Entered By
[redacted]	DER 11/09/21 18:04	[redacted]	[redacted]

entered) 11/09/21 18:04
CCE-CC Eligibility Status: ELIGIBLE
VCC-Veteran CC option: OPT-IN
BVP-Basis for Veteran Preference: Existing relationship with provider
CSC-Consult stop code: 420
CSN-Clinical service: Pain Clinic
CST-Consult service type: Specialty Care
SEV-CC Eligibility:
Needs renewal of [redacted]
CCE----------
SEOC - VHA Office of Community Care----------
VHA Office of Community Care - Standardized Episode of Care
Pain Management Comprehensive
CAT-SEOC CoC: PAIN MANAGEMENT
SEOC ID: MSC_PAIN MANAGEMENT COMPREHENSIVE_1.2.7_PRCT
Description: This authorization covers services associated with the specialty(s) identified for this episode of care, including all medical care listed below relevant to the referred care specified on the consult order. Note: Medication Management including any opioid therapy should

be consistent with VA/DOD clinical practice guidelines.
This episode of care does not include intrathecal drug delivery (IDD) or neuromodulation device care. Separate approval is required for IDD or neuromodulation device initiation and care.
Duration: 180 days
Procedural Overview:
1. Initial outpatient evaluation and treatment for the referred condition indicated on the consult order, including any restrictions for or against treatment options
2. Diagnostic imaging relevant to the referred condition on the consult order
3. Diagnostic studies relevant to the referred condition on the consult order including but not limited to: EMG/NCV
4. Labs including necessary drug screens and pathology relevant to the referred condition on the consult order
5. Injections including but not limited to: Medial branch blocks, epidural injections, facet injections, trigger point injections, genicular injections, joint injections
6. Procedures including but not limited to: radiofrequency ablation, vertebroplasty and spinal decompression
7. Anesthesia consultation related to a procedure
8. Pre-procedure medical and basic cardiac clearance, as indicated (including H+P/labs, EKG, CXR, echo)
Note: cardiac testing or evaluation outside of the above CXR, EKG and echo will require an RFS for a cardiology referral
9. Inpatient or observation admission for procedure and/or procedure related complications, if indicated.
Notify the referring VA of admission status to initiate and facilitate care coordination and discharge planning.
10. Follow-up visits as related to the referred condition on the consult order
11. Outpatient Physical Therapy: as indicated up to 15 visits as related to the referred condition on the consult order; Notify VA to request additional visits with supporting medical documentation
12. Outpatient Occupational Therapy: as indicated up to 15 visits as related to the referred condition on the consult order; Notify VA to request additional visits with supporting medical documentation
Please visit the VHA Storefront www.va.gov/COMMUNITYCARE/providers/index.asp for additional resources and requirements pertaining to the following:
Pharmacy prescribing requirements
Durable Medical Equipment (DME), Prosthetics, and Orthotics prescribing requirements
Precertification (PRCT) process requirements
Request for Services (RFS) requirements
SEO----------

[redacted]

PRINTED TO 11/09/21 18:04

CTX-PTPMRS3 (BIG)
RECEIVED 11/10/21 10:46 [redacted] [redacted]
M
Please schedule this patient in the Pain Management Consultation Clinic following the updated guidelines for the Mission Act and the current COVID-19 scheduling modifications. Please inform the patient that the initial visit to this Pain Clinic is a consultation appointment that may be carried out as a VA Video encounter. There will be no procedure performed during the initial consultation. If the patient is interested in the Austin VA for consultation and procedures in Austin, you may forward this consultation to the "Austin Surg Pain Management Clinic.

-You may discontinue this consultation after failed outreach attempts and/or after reaching the appropriate number of Cancellations by Patient or No Shows as per policy.

Note: TIME ZONE is local if not indicated

No local TIU results or Medicine results available for this consult
========== END
==========

From: [redacted]
To: [redacted]
Subject: OMI — Consults under Whole Health — Deviations from the Mission Act
Date: Wednesday, October 6, 2021 12:21:00 PM

Hello OMI team,

Below is another example of a veteran consult request that clarifies the matter very cleanly / Mission Act ...

Sincerely,

[redacted]

//

< EXCERPT >

CCE-CC Eligibility Status: ELIGIBLE
VCC-Veteran CC option: OPT-IN
BVP-Basis for Veteran Preference: Existing relationship with provider
CSC-Consult stop code: 420
CSN-Clinical service: Pain Clinic
CST-Consult service type: Specialty Care
SEV-CC Eligibility: BMI-Potential for improved continuity of care
Pt. is currently established with CC PAIN
MANAGEMENT for his CHRONIC PAIN SYNDROME and needs renewal of expiring CC
PAIN MANAGEMENT referral for continuity of care

//

Re:

[redacted] [redacted] [redacted]

//

< FULL >

Current PC Provider: [redacted]WH*
Current PC Team: [redacted]
[redacted]nt Pat. Status: [redacted]
[redacted]ry Eligibility: [redacted]NECTED 50% to 100%(VERIFIED)

Patient Type: SC VETERAN
OEF/OIF: YES

Service Connection/Rated Disabilities
SC Percent: 100%
Rated Disabilities: MAJOR DEPRESSIVE DISORDER (70%)
SLEEP APNEA SYNDROMES (50%)
PARALYSIS OF SCIATIC NERVE (40%)
INTERVERTEBRAL DISC SYNDROME (20%)
SUPERFICIAL SCARS (10%)
ARTERIOSCLEROTIC HEART DISEASE (10%)
TINNITUS (10%)
SUPERFICIAL SCARS (10%)
HIATAL HERNIA (10%)
LIMITED FLEXION OF KNEE (10%)
ALLERGIC OR VASOMOTOR RHINITIS (0%)
MIGRAINE HEADACHES (0%)
2ND DEGREE BURNS (0%)
2ND DEGREE BURNS (0%)
HYPERTENSIVE VASCULAR DISEASE (0%)
IMPAIRED HEARING (0%)

Order Information
To Service: TEM WHS OUTPT PAIN MANAGEMENT
From Service:
Requesting Provider: [redacted]
Service is to be render[redacted]asis
Place: Consultant's choice
Urgency: Routine
Clinically Ind. Date: Oct 06, 2021
DST ID: 9c30777f-2748-4380-b618-5494ee67047c
Orderable Item: TEM WHS OUTPT PAIN MANAGEMENT
Consult: Consult Request
Provisional Diagnosis: Chronic Pain Syndrome(ICD-10-CM G89.4)
Reason For Request:
1. Reason for Request: Where is the primary location of the patient's worst pain for the consultant to address?
- Back Pain Yes
- Neck Pain Yes
- Other No (please specify): Pt. Pt. is currently established with CC PAINMANAGEMENT for his CHRONIC PAIN SYNDROME and needs renewal of expiring CCPAIN MANAGEMENT referral for continuity of care

2. Interventional Pain Management Procedures:
- Does the patient desire to receive interventional pain management injections for the management of Chronic Pain? Yes
3. Imaging:
- The patient needs to have advanced imaging of the area involved within the last two years. MRI is usually the preferred advanced imaging for the spine.
If MRI is contraindicated then obtain CT scan of the involved area. If the patient had prior surgery to the spine then please request MRI with and without contrast if the renal function allows it. The official imaging report must be reviewed by pain management before the consultation can be accepted. Please specify where the official imaging report is found:
(Choice of only one is accepted; may not choose more than one)
CPRS
4. Blood Thinners:
- Is the patient receiving any blood thinners such as Coumadin, aspirin, clopidogrel, TSOACs (apixaban, dabigatran, or rivaroxaban)
etc. No
- If the patient is on blood thinners, can the patient discontinue that medication for about 7 days WITHOUT ANY BRIDGING medication and without significant risk of developing stroke, cardiovascular insult, or any other problem for which the patient is receiving that medication to prevent. Not applicable
5. Laboratory investigations:
- Is the patient Diabetic? No
- If YES, then the HGB A1C within the last three months of the date of the consultation needs to be less than 8 for intervention.
- Please indicate the VALUE and the DATE of the last HGB A1C:
Collection DT Specimen Test Name Result Units Ref Range

03/24/2021 11:01 BLOOD GLYCOHEMOGLOBIN 6.0 % 4.8 - 6.0

6. The Interventional Pain Management Clinic requires responses to the following questions regarding various modalities that may have been used in the management of pain in this patient's pain:

a) Has the patient tried Physical Therapy or exercise within the last year? Yes

b) Has the patient tried Acetaminophen and/or NSAIDs within the last year? Yes

c) Has the patient tried Gabapentin and /or Duloxetine if neuropathic pain was suspected? Yes

d) Has the patient tried the TENS Unit be tried within the last year? Yes

e) Has the patient tried Cognitive Behavioral Therapy (CBT) or Pain Psychology within the last year? No

7. Comments:
Needs renewal of expiring CC PAIN MANAGEMENT consult with whom he has established care.

**********NOTES**********
ALL FIELDS MUST BE FILLED OUT for the consultation to go through, just like the MRI template. The consultation will not go through if one field is not answered.
****

Inter-facility Information
This is not an inter-facility consult request.

Status: ACTIVE
Last Action: RECEIVED

Facility Activity	Date/Time/Zone	Responsible Person	Entered By
CPRS RELEASED ORDER BER	10/06/21 06:07	[redacted]	[redacted]
ADDED COMMENT BER	10/06/21	[redacted]	[redacted]

(entered) 10/06/21 06:07

CCE-CC Eligibility Status: ELIGIBLE
VCC-Veteran CC option: OPT-IN
BVP-Basis for Veteran Preference: Existing relationship with provider
CSC-Consult stop code: 420
CSN-Clinical service: Pain Clinic
CST-Consult service type: Specialty Care
SEV-CC Eligibility: BMI-Potential for improved continuity of care
Pt. is currently established with CC PAIN MANAGEMENT for his CHRONIC PAIN SYNDROME and needs renewal of expiring CC PAIN MANAGEMENT referral for continuity of care
CCE----------
SEOC - VHA Office of Community Care----------
VHA Office of Community Care - Standardized Episode of Care
Pain Management Comprehensive
CAT-SEOC CoC: PAIN MANAGEMENT
SEOC ID: MSC_PAIN MANAGEMENT COMPREHENSIVE_1.2.7_PRCT
Description: This authorization covers services associated with the specialty(s) identified for this episode of care, including all medical care listed below relevant to the referred care specified on the consult order. Note: Medication Management including any opioid therapy should be consistent with VA/DOD clinical practice guidelines. This episode of care does not include intrathecal drug delivery (IDD) or neuromodulation device care. Separate approval is required for IDD or neuromodulation device initiation and care.
Duration: 180 days
Procedural Overview:
1. Initial outpatient evaluation and treatment for the referred condition indicated on the consult order, including any restrictions for or against treatment options
2. Diagnostic imaging relevant to the referred condition on the consult order
3. Diagnostic studies relevant to the referred condition on the consult order including but not limited to: EMG/NCV
4. Labs including necessary drug screens and pathology

relevant to the referred condition on the consult order
5. Injections including but not limited to: Medial branch blocks, epidural injections, facet injections, trigger point injections, genicular injections, joint injections
6. Procedures including but not limited to: radiofrequency ablation, vertebroplasty and spinal decompression
7. Anesthesia consultation related to a procedure
8. Pre-procedure medical and basic cardiac clearance, as indicated (including H+P/labs, EKG, CXR, echo)
Note: cardiac testing or evaluation outside of the above CXR, EKG and echo will require an RFS for a cardiology referral
9. Inpatient or observation admission for procedure and/ or procedure related complications, if indicated.
Notify the referring VA of admission status to initiate and facilitate care coordination and discharge planning.
10. Follow-up visits as related to the referred condition on the consult order
11. Outpatient Physical Therapy: as indicated up to 15 visits as related to the referred condition on the consult order; Notify VA to request additional visits with supporting medical documentation
12. Outpatient Occupational Therapy: as indicated up to 15 visits as related to the referred condition on the consult order; Notify VA to request additional visits with supporting medical documentation
Please visit the VHA Storefront www.va.gov/COMMUNITYCARE/ providers/index.asp for additional resources and requirements pertaining to the following:
Pharmacy prescribing requirements
Durable Medical Equipment (DME), Prosthetics, and Orthotics prescribing requirements
Precertification (PRCT) process requirements
Request for Services (RFS) requirements
SEO----------

PRINTED TO 10/06/21 06:07
CTX-PTPMRS3 (BIG)
RECEIVED 10/06/21 12:19 [redacted] [redacted]
M
Please schedule this patient in the Pain Management Consultation Clinic following the updated guidelines for the Mission Act and the current COVID-19 scheduling modifications. Please inform the patient that the initial visit to this Pain Clinic is a consultation appointment that may be carried out as a VA Video encounter. There will be no procedure performed during the initial consultation. If the patient is interested in the Austin VA for consultation and procedures in Austin, you may forward this consultation to the "Austin Surg Pain Management Clinic.

-You may discontinue this consultation after failed outreach attempts and/or after reaching the appropriate number of Cancellations by Patient or No Shows as per policy.

Note: TIME ZONE is local if not indicated

No local TIU results or Medicine results available for this consult
========== END
==========

From: [redacted]
To: [redacted]
Subject: RE: OMI — re: the Mission Act — Another example
Date: Monday, September 20, 2021 3:01:00 PM

Hello OMI Team:

I wanted to forward this one to you.

It is one example of many such consult requests ... that the Pain Management section still receives...
I have highlighted in yellow some comments back and forth.

Current PC Provider: [redacted]
Current PC Team:
Current Pat. Status: Outpatient
UCID: 674 6143023
Primary Eligibility: SERVICE CONNECTED 50% to 100%(VERIFIED)
Patient Type: SC VETERAN
OEF/OIF: NO

Service Connection/Rated Disabilities
SC Percent: 100%
Rated Disabilities: POST-TRAUMATIC STRESS DISORDER (50%)
MIGRAINE HEADACHES (50%)
PARALYSIS OF MIDDLE RADICULAR NERVES (20%)
DEGENERATIVE ARTHRITIS OF THE SPINE (20%)
LIMITED MOTION OF ARM (20%)
PARALYSIS OF MIDDLE RADICULAR NERVES (20%)
LUMBOSACRAL OR CERVICAL STRAIN (20%)
TINNITUS (10%)
SINUSITIS,MAXILLARY,CHRONIC (10%)
LIMITED MOTION OF ANKLE (10%)
HEMORRHOIDS (0%)
SUPERFICIAL SCARS (0%)
SCARS (0%)
IMPAIRED HEARING (0%)
LIMITED MOTION OF ANKLE (0%)

Order Information
To Service: TEM WHS OUTPT PAIN MANAGEMENT
From Service:
Requesting Provider: [redacted]
Service is to be render[redacted] basis
Place: Consultant's choice
Urgency: Routine
Clinically Ind. Date: Sep 17, 2021
DST ID: bf10f6a4-9206-4e2e-994f-b4a7dd125664
Orderable Item: TEM WHS OUTPT PAIN MANAGEMENT
Consult: Consult Request
Provisional Diagnosis: Dorsalgia, unspecified(ICD-10-CM M54.9)
Reason For Request:
CONTINUATINO OF CARE
IMAGES OF LUMBAR ARE FROM CITC PAIN MANGAEMENT PROVIDER
--IMAGES ALSO UPLOADED IN CPRS

1.

Reason for Request: Where is the primary location of the patient's
worst pain for the consultant to address?
- Back Pain Yes

- Neck Pain Yes
- Other No (please specify): back pain. The veteran is in need of continuation of care
2. Interventional Pain Management Procedures:
- Does the patient desire to receive interventional pain management injections for the management of Chronic Pain? Yes
3. Imaging:
- The patient needs to have advanced imaging of the area involved within the last two years. MRI is usually the preferred advanced imaging for the spine.
If MRI is contraindicated then obtain CT scan of the involved area. If the patient had prior surgery to the spine then please request MRI with and without contrast if the renal function allows it. The official imaging report must be reviewed by pain management before the consultation can be accepted. Please specify where the official imaging report is found:
(Choice of only one is accepted; may not choose more than one)
   VISTA Imaging
4. Blood Thinners:
- Is the patient receiving any blood thinners such as Coumadin, aspirin, clopidogrel, TSOACs (apixaban, dabigatran, or rivaroxaban)
etc. No
- If the patient is on blood thinners, can the patient discontinue that medication for about 7 days WITHOUT ANY BRIDGING medication and without significant risk of developing stroke, cardiovascular insult, or any other problem for which the patient is receiving that medication to prevent. Not applicable
5. Laboratory investigations:
- Is the patient Diabetic? No
- If YES, then the HGB A1C within the last three months of the date of the consultation needs to be less than 8 for intervention.
- Please indicate the VALUE and the DATE of the last HGB A1C:

Collection DT	Specimen	Test Name	Result	Units	Ref Range
11/29/2019 07:34	BLOOD	GLYCOHEMOGLOBIN	5.7	%	4.8 - 6.0

6. The Interventional Pain Management Clinic requires responses to the following questions regarding various modalities that may have been used in the management of pain in this patient's pain:
a) Has the patient tried Physical Therapy or exercise within the last year? Yes
b) Has the patient tried Acetaminophen and/or NSAIDs within the last year? Yes
c) Has the patient tried Gabapentin and /or Duloxetine if neuropathic pain was suspected? Yes
d) Has the patient tried the TENS Unit be tried within the last year? Yes
e) Has the patient tried Cognitive Behavioral Therapy (CBT) or Pain Psychology within the last year? Yes
7. Comments:
    CONTINUATION OF CARE

**********NOTES**********
ALL FIELDS MUST BE FILLED OUT for the consultation to go through, just like the MRI template. The consultation will not go through if one field is not answered.
****
Inter-facility Information
This is not an inter-facility consult request.

Status: ACTIVE
Last Action: ADDED COMMENT

Facility Activity	Date/Time/Zone	Responsible Person	Entered By
[redacted] ER	09/17/21 16:35	[redacted]	[redacted]
[redacted] ntered)	09/17/21 16:35		

CCE-CC Eligibility Status: ELIGIBLE
  VCC-Veteran CC option: OPT-IN

BVP-Basis for Veteran Preference: Scheduling flexibility
CSC-Consult stop code: 420
CSN-Clinical service: Pain Clinic
CST-Consult service type: Specialty Care
SEV-CC Eligibility: Specific clinical service not available at VA
CCE----------
SEOC - VHA Office of Community Care----------
VHA Office of Community Care - Standardized Episode of Care
Pain Management Comprehensive
CAT-SEOC CoC: PAIN MANAGEMENT
SEOC ID: MSC_PAIN MANAGEMENT COMPREHENSIVE_1.2.7_PRCT
Description: This authorization covers services associated with the specialty(s) identified for this episode of care, including all medical care listed below relevant to the referred care specified on the consult order. Note: Medication Management including any opioid therapy should be consistent with VA/DOD clinical practice guidelines. This episode of care does not include intrathecal drug delivery (IDD) or neuromodulation device care. Separate approval is required for IDD or neuromodulation device initiation and care.
Duration: 180 days
Procedural Overview:
1. Initial outpatient evaluation and treatment for the referred condition indicated on the consult order, including any restrictions for or against treatment options
2. Diagnostic imaging relevant to the referred condition on the consult order
3. Diagnostic studies relevant to the referred condition on the consult order including but not limited to: EMG/NCV
4. Labs including necessary drug screens and pathology relevant to the referred condition on the consult order
5. Injections including but not limited to: Medial branch blocks, epidural injections, facet injections, trigger point injections, genicular injections, joint injections
6. Procedures including but not limited to: radiofrequency ablation, vertebroplasty and spinal decompression
7. Anesthesia consultation related to a procedure
8. Pre-procedure medical and basic cardiac clearance, as indicated (including H+P/labs, EKG, CXR, echo)
Note: cardiac testing or evaluation outside of the above CXR, EKG and echo will require an RFS for a cardiology referral
9. Inpatient or observation admission for procedure and/or procedure related complications, if indicated. Notify the referring VA of admission status to initiate and facilitate care coordination and discharge planning.
10. Follow-up visits as related to the referred condition on the consult order
11. Outpatient Physical Therapy: as indicated up to 15 visits as related to the referred condition on the consult order; Notify VA to request additional visits with supporting medical documentation
12. Outpatient Occupational Therapy: as indicated up to 15 visits as related to the referred condition on the consult order; Notify VA to request additional visits with supporting medical documentation
Please visit the VHA Storefront www.va.gov/COMMUNITYCARE/providers/index.asp for additional resources and requirements pertaining to the following:
Pharmacy prescribing requirements
Durable Medical Equipment (DME), Prosthetics, and Orthotics prescribing requirements
Precertification (PRCT) process requirements
Request for Services (RFS) requirements
SEO----------
COM-Additional Comments:
CONTINUATION OF CARE
COM----------

PRINTED TO 09/17/21 16:35
CTX-PTPMRS3 (BIG)
ADDED COMMENT 09/18/21 10:07 [redacted]

[redacted] y established with [redacted]
Please forward to the community.
Thank you

RECEIVED 09/20/21 08:24 [redacted] [redacted]
M
Please schedule this patient in the Pain Management Consultation Clinic following the updated guidelines for the Mission Act and the current COVID-19 scheduling modifications. Please inform the patient that the initial visit to this Pain Clinic is a consultation appointment that may be carried out as a VA Video encounter. There will be no procedure performed during the initial consultation. If the patient is interested in the Austin VA for consultation and procedures in Austin, you may forward this consultation to the "Austin Surg Pain Management Clinic.

-You may discontinue this consultation after failed outreach attempts and/or after reaching the appropriate number of Cancellations by Patient or No Shows as per policy.

ADDED COMMENT 09/20/21 08:32 [redacted] [redacted]
[redacted]
Consult requests are being processed by the Pain Management section according to the instructions given to us via the chain of command.

09/20/21 13:51 [redacted]
[redacted] ALREADY ESTABLISHED VETERAN ALREADY WITH PAIN MANAGEMENT; PLEASE FORWARD TO CTIC CARE.

ADDED COMMENT 09/20/21 14:58 [redacted] [redacted]
M
According to current instructions given to us via the chain of command, I am unable to forward this to CITC.

Note: TIME ZONE is local if not indicated

No local TIU results or Medicine results available for this consult
========== END
==========

Sincerely,

[redacted]

From: [redacted]
To: [redacted]
Subject: OMI — Consults under Whole Health — Deviations from the Mission Act
Date: Friday, November 12, 2021 8:30:00 AM

Hello OMI team,

Below is another example of a veteran consult request that clarifies the matter very cleanly / Mission Act ...

Like all the other consults I have sent your way, I have processed it according to orders from [redacted]

I try to send you just a few of these from time to time, balancing the repetition of the event(s) with the demonstration that this continues to be an issue...

Sincerely,

[redacted]

//

< EXCERPT >

```
CCE-CC Eligibility Status: ELIGIBLE
  VCC-Veteran CC option: OPT-IN
  BVP-Basis for Veteran Preference: Existing relationship with provider
  CSC-Consult stop code: 420
  CSN-Clinical service: Pain Clinic
  CST-Consult service type: Specialty Care
  SEV-CC Eligibility: BMI-Potential for improved continuity of care
    RDR-RFS Date Received: 11/11/2021
RDS-RFS sent for scanning: 11/12/2021
RRD-RFS details of what was requested:
REQUESTING CONTINUATION OF CARE; VETERAN HAS AN APPT ON [redacted]
```

//

Re: [redacted]

//

< FULL >

Current PC Provider: [redacted]
Current PC Team:
[redacted]nt Pat. Status: [redacted]
[redacted]ry Eligibility: [redacted]N 50%(VERIFIED)
Patient Type: SC VETERAN
OEF/OIF: NO

Service Connection/Rated Disabilities
SC Percent: 30%
Rated Disabilities: PARALYSIS OF SCIATIC NERVE (20%)
DEGENERATIVE ARTHRITIS OF THE SPINE (10%)
2ND DEGREE BURNS (0%)
ATROPHY OF BOTH OVARIES (0%)
FALLOPIAN TUBE,DISEASE,INJURY,OR ADHESIONS TO (0%)

Order Information
To Service: TEM WHS OUTPT PAIN MANAGEMENT
From Service:
Requesting Provider: [redacted]
Service is to be render[redacted] basis
Place: Consultant's choice
Urgency: Routine
Clinically Ind. Date: Nov 19, 2021
DST ID: 4d727826-e1a5-4216-9429-4acff4528d06
Orderable Item: TEM WHS OUTPT PAIN MANAGEMENT
Consult: Consult Request
Provisional Diagnosis: Radiculopathy, Lumbar Region(ICD-10-CM M54.16)
Reason For Request:
PAIN MANAGEMENT CONSULTATION GUIDELINES:
This consultation request is for Pain Management Procedures.
1. Reason for Request: Where is the primary location of the patient's worst pain for the consultant to address?
- Back Pain Yes
- Neck Pain No
- Other No (please specify): radiculopathy
2. Interventional Pain Management Procedures:
- Does the patient desire to receive interventional pain management injections for the management of Chronic Pain? Yes
3. Imaging:
- The patient needs to have advanced imaging of the area involved within the last two years. MRI is usually the preferred advanced imaging for the spine.
If MRI is contraindicated then obtain CT scan of the involved area. If the patient had prior surgery to the spine then please request MRI with and without contrast if the renal function allows it. The official imaging report must be reviewed by pain management before the consultation can be accepted. Please specify where the official imaging report is found:
(Choice of only one is accepted; may not choose more than one)
CPRS
4. Blood Thinners:
- Is the patient receiving any blood thinners such as Coumadin,

aspirin, clopidogrel, TSOACs (apixaban, dabigatran, or rivaroxaban)
etc. No
- If the patient is on blood thinners, can the patient discontinue that medication for about 7 days WITHOUT ANY BRIDGING medication and without significant risk of developing stroke, cardiovascular insult, or any other problem for which the patient is receiving that medication to prevent. Not applicable
5. Laboratory investigations:
- Is the patient Diabetic? No
- If YES, then the HGB A1C within the last three months of the date of the consultation needs to be less than 8 for intervention.
- Please indicate the VALUE and the DATE of the last HGB A1C:

Collection DT	Specimen	Test Name	Result	Units	Ref Range
10/05/2021 06:55	BLOOD	GLYCOHEMOGLOBIN	6.0	%	4.8 - 6.0

6. The Interventional Pain Management Clinic requires responses to the following questions regarding various modalities that may have been used in the management of pain in this patient's pain:
a) Has the patient tried Physical Therapy or exercise within the last year? Yes
b) Has the patient tried Acetaminophen and/or NSAIDs within the last year? Yes
c) Has the patient tried Gabapentin and /or Duloxetine if neuropathic pain was suspected? Yes
d) Has the patient tried the TENS Unit be tried within the last year? Yes
e) Has the patient tried Cognitive Behavioral Therapy (CBT) or Pain Psychology within the last year? Yes
7. Comments:
currently receiving care through CITC consult with:
Servicing Group
[redacted]
Service Date
03/17/2021 ~09/13/2021
RFS received

**********NOTES**********
ALL FIELDS MUST BE FILLED OUT for the consultation to go through, just like the MRI template. The consultation will not go through if one field is not answered.
****
Inter-facility Information
This is not an inter-facility consult request.

Status: ACTIVE
Last Action: RECEIVED

Facility Activity	Date/Time/Zone	Responsible Person	Entered By
[redacted] ER	11/12/21 06:42	[redacted]	
	11/12/21 06:42		
CTX-PTPMRS3 (BIG)	11/12/21	[redacted]	
[redacted] ntered)	11/12/21 06:42		

CCE-CC Eligibility Status: ELIGIBLE
VCC-Veteran CC option: OPT-IN
BVP-Basis for Veteran Preference: Existing relationship with provider
CSC-Consult stop code: 420
CSN-Clinical service: Pain Clinic
CST-Consult service type: Specialty Care
SEV-CC Eligibility: BMI-Potential for improved continuity of care
RDR-RFS Date Received: 11/11/2021

RDS-RFS sent for scanning: 11/12/2021
RRD-RFS details of what was requested:
REQUESTING CONTINUATION OF CARE; VETERAN HAS AN APPT ON 11/24/21
RRD----------
CCE----------
SEOC - VHA Office of Community Care----------
VHA Office of Community Care - Standardized Episode of Care
Pain Management Comprehensive
CAT-SEOC CoC: PAIN MANAGEMENT
SEOC ID: MSC_PAIN MANAGEMENT COMPREHENSIVE_1.2.7_PRCT
Description: This authorization covers services associated with the specialty(s) identified for this episode of care, including all medical care listed below relevant to the referred care specified on the consult order. Note: Medication Management including any opioid therapy should be consistent with VA/DOD clinical practice guidelines. This episode of care does not include intrathecal drug delivery (IDD) or neuromodulation device care. Separate approval is required for IDD or neuromodulation device initiation and care.
Duration: 180 days
Procedural Overview:
1. Initial outpatient evaluation and treatment for the referred condition indicated on the consult order, including any restrictions for or against treatment options
2. Diagnostic imaging relevant to the referred condition on the consult order
3. Diagnostic studies relevant to the referred condition on the consult order including but not limited to: EMG/NCV
4. Labs including necessary drug screens and pathology relevant to the referred condition on the consult order
5. Injections including but not limited to: Medial branch blocks, epidural injections, facet injections, trigger point injections, genicular injections, joint injections
6. Procedures including but not limited to: radiofrequency ablation, vertebroplasty and spinal decompression
7. Anesthesia consultation related to a procedure
8. Pre-procedure medical and basic cardiac clearance, as indicated (including H+P/labs, EKG, CXR, echo)
Note: cardiac testing or evaluation outside of the above CXR, EKG and echo will require an RFS for a cardiology referral
9. Inpatient or observation admission for procedure and/or procedure related complications, if indicated.
Notify the referring VA of admission status to initiate and facilitate care coordination and discharge planning.
10. Follow-up visits as related to the referred condition on the consult order
11. Outpatient Physical Therapy: as indicated up to 15 visits as related to the referred condition on the consult order; Notify VA to request additional visits with supporting medical documentation
12. Outpatient Occupational Therapy: as indicated up to 15 visits as related to the referred condition on the consult order; Notify VA to request additional visits with supporting medical documentation
Please visit the VHA Storefront www.va.gov/COMMUNITYCARE/providers/index.asp for additional resources and requirements pertaining to the following:
Pharmacy prescribing requirements
Durable Medical Equipment (DME), Prosthetics, and Orthotics prescribing requirements
Precertification (PRCT) process requirements
Request for Services (RFS) requirements
SEO----------
COM-Additional Comments:
current care with:
Servicing Group
[redacted]

[redacted]

03/17/2021 ~09/13/2021
COM-------- --

RECEIVED 11/15/21 04:16 [redacted] [redacted]
M
Please schedule this patient in the Pain Management Consultation Clinic following the updated guidelines for the Mission Act and the current COVID-19 scheduling modifications. Please inform the patient that the initial visit to this Pain Clinic is a consultation appointment that may be carried out as a VA Video encounter. There will be no procedure performed during the initial consultation. If the patient is interested in the Austin VA for consultation and procedures in Austin, you may forward this consultation to the "Austin Duty Pain Management Clinic.

-You may discontinue this consultation after failed outreach attempts and/or after reaching the appropriate number of Cancellations by Patient or No Shows as per policy.

Note: TIME ZONE is local if not indicated

No local TIU results or Medicine results available for this consult
END

From: [redacted]
To: [redacted]
Subject: RE: OMI — re: the Mission Act — Another example
Date: Tuesday, November 2, 2021 9:48:00 AM

Hello OMI Team:

I wanted to forward this one to you.

It is one example of many such consult requests ... that the Pain Management section still receives... I have highlighted in yellow some comments back and forth.

- How does this affect the veterans and their care?
- Who do the veterans get upset with; how are the relationships affected?
- Who do the referring providers get upset with; how are the relationships affected?
- Where is Whole Health and [redacted] in all of this?
- Who can the veterans and the referring providers go with questions/concerns/appeals?

Would the answers to the above questions shed light on why [redacted] ordered the chart redactions previously?

[redacted]

//

Re:

[redacted]

//

Current PC Provider: [redacted]
Current PC Team: H*
Current Pat. Status:
UCID:
Primary Eligibility: [redacted] NECTED 50% to 100%(VERIFIED)
Patient Type: SC VETERAN
OEF/OIF: NO

Service Connection/Rated Disabilities
SC Percent: 70%
Rated Disabilities: NEUROSIS (70%)
TINNITUS (10%)
IMPAIRED HEARING (0%)

Order Information
To Service: TEM WHS OUTPT PAIN MANAGEMENT
From Service: 6
Requesting Provider: [redacted]
Service is to be render ENT basis
Place: Consultant's choice
Urgency: Routine
Clinically Ind. Date: Oct 29, 2021
DST ID:
Orderable Item: TEM WHS OUTPT PAIN MANAGEMENT
Consult: Consult Request
Provisional Diagnosis: Pain in left Hip(ICD-10-CM M25.552)
Reason For Request:
PAIN MANAGEMENT CONSULTATION GUIDELINES:
This consultation request is for Pain Management Procedures.
1. Reason for Request: Where is the primary location of the patient's worst pain for the consultant to address?
- Back Pain No
- Neck Pain No
- Other No (please specify): left hip pain- continuation of care- recent had
right hip surgery and continues to have left hip pain. PLease forward to cc
Pain management for continuity of care.

2. Interventional Pain Management Procedures:
- Does the patient desire to receive interventional pain management injections for the management of Chronic Pain? Yes
3. Imaging:
- The patient needs to have advanced imaging of the area involved within the last two years. MRI is usually the preferred advanced imaging for the spine.
If MRI is contraindicated then obtain CT scan of the involved area. If the patient had prior surgery to the spine then please request MRI with and without contrast if the renal function allows it. The official imaging report must be reviewed by pain management before the consultation can be accepted. Please specify where the official imaging report is found:
(Choice of only one is accepted; may not choose more than one)
CPRS
4. Blood Thinners:
- Is the patient receiving any blood thinners such as Coumadin, aspirin, clopidogrel, TSOACs (apixaban, dabigatran, or rivaroxaban)
etc. No
- If the patient is on blood thinners, can the patient discontinue that medication for about 7 days WITHOUT ANY BRIDGING medication and without significant risk of developing stroke, cardiovascular insult, or any other problem for which the patient is receiving that medication to prevent. Not applicable
5. Laboratory investigations:
- Is the patient Diabetic? No
- If YES, then the HGB A1C within the last three months of the date of the consultation needs to be less than 8 for intervention.
- Please indicate the VALUE and the DATE of the last HGB A1C:

Collection DT	Specimen	Test Name	Result	Units	Ref Range
05/04/2021 09:03	BLOOD	GLYCOHEMOGLOBIN	5.5	%	4.8 - 6.0

6. The Interventional Pain Management Clinic requires responses to the following questions regarding various modalities that may have been used in the management of pain in this patient's pain:
a) Has the patient tried Physical Therapy or exercise within the last year? Yes
b) Has the patient tried Acetaminophen and/or NSAIDs within the last year? Yes
c) Has the patient tried Gabapentin and /or Duloxetine if neuropathic pain was suspected? Yes
d) Has the patient tried the TENS Unit be tried within the last year? No
e) Has the patient tried Cognitive Behavioral Therapy (CBT) or Pain Psychology within the last year? No
7. Comments:

**********NOTES**********
ALL FIELDS MUST BE FILLED OUT for the consultation to go through, just like the MRI template. The consultation will not go through if one field is not answered.
****
Inter-facility Information
This is not an inter-facility consult request.

Status: DISCONTINUED
Last Action: ADDED COMMENT

Facility Activity	Date/Time/Zone	Responsible Person	Entered By
CPRS RELEASED ORDER	10/07/21 12:31	[redacted]	[redacted]
PARAS PRINTED TO CTX-PTPMRS3 (BIG)	10/07/21 12:31		
[redacted] RECEIVED	10/07/21 15:50	[redacted]	[redacted]

Please schedule this patient in the Pain Management Consultation Clinic following the updated guidelines for the Mission Act and the current COVID-19 scheduling modifications. Please inform the patient that the initial visit to this Pain Clinic is a consultation appointment that may be carried out as a VA Video encounter. There will be no procedure performed during the initial consultation. If the patient is interested in the Austin VA for consultation and procedures in Austin, you may forward this consultation to the "Austin Surg Pain Management Clinic.

-You may discontinue this consultation after failed outreach attempts and/or after reaching the appropriate number of Cancellations by Patient or No Shows as per policy.

10/12/21 12:09 [redacted]

[redacted]y Status: NO ELIGIBILITY FOUND
CSC-Consult stop code: 420
CSN-Clinical service: Pain Clinic
CST-Consult service type: Specialty Care
CCE----------

C1-First call to Veteran: Left voicemail
L1-Unable to schedule letter sent by mail to Veteran.
COM-Additional Comments:
LETTER EXPIRES 10/25/21
COM----------

DISCONTINUED	11/01/21 15:11	[redacted]	[redacted]
M			

From review of requesting provider, veteran is not requesting care with our service.
Request is for continuity of care with established CC-provider.

Consult requests are being processed according to instructions given by the chain of command.

PRINTED TO 11/01/21 15:11
CTX-PTPMRS3 (BIG)
ADDED COMMENT 11/02/21 08:01 [redacted] [redacted]

[redacted] please review the request on referral- as requested, please community care pain clinic if indicated for continuity of care.

ADDED COMMENT 11/02/21 09:38 [redacted] [redacted]
M
Referral reviewed. Consult requests are being processed as per the instructions given to us by the chain of command.

Note: TIME ZONE is local if not indicated

No local TIU results or Medicine results available for this consult
END

From: [redacted]
To:

Subject: OMI — Consults under Whole Health — Deviations from the Mission Act
Date: Tuesday, September 28, 2021 1:01:00 PM

Hello OMI team,

The new consult toolbox makes some things very clear; I hope the below aids in clarification for the team.

Below is an excellent example of a veteran consult request that clarifies the matter very cleanly.

I have cut/paste the most relevant part below:

//

< EXCERPT; with added commentary >

From the output from the Consult Toolbox:

CCE-CC Eligibility Status: ELIGIBLE — We see that per the toolbox, the veteran **is ELIGIBLE** for Pain Management care in the Community.

VCC-Veteran CC option: OPT-IN

BVP-Basis for Veteran Preference: Existing relationship with provider — **From the choice boxes from the toolbox**, we see that **existing relationship with provider is a selectable reason** for the preference.

CSC-Consult stop code: 420

CSN-Clinical service: Pain Clinic — Specifically denotes the specialty care of Pain Management.

CST-Consult service type: Specialty Care

SEV-CC Eligibility: BMI-Potential for improved continuity of care — Specifically Potential for **improved continuity of care is a subsection of BMI**.

//

For the past who knows how many months, the Pain Management section has been instructed to not allow such consult requests to go to the community. The

matter was raised for investigation to the appropriate authorities / investigative bodies by the staff of our section.

<u>How many veterans have been affected by this? Hundreds and hundreds?</u>

In my view, it appears that due to the orders handed down to the Pain Management section under Whole Health, under threat of administrative action, that veterans are being denied services that are owed to them under the law.

Sincerely,

[redacted]

//

Re:

[redacted]

//

< FULL >

Current PC Provider: [redacted]
Current PC Team:
Current Pat. Status:
UCID:
Primary Eligibility: [redacted]NECTED 50% to 100%(VERIFIED)
Patient Type: SC VETERAN
OEF/OIF: NO

Service Connection/Rated Disabilities
SC Percent: 70%
Rated Disabilities: MAJOR DEPRESSIVE DISORDER (50%)
MIGRAINE HEADACHES (30%)
HIATAL HERNIA (10%)
FOOT CONDITION (0%)
FOOT CONDITION (0%)
TRAUMATIC ARTHRITIS (0%)
DERMATOPHYTOSIS (0%)
HYPERTENSIVE VASCULAR DISEASE (0%)
RESIDUALS OF GALL BLADDER REMOVAL (0%)

NEOPLASMS, BENIGN, RESPIRATORY SYSTEM (0%)
SCARS (0%)

Order Information
To Service: TEM WHS OUTPT PAIN MANAGEMENT
From Service:
Requesting Provider: [redacted]
Service is to be render[redacted] basis
Place: Consultant's choice
Urgency: Routine
Clinically Ind. Date: Sep 28, 2021
DST ID: fc2ba1b8-f3c4-4cb2-b580-a6d34a06483c
Orderable Item: TEM WHS OUTPT PAIN MANAGEMENT
Consult: Consult Request
Provisional Diagnosis: Cervicalgia(ICD-10-CM M54.2)
Reason For Request:
PAIN MANAGEMENT CONSULTATION GUIDELINES:
This consultation request is for Pain Management Procedures.
1. Reason for Request: Where is the primary location of the patient's worst pain for the consultant to address?
- Back Pain Yes
- Neck Pain Yes
- Other No (please specify): pt is c/o of pain and difficuty in neck pain
and raising her left arm
2. Interventional Pain Management Procedures:
- Does the patient desire to receive interventional pain management injections for the management of Chronic Pain? Yes
3. Imaging:
- The patient needs to have advanced imaging of the area involved within the last two years. MRI is usually the preferred advanced imaging for the spine.
If MRI is contraindicated then obtain CT scan of the involved area. If the patient had prior surgery to the spine then please request MRI with and without contrast if the renal function allows it. The official imaging report must be reviewed by pain management before the consultation can be accepted. Please specify where the official imaging report is found:
(Choice of only one is accepted; may not choose more than one)
CPRS
4. Blood Thinners:
- Is the patient receiving any blood thinners such as Coumadin, aspirin, clopidogrel, TSOACs (apixaban, dabigatran, or rivaroxaban)
etc. No
- If the patient is on blood thinners, can the patient discontinue that medication for about 7 days WITHOUT ANY BRIDGING medication and without significant risk of developing stroke, cardiovascular insult, or any other problem for which the patient is receiving that medication to prevent. Not applicable
5. Laboratory investigations:
- Is the patient Diabetic? No
- If YES, then the HGB A1C within the last three months of the date of the consultation needs to be less than 8 for intervention.
- Please indicate the VALUE and the DATE of the last HGB A1C:

Collection DT	Specimen	Test Name	Result	Units	Ref Range
04/06/2021 10:37	BLOOD	GLYCOHEMOGLOBIN	5.3	%	4.8 - 6.0

6. The Interventional Pain Management Clinic requires responses to the following questions regarding various modalities that may have been used in the management of pain in this patient's pain:
a) Has the patient tried Physical Therapy or exercise within the last year? Yes
b) Has the patient tried Acetaminophen and/or NSAIDs within the last year? No
c) Has the patient tried Gabapentin and /or Duloxetine if neuropathic pain was suspected? Yes
d) Has the patient tried the TENS Unit be tried within the last year? Yes
e) Has the patient tried Cognitive Behavioral Therapy (CBT) or Pain Psychology within the last year? No
7. Comments:

**********NOTES**********
ALL FIELDS MUST BE FILLED OUT for the consultation to go through, just like the MRI template. The consultation will not go through if one field is not answered.
****

Inter-facility Information
This is not an inter-facility consult request.

Status: PENDING
Last Action: PRINTED TO

Facility Activity	Date/Time/Zone	Responsible Person	Entered By
RELEASED ORDER	09/28/21 11:39	[redacted]	[redacted]
[redacted] COMMENT	09/28/21		

(entered) 09/28/21 11:39
CCE-CC Eligibility Status: ELIGIBLE
VCC-Veteran CC option: OPT-IN
BVP-Basis for Veteran Preference: Existing relationship with provider
CSC-Consult stop code: 420
CSN-Clinical service: Pain Clinic
CST-Consult service type: Specialty Care
SEV-CC Eligibility: BMI-Potential for improved continuity of care
neck pain and difficulty in raising her left arm
CCE----------
SEOC - VHA Office of Community Care----------
VHA Office of Community Care - Standardized Episode of Care
Pain Management Comprehensive
CAT-SEOC CoC: PAIN MANAGEMENT
SEOC ID: MSC_PAIN MANAGEMENT COMPREHENSIVE_1.2.7_PRCT
Description: This authorization covers services associated with the specialty(s) identified for this episode of care, including all medical care listed below relevant to the referred care specified on the consult order. Note: Medication Management including any opioid therapy should be consistent with VA/DOD clinical practice guidelines. This episode of care does not include intrathecal drug delivery (IDD) or neuromodulation device care. Separate approval is required for IDD or neuromodulation device initiation and care.
Duration: 180 days
Procedural Overview:
1. Initial outpatient evaluation and treatment for the referred condition indicated on the consult order, including any restrictions for or against treatment options
2. Diagnostic imaging relevant to the referred condition on the consult order
3. Diagnostic studies relevant to the referred condition on the consult order including but not limited to: EMG/NCV
4. Labs including necessary drug screens and pathology relevant to the referred condition on the consult order
5. Injections including but not limited to: Medial branch blocks, epidural injections, facet injections, trigger point injections, genicular injections, joint injections
6. Procedures including but not limited to: radiofrequency ablation, vertebroplasty and spinal decompression
7. Anesthesia consultation related to a procedure
8. Pre-procedure medical and basic cardiac clearance, as indicated (including H+P/labs, EKG, CXR, echo)
Note: cardiac testing or evaluation outside of the above CXR, EKG and echo will require an RFS for a cardiology referral
9. Inpatient or observation admission for procedure and/or procedure related complications, if indicated.
Notify the referring VA of admission status to initiate and facilitate care coordination and discharge planning.
10. Follow-up visits as related to the referred condition on the consult order
11. Outpatient Physical Therapy: as indicated up to 15 visits as related to the referred condition on the consult

order; Notify VA to request additional visits with
supporting medical documentation
12. Outpatient Occupational Therapy: as indicated up to 15
visits as related to the referred condition on the consult
order; Notify VA to request additional visits with
supporting medical documentation
Please visit the VHA Storefront www.va.gov/COMMUNITYCARE/
providers/index.asp for additional resources and
requirements pertaining to the following:
Pharmacy prescribing requirements
Durable Medical Equipment (DME), Prosthetics, and Orthotics
prescribing requirements
Precertification (PRCT) process requirements
Request for Services (RFS) requirements
SEO----------
COM-Additional Co
pt is seeing PSA [redacted]
COM----------

PRINTED TO 09/20/21
11:39
CTX-PTPMRS3 (BIG)

Note: TIME ZONE is local if not indicated

No local TIU results or Medicine results available for this consult
---------- END
==========

Reference 41

From: [redacted]
To:
Subject: RE: Concerns about Consult being Discontinued causing delay in Care.
Date: Monday, September 28, 2020 10:57:00 AM
Attachments: image001.jpg

I will continue to be on the look-out.

Appreciate the input.

Be well ---

[redacted]

From: [redacted]
Sent: [redacted]
To: [redacted]
Subject: RE: Concerns about Consult being Discontinued causing delay in Care.

Goodness, we do not want the Veteran moved in the wrong direction by any means,

We rely on you and your expertise for these decisions [redacted] for sure, please do not misunderstand in any way!

My only intent was to try to provide some helpful tips, again we rely tremendously on you and your colleagues for your expertise!!

[redacted]

From: [redacted]
Sent: Monday, September 28, 2020 9:52 AM
To: [redacted]
Subject: RE: Concerns about Consult being Discontinued causing delay in Care.

Hello [redacted]

I know what you are saying at the individual consult request level, but I can tell you that over the past 1.5 weeks alone, I have gotten a few consult requests where if I relied strictly on the wording in the consult request, the veteran would have been moved in the wrong direction...

Either way, noting these exchanges, I have already taken a more permissive approach to these requests ... I will defer the finer points of evaluation of appropriateness to the CITC section...

Be well,

[redacted]

From: [redacted]
Sent: Monday, September 28, 2020 9:48 AM
To: [redacted]
Subject: RE: Concerns about Consult being Discontinued causing delay in Care.

Well the first consult clearly says to forward to Community Care so this one is confusing. There isn't much wording problem on this one.

I understand you are doing your best, we all are. These are busy times. Thank you for all you do.

I would be cautious on the reviews

Also continuation/continuity/ are similar terms mean the same thing if they have been seeing a Community Provider for a period of time I approve these consults thank you [redacted],

From: [redacted]
Sent: Monday, September 28, 2020 9:31 AM
To: [redacted]
Subject: RE: Concerns about Consult being Discontinued causing delay in Care.

Hello [redacted]

There was no technical reason for why I could not forward on the first consult, but again, this boils down to requesting provider wording. In other situations with similar wording, the reason ends up not being for improved continuity of care, and instead, ends up being simply that the veteran or the requesting provider is asking for it.

None of the wording on the consult request is "wrong," but what I have seen over processing many of these requests, is that every requesting provider can mean different things with either the same or markedly similar wording.

Per my prior response, these differences in wording are ones that I either figure out and process accordingly, or if there is any doubt left in my mind, I ask for clarification as I had done here.

In such cases, if there is any question in my mind, I simply communicate back to the requesting provider.

I really try to do my best with it to honor the wishes of the requesting provider and the veteran as well as the system rules/restraints.

[redacted]

From: [redacted]
Sent: Monday, September 28, 2020 9:23 AM
To: [redacted]
Subject: RE: Concerns about Consult being Discontinued causing delay in Care.

Thank you [redacted]

So, why couldn't you forward the first consult? What prevented you from being able to forward the first consult? I am still a little confused on that note,

From: [redacted]
Sent: Monday, September 28, 2020 8:45 AM
To: [redacted]
Subject: RE: Concerns about Consult being Discontinued causing delay in Care.

Hello [redacted]

Thank you for asking; I appreciate the question.

When this question was initially broached to me by the patient representative, I felt that my comments noted on the consult were ignored... the manner in which this was initially brought up to me seemed odd.

To answer your question, there was not a technical --- as in CPRS-related block --- reason for why the consult was initially discontinued. There *is* a technical reason for why I could not re-process the consult afterwards (CRPS will not allow it) without re-requesting the consult request from the requesting provider.

When I review the consult requests, I try to understand:

1. Reason for the consult
2. Appropriateness of consult
3. Wording used in the request

Different providers use different wording.

So, I may get a consult that says "continuity" and another that says "continuation" and another that cites "community" and so on with only some of them actually indicating continuity of care. If there was anything about the request that seemed anything other than very clear to me, on discontinuation, I would try to state, as I did here, something along the lines of:

This appears to be a request for forwarding to CC-Pain for continuity of

care; is it correct?

If so, please resubmit stating as such so I may forward onwards.

(Actually, there have also been times where the requesting provider does not even state that it is a request for continuity of care in the consult request, and I figure out on my own, based on further review, that this is what is desired...)

I suspect this may seem odd to the outside observer, and that reading this particular case, it may seem quite straight-forward, but there have been several similar consult requests where there wasn't a previously established community provider OR that the forwarding is inappropriate based on (I think) the veteran actually being referred to a different provider in the community for continuation of care on the same issue. In several cases, forwarding to community would have been inappropriate.

Oftentimes, the referring provider does not specify **which clinic the veteran had gone to and that the veteran is being requested to go to the same clinic.**

I know discussion had taken place at some point about whether or not an actual DST is needed in the processing or whether it should specifically state "improved continuity of care." I am not sure objectively any of these as requirements are strictly right or wrong.

I simply try to do my best in processing the request and if there is any lack of clarity, I communicate it back to the requesting provider --- communication is key in both minimizing lapses in care and identifying where the actual lapse occurred/occurs.

In this particular case, please note that on **08/17/20**, I added comment indicating that I can forward the consult request, if it can be resubmitted for processing. **That was over a month ago**, and no further action was taken by the requesting provider.

I hope this addresses the question.

Be well,

[redacted]

From: [redacted]
Sent: Saturday, September 26, 2020 12:26 PM
To: [redacted]
Subject: FW: Concerns about Consult being Discontinued causing delay in Care.

[redacted]

Some concerns have been raised about the discontinuation of the consult on patient [redacted]

I am looking at your comments and I am questioning, was there some technical issue in that you were unable to forward the consult to Community Care?

It look like this is the case from your comments, it looks to me like the way the consult was sent to you, you were unable to forward it.

Is this correct?

Please advise,

Thank you

[redacted]

From: [redacted]
Sent: Friday, September 25, 2020 3:03 PM
To: [redacted]
Cc: [redacted]
Subject: RE: Concerns about Consult being Discontinued causing delay in Care.

Adding [redacted]

[redacted]
Chief of Staff
Central Texas Veterans Health care System.

[redacted]

From: [redacted]
Sent: Friday, September 25, 2020 10:04 AM
To: [redacted]
Cc: [redacted]
Subject: Concerns about Consult being Discontinued causing delay in Care.

[redacted]

I wanted to bring to your attention concerns I have about consults being discontinued to quickly by providers stating additional information needed, but the information was in the consult. Please review the following consult for a patient that has major medical issues that has been seeing

providers in community care for years. Patient: [redacted]

REASON FOR REQUEST (STAT CONSULT GUIDANCE):

Pertinent History/Physical/Diagnostic Information:
patient has been seeing community care pain management for chronic pain,cervicalgia and low back pain. consult expires in 9/8/20. please for ward to community care pain mangement for continuation of care

Existing Treatment Plan:
Through community care pain managment

Inter-facility Information
This is not an inter-facility consult request.

Status: DISCONTINUED
Last Action: ADDED COMMENT

Facility
Activity Date/Time/Zone Responsible Person Entered By

CPRS RELEASED ORDER 08/11/20 18:30 [redacted]
ADDED COMMENT 08/11/20 [redacted]
(entered) 08/11/20 18:30
DST-DST ID: 8af897d4-0654-4f93-a15d-2b51fbea0a33
CSC-Consult stop code: 420
CSN-Clinical Service: PAIN CLINIC
CST-Consult service type: SPECIALTY CARE
CCE-CC Eligibility Status: NO ELIGIBILITY FOUND
DSP-DST data saved prior to signing consult

PRINTED TO 08/11/20 18:30
CTX-PTPMRS3 (BIG)
DISCONTINUED 08/12/20 10:33 [redacted]
This appears to be a request for forwarding to CC-Pain for continuity of care; is it correct?

If so, please resubmit stating as such so I may forward onwards.

PRINTED TO 08/12/20 10:33
CTX-PTPMRS3 (BIG)
ADDED COMMENT 08/15/20 19:29 [redacted]
Patient is seeing the community care pain management. this consult is for continuation of care. please forward to community care.

ADDED COMMENT 08/17/20 08:28 [redacted] [redacted]
I can forward it, If you can resubmit for processing (current accession does not allow).

The only reason this issue is being corrected is because patient sent secured message to the Advocate's office requesting authorization information for Pain Management for upcoming appointment, but that authorization expired on 9/8/20. I hope this information is helpful for looking at our process to make sure our patient are getting the care they need timely. Thank you all for taking the time to review this concern.

[redacted]
Patient Advocate
Veterans Experience Section (004VES)
[redacted]

[redacted]

RE: [SECURE] - PATIENT CONFIDENTIAL
Friday, September 25, 2020 8:54:00 AM

[redacted]

[redacted]

From: [redacted]
Sent: Friday, September 25, 2020 8:54 AM
To: [redacted]
Subject: [SECURE] - PATIENT CONFIDENTIAL

Hello [redacted]

[redacted] **seems to want to forward this case to Chief of Staff** as I had discontinued the consult request initially for no DST (although continuity stated in the consult request).

I requested the consult re-request over a month ago [redacted]

[redacted] for having discontinued it...

[redacted]

Redacted

Reference 42

From: [redacted]
To: [redacted]
Subject: OSC — Consult Processing
Date: Tuesday, December 7, 2021 11:45:00 AM

Hello [redacted]

Here is a blatant example of a case where I simply raised the issue of the clinical decision-making, and as we had been forbidden to make such decisions in forwarding to CITC, I stated clearly my concern and deferred to [redacted] as he had, here, very obviously inserted himself into the clinical-decision making.

Because [redacted] otherwise inserted himself into the clinical care decision-making through his changing instructions accompanied by threats of administrative action, most other examples are not so blatant, and otherwise, only evidenced by the wording left on the charts regarding the referring providers being referred to discuss any such cases with [redacted] for achieving resolution.

Sincerely,

[redacted]

//

Re:

[redacted] [redacted] [redacted]

DSP-DST data saved prior to signing consult

FORWARDED FROM 01/08/21 11:31 [redacted]
TEM SUR OUTPT PAIN MANAGEMENT
Approved

FORWARDED FROM 01/08/21 13:06 [redacted]
COMMUNITY CARE-PAIN
Per CITC CHIEF please attempt to schedule within VA.

PRINTED TO 01/08/21 13:07
CTX-PTPMRS3 (BIG)

FORWARDED FROM 01/08/21 15:02 [redacted]

TEM SUR OUTPT PAIN MANAGEMENT
Approved

ADDED COMMENT 01/10/21 18:13 [redacted]

[redacted] - patient should be scheduled for VA pain management if there is availability. Please forward back to your service.

ADDED COMMENT 01/11/21 07:59 [redacted]

pt is betetr to contnue with current private provider as to be seen at VA , wa have to reapet MRI as last was 3 yeaers ago, which is un necesary . so will advise to contine to get care outisde which is contnuation of care and pateint is happy
Thanks

FORWARDED FROM 01/11/21 10:38 [redacted]

COMMUNITY CARE-PAIN
per Chief of Pain

PRINTED TO 01/11/21 10:38
CTX-PTPMRS3 (BIG)

FORWARDED FROM 01/11/21 16:31 [redacted]

TEM SUR OUTPT PAIN MANAGEMENT
I am very confused as to what to do with this. As per [redacted] note, the veteran does not meet our requirement for acceptance, but discontinuation seems less favorable than forwarding on? Reviewing the comments, [redacted] has noted per Chief of Pain which I believe is indicating [redacted] from the context; will defer to [redacted] re: scheduling decision. I am forwarding back to CITC just so this consult request does not drop from everyone's list.

Note: TIME ZONE is local if not indicated

No local TIU results or Medicine results available for this consult

========== END ==========

From: [redacted]
To:
Subject: RE: [SECURE] - PATIENT CONFIDENTIAL
Date: Wednesday, February 24, 2021 12:18:00 PM

Yes sir.

Be well --

[redacted]

From: [redacted]
Sent: Wednesday, February 24, 2021 12:05 PM
To: [redacted]
Subject: RE: [SECURE] - PATIENT CONFIDENTIAL

I will submit a new cx

From: [redacted]
Sent: Wednesday, February 24, 2021 9:46 AM
To: [redacted]
Cc: [redacted]
Subject: [SECURE] - PATIENT CONFIDENTIAL

Hello!

Re: [redacted]

I would have no problem accepting this consultation request.

My concern is that given the comment added to the request:

please see below secure message-he needs CC pain extension
"I was seen at the [redacted] pain management clinic yesterday for my second injection test on my back. The front desk let me know that my authorization will run out around the time of my second appointment for getting the nerves in my back burned. I have an appointment on the 8th for the left side and on the [redacted] for the right side. Any way of extending the authorization or getting a new one by the [redacted]?"

My sense was that you and/or the veteran would likely strongly prefer to try to complete that care with the CC-Pain provider, and that is the reason for why I had included:

"Please discuss this consult request directly with [redacted] and CITC."

if my sense was incorrect on that, please resubmit the consult request, and I can accept it.

Be well,

[redacted]

From: [redacted]
To:
Subject: [redacted] - Care affected with consult rules --- CITC
Date: Tuesday, February 2, 2021 2:56:00 PM

[redacted]

Current PC Provider: [redacted]
Current PC Team: T AMB PACT BLUE 1 *WH*
Current Pat. Status: Outpatient
UCID: [redacted]
Primary Eligibility: SERVICE CONNECTED 50% to 100%(VERIFIED)
Patient Type: SC VETERAN
OEF/OIF: YES

Service Connection/Rated Disabilities
SC Percent: 80%
Rated Disabilities: DEGENERATIVE ARTHRITIS OF THE SPINE (40%)
PARALYSIS OF ANTERIOR CRURAL NERVE (20%)
PARALYSIS OF SCIATIC NERVE (20%)
PARALYSIS OF SCIATIC NERVE (10%)
FLAT FOOT CONDITION (10%)
TINNITUS (10%)
PARALYSIS OF ANTERIOR CRURAL NERVE (10%)
LIMITED MOTION OF ANKLE (10%)
FOOT PAIN (10%)
2ND DEGREE BURNS (0%)
2ND DEGREE BURNS (0%)

Order Information
To Service: COMMUNITY CARE-PAIN
From Service: TEM PACT BLUE PHY1
Requesting Provider: [redacted]
Service is to be rendered on an OUTPATIENT basis
Place: Consultant's choice
Urgency: Routine
Clinically Ind. Date: Feb 08, 2021
DST ID:
Orderable Item: COMMUNITY CARE-PAIN
Consult: Consult Request
Provisional Diagnosis: Intercostal Pain(ICD-10-CM R07.82)
Reason For Request:
INTERVENTIONAL PAIN MANAGEMENT CONSULTATION GUIDELINES:
This consultation request is for Interventional Pain
Management Procedures.
1. Reason for Request: Where is the primary location of the patient's

worst pain for the consultant to address?

- Back Pain No
- Neck Pain No
- Other Yes (please specify): left rib pain - pt has existing citc pain consult to bsw. for continuity of care, please grant consult for bsw provider to treat left rib pain

2. Controlled Substances:
   - Does the patient understand that the Interventional Pain Clinic offers procedures for the management of chronic pain and does not prescribe chronic controlled substances in the management of chronic pain? Yes
3. Interventional Pain Management Procedures:
   - Does the patient desire to receive interventional pain management injections for the management of Chronic Pain? Yes
4. Imaging:
   - The patient needs to have advanced imaging of the area involved within the last two years. MRI is usually the preferred advanced imaging for the spine.

   If MRI is contraindicated then obtain CT scan of the involved area. If the patient had prior surgery to the spine then please request MRI with and without contrast if the renal function allows it. The official imaging report must be reviewed by pain management before the consultation can be accepted. Please specify where the official imaging report is found:

   (Choice of only one is accepted; may not choose more than one)

   CPRS
5. Blood Thinners:
   - Is the patient receiving any blood thinners such as Coumadin, aspirin, clopidogrel, TSOACs (apixaban, dabigatran, or rivaroxaban) etc. No
   - If the patient is on blood thinners, can the patient discontinue that medication for about 7 days WITHOUT ANY BRIDGING medication and without significant risk of developing stroke, cardiovascular insult, or any other problem for which the patient is receiving that medication to prevent. Not applicable
6. Laboratory investigations:

- Is the patient Diabetic? No
- If YES, then the HGB A1C within the last three months of the date of
the consultation needs to be less than 8.
- Please indicate the VALUE and the DATE of the last HGB A1C:

Collection DT	Specimen	Test Name	Result	Units	Ref Range
10/15/2020 10:53	BLOOD	GLYCOHEMOGLOBIN	6.1 H	%	4.8 - 6.0

7. The Interventional Pain Management Clinic requires responses to the following questions regarding various modalities that may have been used in the management of pain in this patient's pain:

a) Has the patient tried Physical Therapy or exercise within the last year? Yes

b) Has the patient tried Acetaminophen and/or NSAIDs within the last year? Yes

c) Has the patient tried Gabapentin and /or Duloxetine if neuropathic pain was suspected?
Yes

d) Has the patient tried the TENS Unit be tried within the last year?
Yes

e) Has the patient tried Cognitive Behavioral Therapy (CBT) or Pain Psychology within the last year?
Yes

8. Comments:

**********NOTES**********

ALL FIELDS MUST BE FILLED OUT for the consultation to go through, just like the MRI template. The consultation will not go through if one field is not answered.

****

Inter-facility Information
This is not an inter-facility consult request.

Status: PENDING
Last Action: FORWARDED FROM

Facility Activity	Date/Time/Zone	Responsible Person	Entered By
CPRS RELEASED ORDER	02/01/21 15:20	[redacted]	
PRINTED TO CTX-PTPMRS3 (BIG)	02/01/21 15:20		
FORWARDED FROM	02/02/21 14:55	[redacted]	[redacted]

TEM SUR OUTPT PAIN MANAGEMENT

This is forwarded to CC-Pain only to add rib complaint per requesting provider as veteran has active CC-Pain consult/approval and is currently being treated with his current provider. This is not forwarded for an increased duration of approval. Defer to / please discuss directly with [redacted] for his approval.

Note: TIME ZONE is local if not indicated

No local HD results or Medicine results available for this consult

========== END ==========

From: [redacted]
To:
Subject: FW: CC Pain referrals
Date: Tuesday, May 25, 2021 3:36:00 PM
Attachments: image003.png
Community Care Field Guidebook - Chapter 2.docx
Pamela Hamblin Eligibility Verification Letter.pdf
Community Care Consult Overview Specialty Services (2) (002) (002).vsdx

---

Hello [redacted]

Re: [redacted]

So, here is a good example of a veteran whose care has been affected.

This man is a veteran that has been seeing a Community Care Pain physician, for years --- per the veteran.

His consult was scheduled here through us by order of [redacted] --- at this point, for veterans too numerous to count --- **under threat of administrative action**.

As [redacted], the Director of Whole Health, has used his administrative role over the Pain Management section to clinically intervene to make the BMI decision for us on the clinical care side of processing these consult requests, the veterans are simply being scheduled here at CTVHCS instead of with their established physicians in the community --- in regards to Continuity of Care.

This veteran will likely receive no letter from the Office of the CoS, or the designated representative, indicating the denial of their referral to the community for BMI.

Further, the veteran is likely not being advised of any possibility or right of appeal.

Approved Best Medical Interest Hardship Determination Letters_508.pdf (sharepoint.com)

And this veteran wants to know what to do.

And today I am being instructed today by the Medical Director of Community Care:

Don't tell veterans to call CITC with questions.

Sincerely,

[redacted]

//

According to the Community Care Fieldbook:

//

Review for Community Care Eligibility by Scheduling Staff

As part of the updated process, DST should be used by the referring provider ONLY when he/she has a strong clinical reason for the Veteran to be made eligible to receive community care under the best medical interest (BMI) provision in the MISSION Act. **It is important to note, BMI decisions are only to be made by clinical staff members, that are part of the patient's care team. Administrative staff are not to make BMI community care eligibility determinations.**

//

Send letter to Veteran regarding determination

- If the Chief of Staff approved or disapproved of the General Best Medical Interest (Hardship) eligibility, send the Veteran a letter regarding the determination.
- If the Chief of Staff did not approve or disapprove of the General Best Medical Interest (Hardship) eligibility, document the status and the duration in Consult Toolbox and then send the Veteran a letter regarding the determination.
- COS or designee should send the decision letter
- The Hardship Determination Letter Template is available here

Approved Community Care-Best Medical Interest (Hardship) Determination Approval & Disapproval Letter

Note: These letters are also available to the facility Clinical Application Coordinators to create a letter template in CPRS.

//

From: [redacted]
Sent: Tuesday, May 25, 2021 1:33 PM
To: [redacted]

Subject: FW: QC Pain referrals

Hello [redacted]

I have been notified of your patient [redacted]

Please see attached Power Point for information on Community Care referrals in Specialty areas. This may be helpful to you.

We do not approve to Community Care based on **patient wants.**

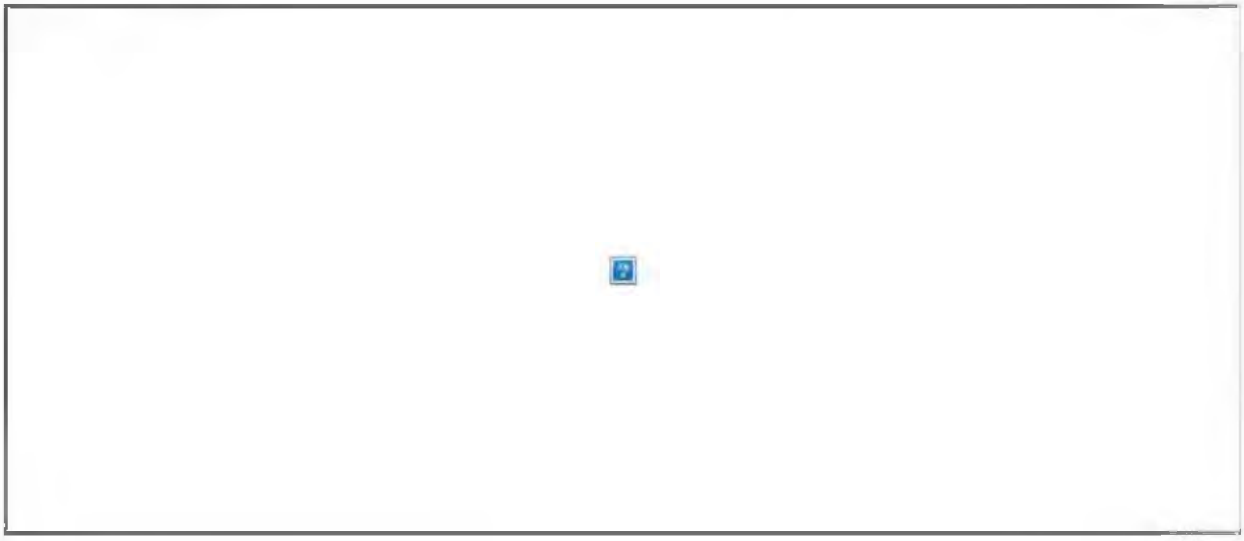
It has to be based on **established access or drive time standards**, please review the above.

Please do not have them call Community Care, the consults are processed according to established standards.

Your AMSAs or Service Adpac can help you with this, if your Service is working with the RCI RNs they will also help to review I am not sure if Pain Management is yet working with the RCI RNs

Thank you so very much,

[redacted]
Community Care



From: [redacted]
To:
Subject: [redacted] CITC policy --- consequences
Date: Tuesday, February 2, 2021 12:37:55 PM

[redacted]

Current PC Provider: [redacted]
Current PC Team: T AMB PACT MAROON 4 *WH*
Current Pat. Status: Outpatient
UCID: [redacted]
Primary Eligibility: SERVICE CONNECTED 50% to 100%(VERIFIED)
Patient Type: SC VETERAN
OEF/OIF: YES

Service Connection/Rated Disabilities
SC Percent: 80%
Rated Disabilities: POST-TRAUMATIC STRESS DISORDER (70%)
LIMITED FLEXION OF KNEE (10%)
TINNITUS (10%)
DEGENERATIVE ARTHRITIS OF THE SPINE (10%)
LIMITED EXTENSION OF KNEE (10%)
IMPAIRED HEARING (0%)
LIMITED FLEXION OF KNEE (0%)

Order Information
To Service: COMMUNITY CARE-PAIN
Attention: [redacted]
From Service: TEM PACT MAROON PHY4
Requesting Provider: [redacted]
Service is to be rendered on an OUTPATIENT basis
Place: Consultant's choice
Urgency: Routine
Clinically Ind. Date: Feb 01, 2021
DST ID:
Orderable Item: COMMUNITY CARE-PAIN
Consult: Consult Request
Provisional Diagnosis: Low Back Pain(ICD-10-CM M54.5)
Reason For Request:
INTERVENTIONAL PAIN MANAGEMENT CONSULTATION GUIDELINES:
This consultation request is for Interventional Pain Management Procedures.

1. Reason for Request: Where is the primary location of the patient's worst pain for the consultant to address?
   - Back Pain Yes
   - Neck Pain No

- Other No (please specify): pt need approval for community pain

2. Controlled Substances:
   - Does the patient understand that the Interventional Pain Clinic offers procedures for the management of chronic pain and does not prescribe chronic controlled substances in the management of chronic pain? Yes
3. Interventional Pain Management Procedures:
   - Does the patient desire to receive interventional pain management injections for the management of Chronic Pain? Yes
4. Imaging:
   - The patient needs to have advanced imaging of the area involved within the last two years. MRI is usually the preferred advanced imaging for the spine.
   If MRI is contraindicated then obtain CT scan of the involved area. If the patient had prior surgery to the spine then please request MRI with and without contrast if the renal function allows it. The official imaging report must be reviewed by pain management before the consultation can be accepted. Please specify where the official imaging report is found:
   (Choice of only one is accepted; may not choose more than one)
   CPRS
5. Blood Thinners:
   - Is the patient receiving any blood thinners such as Coumadin, aspirin, clopidogrel, TSOACs (apixaban, dabigatran, or rivaroxaban) etc. No
   - If the patient is on blood thinners, can the patient discontinue that medication for about 7 days WITHOUT ANY BRIDGING medication and without significant risk of developing stroke, cardiovascular insult, or any other problem for which the patient is receiving that medication to prevent. Not applicable
6. Laboratory investigations:
   - Is the patient Diabetic? No
   - If YES, then the HGB A1C within the last three months of the date of the consultation needs to be less than 8.
   - Please indicate the VALUE and the DATE of the last HGB A1C:

Collection DT Specimen Test Name Result Units Ref

Range
11/19/2019 08:56 BLOOD GLYCOHEMOGLOBIN 5.5 % 4.8
- 6.0

7. The Interventional Pain Management Clinic requires responses to the following questions regarding various modalities that may have been used in the management of pain in this patient's pain:

a) Has the patient tried Physical Therapy or exercise within the last year? Yes

b) Has the patient tried Acetaminophen and/or NSAIDs within the last year? Yes

c) Has the patient tried Gabapentin and /or Duloxetine if neuropathic pain was suspected?
Yes

d) Has the patient tried the TENS Unit be tried within the last year?
Yes

e) Has the patient tried Cognitive Behavioral Therapy (CBT) or Pain Psychology within the last year?
No

8. Comments:
second time consult

[redacted], now there are notes from commumity

**********NOTES**********
ALL FIELDS MUST BE FILLED OUT for the consultation to go through, just like the MRI template. The consultation will not go through if one field is not answered.
****

Inter-facility Information
This is not an inter-facility consult request.

Status: SCHEDULED
Last Action: ADDED COMMENT

Facility
Activity Date/Time/Zone Responsible Person Entered By

CPRS RELEASED ORDER 02/01/21 13:26 [redacted] [redacted]
PRINTED TO 02/01/21 13:26
CTX-PTPMRS3 (BIG)
ADDED COMMENT 02/01/21 13:29 [redacted] [redacted]
re submitted

ADDED COMMENT 02/01/21 14:52 [redacted] [redacted]
#COI#

COI-Veteran OPT-IN for Community Care.
PFP-Veteran's Preferred Provider:
[redacted]
PFP----------
OTP-Veteran OK to see other than Preferred Provider: No

FORWARDED FROM 02/01/21 14:57 [redacted] [redacted]
TEM SUR OUTPT PAIN MANAGEMENT
I was contacted by [redacted] regarding this veteran's consult request as well as another veteran's request. She has indicated to me that veterans are getting upset their appts are being cancelled; as such, I am forwarding this on to CITC to discuss directly with [redacted] for his/their consideration as [redacted] indicates the veteran's scheduled procedure appointment is for tomorrow at 2-2-21 @1100.

RECEIVED 02/01/21 16:15 [redacted]

SEOC - VHA Office of Community Care----------

VHA Office of Community Care - Standardized Episode of Care
Pain Management Comprehensive

CAT-SEOC CoC: PAIN MANAGEMENT
SEOC ID: MSC_PAIN MANAGEMENT COMPREHENSIVE_1.2.6_PRCT
Description: This authorization covers services associated with the specialty(s) identified for this episode of care, including all medical care listed below relevant to the referred care specified on the consult order. Medication Management including any opioid therapy should be consistent with VA/DOD clinical practice guidelines. This episode of care does not include intrathecal drug delivery (IDD) or neuromodulation device care. Separate approval is required for IDD or neuromodulation device initiation and care.
Duration: 180 days

Procedural Overview:
1. Initial outpatient evaluation and treatment for the referred condition indicated on the consult order, including any restrictions for or against treatment options
2. Diagnostic imaging relevant to the referred condition on the consult order
3. Diagnostic studies relevant to the referred condition on the consult order including but not limited to: EMG/NCV

4. Labs including necessary drug screens and pathology relevant to the referred condition on the consult order
5. Injections including but not limited to: Medial branch blocks, epidural injections, facet injections, trigger point injections, genicular injections, joint injections
6. Procedures including but not limited to: radiofrequency ablation, vertebroplasty and spinal decompression
7. Anesthesia consultation related to a procedure
8. Pre-operative medical and cardiac clearance as indicated, to include H+P/labs, EKG, CXR, echo
9. Inpatient or observation admission for procedure, if indicated.
** Notify the referring VA of admission status to initiate and facilitate care coordination and discharge planning.
10. Inpatient admission or observation status for complications from the procedure
** Notify the referring VA of admission status to initiate and facilitate care coordination and discharge planning.
11. Follow-up visits for this episode of care
12. Physical Therapy: as indicated up to 15 visits as related to the referred condition on the consult order; Notify VA to request additional visits with supporting medical documentation
13. Occupational Therapy: as indicated up to 15 visits as related to the referred condition on the consult order; Notify VA to request additional visits with supporting medical documentation

*Please visit the VHA Storefront www.va.gov/COMMUNITYCARE/providers/index.asp for additional resources and requirements pertaining to the following
* Pharmacy prescribing requirements
* Durable Medical Equipment (DME), Prosthetics, and Orthotics prescribing requirements
* Precertification (PRCT) process requirements
* Request for Services (RFS) requirements
* DME, prosthetics and orthotics will be reviewed by the VA for provision.

SEO----------

SEV-Community Care Eligibility: BMI-per episode of care
CVA-Accept new consult, received during COVID-19 Pandemic

Scheduling prioritized during COVID-19 Pandemic
CV1-COVID-19 Priority 1
Schedule appointment despite COVID-19 restrictions
As an alternative to a face-to-face appointment:
TEL-Telephone Appointment may be offered to the Veteran

THL-Telehealth Appointment may be offered to the Veteran
CAP-Community Care Approved, Program:
Authorized/Pre-authorized Referral 1703
ME-May discontinue if Veteran cancels/no-shows twice or fails to respond to mandated scheduling effort.
COH-Community Care Appt Scheduling to be handled by: VA schedules based on Veteran's preference
Admin Screening for Care Coordination
SCD Screening Code: 006 66 TN A 35
CAN Score: 35

Admin Screening Care Coordination: Basic
Clinical Triage: Not Required

Scheduler may proceed with scheduling of appointment.

Basic care coordination may include:
-assistance with navigation
-scheduling
-post-appointment follow-up

Upon consult completion, a CPRS alert will be sent to ordering provider.

Recommended frequency of contact: as needed

ICR-Initiate Community Care Referral

SCHEDULED 02/01/21 16:30 [redacted] [redacted]
COM CARE-PAIN Consult Appt. on [redacted]
HSRM, PID=FEB 01, 2021 PEB CONSULT, PROVIDER [redacted]

ADDED COMMENT 02/01/21 16:35 [redacted] [redacted]
IXI-Documents uploaded to TPA Portal.
RSP-Records faxed/sent to Community Care Provider.

VA Referral #: VA0011556753

TW Referral #: 00140B9493

AUTH PACKET SENT TO
[redacted]

[redacted]

SENT VIA SECURE EMAIL TO [redacted]

Note: TIME ZONE is local if not indicated

No local FBI results or Medicine results available for this consult

END

From: [redacted]
To: [redacted]
Subject: [SECURE] - PATIENT CONFIDENTIAL
Date: Monday, July 19, 2021 3:17:00 PM

Hello [redacted]

I have not heard back from you since I last wrote you

The providers here at CTVHCS continue to be unsure of how to handle the issues that have arisen under [redacted]/Whole Health's takeover of the Pain Management section.

To date, I remain unaware of how to consult [redacted] on CPRS as one would any other service/provider... I have tried to ask before, [redacted] has tried to ask before, and I am aware of other providers who have asked before...

Please see below.

Sincerely,

[redacted]

//

Re:

[redacted] [redacted] [redacted]

Current PC Provider: [redacted]
Current PC Team: T AMB PACT BLUE 1 *WH*
Current Pat. Status: Outpatient
UCID: [redacted]
Primary Eligibility: SERVICE CONNECTED 50% to 100%(VERIFIED)
Patient Type: SC VETERAN
OEF/OIF: NO

Service Connection/Rated Disabilities
SC Percent: 80%
Rated Disabilities: HIATAL HERNIA (60%)
CYCLOTHYMIC DISORDER (50%)
TINNITUS (10%)
LIMITED MOTION OF ANKLE (10%)
NEOPLASM, BENIGN, SKIN (0%)
IMPAIRED HEARING (0%)

Order Information
To Service: TEM WHS OUTPT PAIN MANAGEMENT
From Service: TEM PACT BLUE PHY1
Requesting Provider: [redacted]
Service is to be rendered on an OUTPATIENT basis
Place: Consultant's choice
Urgency: Routine
Clinically Ind. Date: Jul 19, 2021
DST ID:
Orderable Item: TEM WHS OUTPT PAIN MANAGEMENT
Consult: Consult Request
Provisional Diagnosis: Dorsalgia, unspecified(ICD-10-CM M54.9)
Reason For Request:
———— MISSION Act Decision Support Information ————
DST ID: 9d59576d-507f-497b-b4f2-ecdf85fd7faf
———— Do not change text above this line ————

PAIN MANAGEMENT CONSULTATION GUIDELINES:
This consultation request is for Pain Management Procedures.
1. Reason for Request: Where is the primary location of the patient's worst pain for the consultant to address?
- Back Pain Yes
- Neck Pain No
- Other Yes (please specify): Patient needng renewal of community care referral to [redacted] for continuity of care
2. Interventional Pain Management Procedures:
- Does the patient desire to receive interventional pain management injections for the management of Chronic Pain? Yes
3. Imaging:
- The patient needs to have advanced imaging of the area involved within the last two years. MRI is usually the preferred advanced imaging for the spine.
If MRI is contraindicated then obtain CT scan of the involved area.
If the patient had prior surgery to the spine then please request MRI with and without contrast if the renal function allows it. The official imaging report must be reviewed by pain management before the consultation can be accepted. Please specify where the official imaging report is found:
(Choice of only one is accepted; may not choose more than one)
VISTA Web
4. Blood Thinners:
- Is the patient receiving any blood thinners such as Coumadin, aspirin, clopidogrel, TSOACs (apixaban, dabigatran, or rivaroxaban)
etc. No

- If the patient is on blood thinners, can the patient discontinue that medication for about 7 days WITHOUT ANY BRIDGING medication and without significant risk of developing stroke, cardiovascular insult, or any other problem for which the patient is receiving that medication to prevent. Not applicable

5. Laboratory investigations:

- Is the patient Diabetic? No
- If YES, then the HGB A1C within the last three months of the date of the consultation needs to be less than 8 for intervention.
- Please indicate the VALUE and the DATE of the last HGB A1C:

Collection DT Specimen Test Name Result Units Ref Range
03/10/2021 05:00 BLOOD GLYCOHEMOGLOBIN 7.1 H % 4.8 - 6.0

6. The Interventional Pain Management Clinic requires responses to the following questions regarding various modalities that may have been used in the management of pain in this patient's pain:

a) Has the patient tried Physical Therapy or exercise within the last year? Yes
b) Has the patient tried Acetaminophen and/or NSAIDs within the last year? Yes
c) Has the patient tried Gabapentin and /or Duloxetine if neuropathic pain was suspected? No
d) Has the patient tried the TENS Unit be tried within the last year? No
e) Has the patient tried Cognitive Behavioral Therapy (CBT) or Pain Psychology within the last year? No

7. Comments:

Patient needng renewal of community care referral to [redacted] for continuity of care

**********NOTES**********

ALL FIELDS MUST BE FILLED OUT for the consultation to go through, just like the MRI template. The consultation will not go through if one field is not answered.

****

Inter-facility Information
This is not an inter-facility consult request.

Status: DISCONTINUED
Last Action: PRINTED TO

Facility
Activity Date/Time/Zone Responsible Person Entered By

CPRS RELEASED ORDER 07/19/21 13:57 [redacted]
PRINTED TO 07/19/21 13:57
CTX-PTPMRS3 (BIG)
ADDED COMMENT 07/19/21 [redacted]
(entered) 07/19/21 13:57
DST-DST ID: 9d59576d-507f-497b-b4f2-ecdf85fd7faf
CSC-Consult stop code: 420
CSN-Clinical Service: PAIN CLINIC
CST-Consult service type: SPECIALTY CARE
CCE-CC Eligibility Status: ELIGIBLE
VCC-Veteran's CC option: OPT_IN
DCI-DST CC Best Interest of Vet: POTENTIAL FOR IMPROVED CONTINUITY OF CARE
MIE-Explanation of BMI - POTENTIAL FOR IMPROVED CONTINUITY OF CARE:----------
Patient needng renewal of community care referral to [redacted]
[redacted] for continuity of care
MIE--------
SEOC - VHA Office of Community Care----------
VHA Office of Community Care - Standardized Episode of Care
Pain Management Comprehensive
CAT-SEOC CoC: PAIN MANAGEMENT
SEOC ID: MSC_PAIN MANAGEMENT COMPREHENSIVE_1.2.7_PRCT
Description: This authorization covers services associated with the specialty(s) identified for this episode of care, including all medical care listed below relevant to the referred care specified on the consult order. Note: Medication Management including any opioid therapy should be consistent with VA/DOD clinical practice guidelines. This episode of care does not include intrathecal drug delivery (IDD) or neuromodulation device care. Separate approval is required for IDD or neuromodulation device initiation and care.
Duration: 180 days
Procedural Overview:
1. Initial outpatient evaluation and treatment for the referred condition indicated on the consult order, including any restrictions for or against treatment options
2. Diagnostic imaging relevant to the referred condition on the consult order
3. Diagnostic studies relevant to the referred condition on the consult order including but not limited to: EMG/NCV
4. Labs including necessary drug screens and pathology relevant to the referred condition on the consult order
5. Injections including but not limited to: Medial branch blocks, epidural injections, facet injections, trigger

point injections, genicular injections, joint injections
6. Procedures including but not limited to: radiofrequency ablation, vertebroplasty and spinal decompression
7. Anesthesia consultation related to a procedure
8. Pre-procedure medical and basic cardiac clearance, as indicated (including H+P/labs, EKG, CXR, echo)
Note: cardiac testing or evaluation outside of the above CXR, EKG and echo will require an RFS for a cardiology referral
9. Inpatient or observation admission for procedure and/ or procedure related complications, if indicated.
Notify the referring VA of admission status to initiate and facilitate care coordination and discharge planning.
10. Follow-up visits as related to the referred condition on the consult order
11. Outpatient Physical Therapy: as indicated up to 15 visits as related to the referred condition on the consult order; Notify VA to request additional visits with supporting medical documentation
12. Outpatient Occupational Therapy: as indicated up to 15 visits as related to the referred condition on the consult order; Notify VA to request additional visits with supporting medical documentation
Please visit the VHA Storefront www.va.gov/COMMUNITYCARE/ providers/index.asp for additional resources and requirements pertaining to the following:
Pharmacy prescribing requirements
Durable Medical Equipment (DME), Prosthetics, and Orthotics prescribing requirements
Precertification (PRCT) process requirements
Request for Services (RFS) requirements
SEO
DSP-DST data saved prior to signing consult

DISCONTINUED 07/19/21 15:13 [redacted] [redacted]
This appears to be a referral for [redacted] I do not know how one can consult him via CPRS. Please consider emailing him directly if that is the intention.

PRINTED TO 07/19/21 15:13
CTX-PTPMRS3 (BIG)

Note: TIME ZONE is local if not indicated

No local TIU results or Medicine results available for this consult
========== END ==========

From: [redacted]
To: [redacted]
Subject: RE: Wording I have included on some discontinued consults...
Date: Tuesday, February 23, 2021 9:14:00 AM

This is what I have been doing. But if there is any information I can give the PCP to help, then I try to do that. For example, if no MRI in the past 2 years, then I say that I couldn't find that and please resubmit, etc...

[redacted]

From: [redacted]
Sent: Monday, February 22, 2021 4:52 PM
To: [redacted]
Subject: RE: Wording I have included on some discontinued consults...

So if consult doesn't meet our criteria for acceptance, and they're asking for continuity of citc, then you DC with the message below?

From: [redacted]
Sent: Monday, February 22, 2021 10:58 AM
To: [redacted]
Subject: RE: Wording I have included on some discontinued consults...

To be clear, if the consult request is for CITC, and I cannot approve per [redacted] instructions, but the information on the chart meets our criteria for acceptance, then I accept it.

[redacted]

From: [redacted]
Sent: Monday, February 22, 2021 12:45 PM
To: [redacted]
Subject: RE: Wording I have included on some discontinued consults...

I have been discontinuing them under the thought process that [redacted] never instructed us to abandon our screening procedures/consult request template.

From: [redacted]
Sent: Monday, February 22, 2021 12:44 PM
To: [redacted]
Subject: RE: Wording I have included on some discontinued consults...

Thank you.
Do you DC those consults or accept them?

I have used this language for continuity request:

Per updated direction to evaluate within VA including requests
for continuity of community care:
--and then I put the stock message to accept consults

From: [redacted]
Sent: Monday, February 22, 2021 10:24 AM
To: [redacted]
Subject: Wording I have included on some discontinued consults...

"
Per my understanding: per [redacted], continuity of care for chronic pain only applies immediately post-operatively.
"
|
"
Per my understanding: per [redacted], continuity of care for chronic pain only applies to follow-up for a procedural complication that is being treated at that community clinic or a procedure we do not do. Please discuss this consult request directly with [redacted] and CITC.
"

I end up not discussing Wait times or Drive times because if they qualify for that, I can already tell and send it to CITC; if they don't, then its not very informative for me to bring it up in specific case discontinuations (I believe)...

From: [redacted]
To: [redacted]
Subject: RE: pain consults
Date: Friday, February 26, 2021 12:53:00 PM

I guess I am not sure which cases he is referring to.

[redacted]

From: [redacted]
Sent: Friday, February 26, 2021 12:49 PM
To: [redacted]
Subject: RE: pain consults

That's the impression I am under as well..

I guess we will have to wait to see if [redacted] response clarifies the question further...

[redacted]

From: [redacted]
Sent: Friday, February 26, 2021 12:32 PM
To: [redacted]
Cc: [redacted]
Subject: RE: pain consults

I do not see where our consultation guidelines and capturing community care work contradict one another or are mutually exclusive.

From: [redacted]
Sent: Friday, February 26, 2021 12:25 PM
To: [redacted]
Subject: RE: pain consults

If [redacted] is threatening us with "failure to follow orders" ... I would need to see clearly in writing that we are not to discontinue consultation requests if they do not meet our criteria for acceptance.

Can this be addressed?

[redacted]

From: [redacted]
Sent: Friday, February 26, 2021 12:01 PM
To: [redacted]
Subject: RE: pain consults

I cannot find anywhere that [redacted] has told us to abandon our screening procedures/consult request template.

Have you all seen any such instruction?

[redacted]

From: [redacted]
Sent: Friday, February 26, 2021 11:17 AM
To: [redacted]
Subject: RE: pain consults

Is he telling us to abandon our screening procedures/consult request template?

I have only been accepting the consults if they meet our criteria.

[redacted]

From: [redacted]
Sent: Friday, February 26, 2021 11:14 AM
To: [redacted]
Cc: [redacted]
Subject: FW: pain consults
Importance: High

Please note the email below.

From: [redacted]
Sent: Thursday, February 25, 2021 4:13 PM
To: [redacted]
Cc: [redacted]
Subject: pain consults

Consults requesting community care for pain management for "continuity of care" must be scheduled in the VA.

We have discussed this before.

Please reorient your team.

If this continues to occur, it will be considered a failure to follow directions.

[redacted]

[redacted]

Clinical Director, Whole Health and Integrated Health Services
Central Texas VA Healthcare System

[redacted]

From: [redacted]
To: [redacted]
Cc: [redacted]
Subject: RE: pain consults
Date: Monday, March 1, 2021 11:42:00 AM

I would like these matters addressed prior to processing any further consult requests.

[redacted]

From: [redacted]
Sent: Monday, March 1, 2021 8:32 AM
To: [redacted]
Cc: [redacted]
Subject: RE: pain consults

Hello all,

To my understanding, I am doing what has been described.

If this is incorrect, it would be helpful to see an example, so I know what to keep my eyes open for; again this matter was discussed with me on Friday, February 26th, and I believe I understood the discussion, and I believe I had followed the instructions with fidelity from that point on. One point of confusion was clarified during this discussion, which I believe I incorporated.

It would be helpful if [redacted] comment on which case(s) after that point he was referring to, so I can know how to process the requests more closely to what [redacted] is thinking.

It would help if [redacted] commented on what [redacted] had sent out to clarify.

Are we being asked to no longer follow our criteria for acceptance of these consults? **To my knowledge, this was never asked of us.** *Are we being asked to schedule these cases anyway even if not meeting our criteria?*

Thank you,

[redacted]

From: [redacted]
Sent: Monday, March 1, 2021 8:07 AM
To: [redacted]

Cc: [redacted]
Subject: RE: pain consults
Importance: High

[redacted], I have oriented my team regarding "continuity of care" verbally to [redacted], per your instructions, on February 26, 2021, following your personal appearance in my clinic on that date. I was promised that this will be done.

Team, per [redacted], Please follow his continuity of care rules. [redacted], instructions are for us not to approve continuity of care for pain in the community only under the conditions stated below, otherwise, cases are to be accepted by us for management in our pain clinics when they meet our consultation form acceptance criteria.

[redacted], I hope the above-stated orders are acceptable to you. Please feel free to modify, comment, cancel any of the stated in this email. This is how I understand your orders to be. If you see that our consultation template is not good enough for you, please change it to your desire and we shall accept it.

Sincerely,
[redacted]

From: [redacted]
Sent: Saturday, February 27, 2021 8:07 PM
To: [redacted]
Subject: RE: pain consults

[redacted]

You have still not followed my instructions to orient your team to the requirement to schedule in VA pain clinic all patients who are being referred for community care for pain management for "continuity of care", unless they meet the criteria we discussed.

If you do not orient them properly within one week I will have to take administrative action.

[redacted]

From: [redacted]
Sent: Friday, February 26, 2021 12:22 PM
To: [redacted]

Cc: [redacted]
Subject: FW: pain consults
Importance: High

Team,

Please note the email below in light of the following:

Per [redacted], cases may be referred to Community Care Pain under the following conditions:

1-Service not available at this VA
2-Drive Time exceeding 60 minutes and the patient chooses Community Care.
3-Wait Time exceeding 28 days and the patient chooses Community Care.
4-Continuity of care only in case of a complications that were produced by the Community Care Pain Provider.
5-Cases for Spinal Cord Stimulators or other devices are to be seen at this VA Pain Management Clinic before approval for referral to Community Care Pain Providers for the requested procedure.

I shall include [redacted] on the email for comments or corrections.

None of the above implies that we are abandoning our pain management consultation template at this time. But in the future, there will be a comprehensive pain management template that will include multiple pin management service lines, such as chiropractor, Interventional, acupuncture, etc.

Please let me know if you have questions.

Sincerely,
[redacted]

From: [redacted]
Sent: Thursday, February 25, 2021 4:13 PM
To: [redacted]
Cc: [redacted]
Subject: pain consults

Consults requesting community care for pain management for "continuity of care" must be scheduled in the VA.

We have discussed this before.

Please reorient your team.

If this continues to occur, it will be considered a failure to follow directions.

[redacted]

[redacted]
Clinical Director, Whole Health and Integrated Health Service
Central Texas VA Healthcare System

[redacted]

From: [redacted]
To:
Cc:
Subject: Wording
Date: Friday, February 26, 2021 1:44:42 PM

I use the following wordings in accepting and discontinuing consultations:

Receiving Consultations:

Please schedule this patient in the Pain Management Consultation Clinic following the updated guidelines for the Mission Act and the current COVID-19 scheduling modifications. Please inform the patient that the initial visit to this Pain Clinic is a consultation appointment that may be carried out as a VA Video encounter. There will be no procedure performed during the initial consultation. If the patient is interested in the Austin VA for consultation and procedures in Austin, you may forward this consultation to the "Austin Surg Pain Management Clinic."

-You may discontinue this consultation after failed outreach attempts and/or after reaching the appropriate number of "Cancellations by Patient" or "No Shows" as per policy.

Please note that the Pain Management Section is under direct orders from [redacted], our Service Chief, not to refer to Community Care Pain cases for continuity of care if the care is available at this VA.

Per [redacted], cases may be referred to Community Care Pain under the following conditions:
1-Service not available at this VA
2-Drive Time exceeding 60 minutes and the patient chooses Community Care.
3-Wait Time exceeding 28 days and the patient chooses Community Care.
4-Continuity of care only to manage complications that were produced by the Community Care Pain Provider.
5-Cases for Spinal Cord Stimulators or other devices are to be seen at this VA Pain Management Clinic before approval for referral to Community Care Pain Providers for the requested procedure.

Please indicate if the patient meets any of the above-stated criteria for community pain management referral and issue the proper DST in support of this referral.

Also, note that the VA has all necessary medications for the management of the patient's pain, if such is indicated.

If you have questions, you may call me at 43868. You may also direct complaints to our Service Chief, [redacted], or to the Chief of Staff, [redacted]. Pain Management is under orders and we do what we are ordered to do.

++

I could not locate the MRI L-Spine or C-Spine within the last two years in the CPRS where you have indicated that would be found. Please obtain an MRI L-Spine and C-Spine and then re-

consult after the official report is available for review. If the patient had prior surgery on his L-Spine, then obtain an MRI L-Spine with and without contrast. If you have any questions, please call me at 43868.

If imaging were done in the community, please note that the MRI Images AND the official report of the MRI on Letterhead are essential for the processing of this consultation. Both items must be reviewed before this consultation is accepted.

Please note that the Pain Management Section is under direct orders from [redacted], our Service Chief, not to refer to Community Care Pain cases for continuity of care if the care is available at this VA.

Per [redacted], cases may be referred to Community Care Pain under the following conditions:
1-Service not available at this VA
2-Drive Time exceeding 60 minutes and the patient chooses Community Care.
3-Wait Time exceeding 28 days and the patient chooses Community Care.
4-Continuity of care only to manage complications that were produced by the Community Care Pain Provider.
S-Cases for Spinal Cord Stimulators or other devices are to be seen at this VA Pain Management Clinic before approval for referral to Community Care Pain Providers for the requested procedure.

Please indicate if the patient meets any of the above-stated criteria for community pain management referral and issue the proper DST in support of this referral.

Also, note that the VA has all necessary medications for the management of the patient's pain, if such is indicated.

If you have questions, you may call me at [redacted]. You may also direct complaints to our Service Chief, [redacted], or to the Chief of Staff, [redacted]. Pain Management is under orders and we do what we are ordered to do.

++

From: [redacted]
To:
Subject: OSC — FW: Filing — Formal grievance under Article 43 of the Master Agreement
Date: Wednesday, December 8, 2021 12:37:00 PM

From: [redacted]
Sent: Tuesday, April 6, 2021 8:21 AM
To: [redacted]
Subject: RE: Filing — Formal grievance under Article 43 of the Master Agreement

I would really appreciate any sort of reply on this.

Thank you,

[redacted]

From: [redacted]
Sent: Monday, April 5, 2021 8:12 AM
To: [redacted]
Subject: RE: Filing — Formal grievance under Article 43 of the Master Agreement

Hello [redacted]

Please let me know the status of the grievance that I have filed with you.

[redacted]

From: [redacted]
Sent: Wednesday, March 31, 2021 8:37 AM
To: [redacted]
Subject: RE: Filing — Formal grievance under Article 43 of the Master Agreement

Hello.

Is there anything further I should do for this?

Please let me know.

Thank you,

[redacted]

From: [redacted]
To:
Subject: OSC — FW: Filing — Formal grievance under Article 43 of the Master Agreement
Date: Wednesday, December 8, 2021 12:37:00 PM

From: [redacted]
Sent: Tuesday, April 6, 2021 8:21 AM
To: [redacted]
Subject: RE: Filing — Formal grievance under Article 43 of the Master Agreement

I would really appreciate any sort of reply on this.

Thank you,

[redacted]

From: [redacted]
Sent: Monday, April 5, 2021 8:12 AM
To: [redacted]
Subject: RE: Filing — Formal grievance under Article 43 of the Master Agreement

Hello [redacted]

Please let me know the status of the grievance that I have filed with you.

[redacted]

From: [redacted]
Sent: Wednesday, March 31, 2021 8:37 AM
To: [redacted]
Subject: RE: Filing — Formal grievance under Article 43 of the Master Agreement

Hello.

Is there anything further I should do for this?

Please let me know.

Thank you,

[redacted]

From: [redacted]
Sent: Thursday, March 25, 2021 2:32 PM
To: [redacted]
Subject: RE: Filing — Formal grievance under Article 43 of the Master Agreement

Is there any update on this?

[redacted]

From: [redacted]
Sent: Tuesday, March 23, 2021 10:00 AM
To: [redacted]
Subject: RE: Filing — Formal grievance under Article 43 of the Master Agreement

Hello!

Is anything else required of me for the Union to proceed with this grievance?

Thank you,

[redacted]

From: [redacted]
Sent: Monday, March 22, 2021 10:54 AM
To: [redacted]
Subject: Filing — Formal grievance under Article 43 of the Master Agreement

To [redacted]

Please accept this submission as a formal grievance under Article 43 of the Master Agreement between the AFGE and Department of Veterans Affairs. This will also constitute a formal grievance submission pursuant to the agency's administrative grievance procedure, as set forth in VA Directive 5021.

On 3/19/2021, [redacted] the Director of Whole Health, directed the Chief of the Pain Management section, [redacted] that the physicians within Pain Management section are required to submit to [redacted] lists of veteran names whose charts contain certain clinical narratives and/or verbiage. Upon information and belief, [redacted] has identified narratives and verbiage that Pain Management

physicians, in their best clinical judgment, included as part of our processing and decision upon consultation requests for Pain Management services from referring/requesting providers. [redacted] has indicated that these narratives and verbiage will be redacted from Veteran patient charts, thereby altering the permanent patient records of numerous veterans.

It appears that [redacted] directive focuses on entries that Pain Management physicians made within patient charts for purposes of Consult processing within CPRS, and which reflected the Specialty Team's (Pain Management's) determination of disposition for the consult.

For example: to "receive" or "discontinue" or "forward." The wording in question was wording used by us in responding to Consult request submissions from referring/requesting providers who made known their intention for the veterans involved to have their consults forwarded to Care in the Community (CITC); once entered, this wording is part of the permanent chart.

Pain Management physicians also included references to the fact that the referring providers may direct their questions/concerns/complaints to [redacted] the Director of Whole Health, and [redacted] the Chief of Staff, as to the orders given to us by [redacted] as to which consults we were not allowed to forward to the CITC for further processing.

The reason for the inclusion of this wording is that [redacted] who is the administrator of Whole Health, and not part of the Specialty team processing the consult requests, has inserted himself into the clinical decision-making of the Specialty Team (Pain Management experts, who met National and Facility-level criteria for selection and credentialing), and prohibited the physicians of the Pain Management section from forwarding consultation requests, which appear reasonable, lawful, and likely due to the Veterans on to CITC for further administrative processing. Given the direct limitations that [redacted] has placed on Pain Management to make community referrals when otherwise consistent with regulation, our physicians included the above reference to ensure

referring physicians could discuss their concerns with [redacted] (who was ultimately the decisionmaker on this issue). Our purpose was to identify [redacted] "to identify practitioners for continuing care" under VHA Handbook 1907.01.

Specifically, [redacted] who was assigned an administrative role over the Pain Management section, inserted himself within the clinical decision-making of the Pain Management specialty team, and between the team and CITC (and its role in processing); the ramification of this is that [redacted] has exercised uninformed clinical judgment in every one of these individual cases. [redacted] has made himself a party to the clinical identification of practitioners for continuing care in each of these cases. Per our most recent Employee/Union meeting with [redacted] Fashina is aware and has allowed [redacted] decision-making over these consults requests and their processing by the Specialty Team. As such, both of their names were cited as available resources for the referring providers to escalate discussion and allow for improved decision-making with the express purpose of the identification of practitioners for continuing care.

It is our understanding that the agency is now retroactively altering patient medical/health records and removing entries that Pain Management physicians included as part of their best clinical judgment, and in a manner consistent with VHA Handbook 1907.01.

This grievance seeks the following relief:

1. A formal order and prohibition from CTVHCS that [redacted] or any other individual, cease and desist from redacting and/or deleting Pain Management entries from patient medical records;

2. A directive that [redacted] and others refrain from redacting and/or deleting Pain Management entries from patient medical records in the future;

3. The appropriate corrective action be taken, including action sufficient to protect against retaliation by [redacted] against physicians within Pain Management; and

i. That the costs and fees of this grievance be taxed against the agency.

Please process this grievance and address with the appropriate parties.

Sincerely,

[redacted]

_____

From: [redacted]
To:
Subject: [redacted]
Date: [redacted]

From: Mathai, Koshy M
Sent: Tuesday, April 6, 2021 9:53 AM
To: [redacted]
Subject: [redacted] wants to redact this part

<REDACTED>

Facility
Activity Date/Time/Zone Responsible Person Entered by

CPRS RELEASED ORDER 02/09/21 09:24 [redacted]
PR PRINTED TO 02/09/21 09:24
CTX PTPMRS3 (BIG)
RECEIVED 02/09/21 10:41 [redacted]
Per my understanding; per [redacted] continuity of care for chronic pain only applies to follow-up for a procedural complication that is being treated at that community clinic or a procedure we do not do.

Please follow the updated guidelines for the Mission Act and the current COVID-19 scheduling modifications. You may schedule this patient in the Pain Management Consultation Clinic. Please inform the patient that the initial visit to this Pain Clinic is a consultation appointment and is not an appointment for a procedure. If the patient is interested in the Austin VA for consultation and procedures in Austin, you may forward this consultation to the "Austin Surg Pain Management Clinic."

-You may discontinue this consultation after failed outreach attempts and/or after reaching the appropriate number of "Cancellations by Patient" or "No Shows" as
per policy.

SCHEDULED 02/09/21 11:13 [redacted]
[redacted]
#TELE# PER PAQTIENT REQUEST CONSULT#5874119

From: [redacted]
To:
Subject: OSC --- FW: [redacted] wants to redact this part
Date: Wednesday, December 8, 2021 12:36:00 PM

From: [redacted]
Sent: Tuesday, April 6, 2021 9:58 AM
To: [redacted]
Subject: [redacted]

<REDACTED>

Facility
Activity Date/Time/Zone Responsible Person Entered By

CPRS RELEASED ORDER 03/01/21 14:50 [redacted]
MYONG PRINTED TO 03/01/21 14:50
CTX-PTPMRS3 (BIG)
RECEIVED 03/01/21 15:05 [redacted]
Please schedule this patient in the Pain Management Consultation Clinic following the updated guidelines for the Mission Act and the current COVID-19 scheduling modifications. Please inform the patient that the initial visit to this Pain Clinic is a consultation appointment that may be carried out as a VA Video encounter. There will be no procedure performed during the initial consultation. If the patient is interested in the Austin VA for consultation and procedures in Austin, you may forward this consultation to the "Austin Surg Pain Management Clinic."

-You may discontinue this consultation after failed outreach attempts and/or after reaching the appropriate number of "Cancellations by Patient" or "No Shows" as per policy.

Please note that the Pain Management Section is under direct orders from [redacted] our Service Chief, not to refer to Community Care Pain cases for continuity of care if the care is available at this VA.

Per [redacted] cases may be referred to Community Care Pain under the following conditions:
1-Service not available at this VA
2-Drive Time exceeding 60 minutes and the patient chooses Community Care.
3-Wait Time exceeding 28 days and the patient chooses Community Care.
4-Continuity of care only to manage complications that were produced by the Community Care Pain Provider.

S-Cases for Spinal Cord Stimulators or other devices are to be seen at this VA Pain Management Clinic before approval for referral to Community Care Pain Providers for the requested procedure.

Please indicate if the patient meets any of the above-stated criteria for community pain management referral and issue the proper DST in support of this referral.

SCHEDULED 03/02/21 08:53 [redacted]

F2F PER PATIENT REQUEST CONSULT#5892462

Note: TIME ZONE is local if not indicated

No local TIU results or Medicine results available for this consult

END

From: [redacted]
To: [redacted]
Subject: [redacted] wants to redact this part
Date: [redacted]

From: [redacted]
Sent: Tuesday, April 6, 2021 9:57 AM
To: [redacted]
Subject: [redacted] wants to redact this part

<REDACTED>

Facility
Activity Date/Time/Zone Responsible Person Entered By

CPRS RELEASED ORDER 02/05/21 17:19 [redacted]
PRINTED TO 02/05/21 17:19
CTX-PTPMRS3 (RIG)
DISCONTINUED 02/08/21 08:21 [redacted]
Per my understanding: per [redacted] continuity of care for chronic pain only applies to follow-up for a procedural complication that is being treated at that community clinic or a procedure we do not do. Please discuss this consult request directly with [redacted] and OTC.

I could not locate the MRI C-/L-Spine within the last two years. Please obtain an MRI C-/L-Spine and then re-consult after the official report is available for review. If
the patient had prior surgery on his C-/L-Spine, then obtain an MRI C-/L-Spine
with and without contrast; unless contraindicated.

PRINTED TO 02/08/21 08:21
CTX-PTPMRS3 (RIG)

Note: TIME ZONE is local if not indicated

No local TIU results or Medicine results available for this consult
---------- END ----------

From: [redacted]
To:
Subject: OSC -- FW: [redacted] wants to redact this part
Date: Wednesday, December 8, 2021 12:37:00 PM

From: [redacted]
Sent: Tuesday, April 6, 2021 10:01 AM
To: [redacted]
Subject: [redacted] wants to redact this part

<REDACTED>

Facility
Activity Date/Time/Zone Responsible Person Entered By

CPRS RELEASED ORDER 03/03/21 10:37 [redacted]
RAJAR PRINTED TO 03/03/21 10:37
CTX-PTPMRS3 (BIG)
RECEIVED 03/03/21 12:29 [redacted] Please schedule this patient in the Pain Management Consultation Clinic following the updated guidelines for the Mission Act and the current COVID-19 scheduling modifications. Please inform the patient that the initial visit to this Pain Clinic is a consultation appointment that may be carried out as a VA Video encounter. There will be no procedure performed during the initial consultation. If the patient is interested in the Austin VA for consultation and procedures in Austin, you may forward this consultation to the "Austin Surg Pain Management Clinic."

-You may discontinue this consultation after failed outreach attempts and/or after reaching the appropriate number of "Cancellations by Patient" or "No Shows" as per policy.

Please note that the Pain Management Section is under direct orders from [redacted] our Service Chief, not to refer to Community Care Pain cases for continuity of care if the care is available at this VA.

Per [redacted] cases may be referred to Community Care Pain under the following conditions:
1-Service not available at this VA
2-Drive Time exceeding 60 minutes and the patient chooses Community Care.
3-Wait Time exceeding 28 days and the patient chooses Community Care.
4-Continuity of care only to manage complications that were produced by the Community Care Pain Provider.
5-Cases for Spinal Cord Stimulators or other devices are to be seen at

this VA Pain Management Clinic before approval for referral to Community Care Pain Providers for the requested procedure

Please indicate if the patient meets any of the above stated criteria for community pain management referral and issue the proper DST in support of this referral.

SCHEDULED: 03/05/21 12:45 [redacted]

[redacted]

CIF PER PATIENT REQUEST CONSULT #5898179

From: [redacted]
To:
Subject: [redacted]
Date: [redacted]

From: [redacted]
Sent: Tuesday, April 6, 2021 9:52 AM
To: [redacted]
Subject: [redacted] wants to redact this part

<REDACTED>

Facility
Activity Date/Time/Zone Responsible Person Entered By

CPRS RELEASED ORDER 02/03/21 15:21 [redacted]
PRINTED TO 02/03/21 15:23
CTX-PTPMRS3 (BIG)
RECEIVED 02/04/21 09:23 [redacted]
Per [redacted] patients recommended for an SCS need to be seen by us; I suspect that is what is being intended her by "pain modulation device."

Please follow the updated guidelines for the Mission Act and the current COVID 19 scheduling modifications. You may schedule this patient in the Pain Management Consultation Clinic. Please inform the patient that the initial visit to this Pain Clinic is a consultation appointment and is not an appointment for a procedure. If the patient is interested in the Austin VA for consultation and procedures in Austin, you may forward this consultation to the "Austin Surg Pain Management Clinic."

-You may discontinue this consultation after failed outreach attempts and/or after reaching the appropriate number of "Cancellations by Patient" or "No Shows" as
per policy.

ADDED COMMENT 02/04/21 10:27 [redacted]
C1-First call to Veteran(unsuccessful scheduling).
C1-Unable to schedule letter sent by mail to Veteran.
letter expires 03/18/21

From: [redacted]
To:
Subject: OSC — FW: List of community care referrals
Date: Wednesday, December 8, 2021 12:37:00 PM
Attachments: [redacted]

From: [redacted]
Sent: Saturday, April 17, 2021 4:03 PM
To: [redacted]
Subject: RE: List of community care referrals

[redacted]

You will need to find a different way to accomplish this task, other than to delegate this to the other providers, who do not have as much administrative time as you do. I have already given you the suggestion of submitting a LCAT ticket to HIMS for assistance with this.

[redacted]

From: [redacted]
Sent: Friday, April 16, 2021 6:46 PM
To: [redacted]
Cc: [redacted]
Subject: List of community care referrals
Importance: High

Team,

Please help out with this humongous task.

[redacted] cover the cases from Austin to community care.
[redacted] will spit the cases from Temple to community care.

The names of [redacted] appeared within the period between 02/01/2020 and 03/20/2020. Please mark the cases so I may give these to [redacted] for redaction.

Please note the deadline set by [redacted] below.

Best wishes on this humongous endeavor,
[redacted]

From: [redacted]
Sent: Friday, April 16, 2021 11:43 AM
To: [redacted]
Subject: RE: Report of contact

[redacted]

As a section chief, you are expected to take ownership of tasks assigned to you. This was assigned to you because it was a problem that you created. It is clear that you are very intelligent and resourceful, and that you will dedicate any necessary time to complete a task when you are motivated. Hence, I expected that you would be able to find a way to complete the task. As I said, you have the option of submitting a LEAF request to HIMS. It may be possible to pull the list automatically.

[redacted] also pulled consults for pain clinic from 1/1/21 to 3/31/21. See below. This list is significantly longer than the 171 that you pulled, even accounting for the difference in time frame (2/2 - 3/23). Please reconcile this with the ones you already found.

I am extending the deadline to close of business on Wednesday 4/21/21. If there are any barriers to completing this, please let me know prior to the deadline.

The decision stands that if you want me to consider granting additional administrative time, you will have to provide me an accounting of your time.

[redacted]

CONSULT REQUESTS TO
AUS WHS OUTPT PAIN MANAGEMENT
TEM WHS OUTPT PAIN MANAGEMENT

JAN 01, 2021 to MAR 31, 2021
Report Generated On: APR 16, 2021

Consult Requests
To:

Req Physician	Req Service	Patient	SSN	Con Date	Status

REDACTED ~13 PAGES OF VETERAN NAMES/NUMBERS

From: [redacted]
Sent: Friday, April 16, 2021 11:14 AM
To: [redacted]
Cc: [redacted]
Subject: RE: Report of contact
Importance: High

[redacted]

With all due respect to you and to [redacted]

1. I know [redacted] can do this list, but the fact is that I have requested similar lists from [redacted] in the very near past and she referred me to the Surgical Services stating that she did not have the time to do so. This is well documented in emails. Therefore, I requested the list from the Surgical Staff and the AMSAs understanding that [redacted] is too busy to do this job. Until to date I received no lists from the Surgical Staff or the AMSAs.

2. If you really intended to help me, you could have done so by extending the deadline, and help me get the list. But you did not. You were not supportive in this or other issues; just accusatory as your email expresses.

3. Regarding the admin time, please be reasonable, I have no time to document an hourly list for me. I documented a daily list of chores but you disregarded it and requested an hourly list

You give me too many chores to do, but no time to do it. Be reasonable, please give me the proper admin time. I only have three hours every week, half of which I spend in meeting with you. This is not enough and is stressing me out. I have clinical duties that take precedence.

4. Exactly 496 entries that you are giving me in this email to review to review. If everyone takes 7 minutes to review and document, that is 496 x 7 min = 3,472 minutes, or 58 hours. That is much more that the 40 hour work week.
    a. What exactly are you trying to achieve: punish me, harass me, set me up for failure, give me a nervous breakdown, have me discharged?
    b. Are you aware that your actions negatively impact our clinical care and our Veterans.
    c. As a Service Chief you ought to support your employees and not break them down. You ought to be building teams and coalitions.
    d. 58 hours, from my sleep, from my weekends, from my evenings? Do you still need an hourly account of my work? Can't you figure it out? Check the multitude daily requests from you to me, with time limits, deadlines, and threats. Don't you think I need time to process these? Giving you a daily account of my weekly activities was not good enough for you. Now you want hourly, next you will ask me for a minute account. You are given ample admin time. I have only three hours not a minute more.

5. How much I yearn for your support as my chief, but you never give me any support. All I get from you are confusing orders and threats of administrative actions. Such is well documented.

6. You did not even change the deadline for submission.

7. I am including [redacted] on this email as he is already involved regarding the deadline. I am appealing for his guidance in this matter as I go up the chain of command in this matter.

Respectfully,
[redacted]

From: [redacted]
Sent: Friday, April 16, 2021 9:07 AM
To: [redacted]
Cc: [redacted]
Subject: RE: Report of contact

[redacted]

I was alerted to the problem because of the comments on the community care consult for <REDACTED>

As the section chief you are expected to be proactive and resourceful.

You could have asked me for more direction. You could have asked [redacted] for help. She was able to

pull the consult list in a few minutes. You could have then put a I EAF ticket in for Health Informatics to help you.

I also told you to submit your hourly workload so that I could determine whether additional administrative time would be justified.

[redacted]

CONSULT REQUESTS TO
COMMUNITY CARE-PAIN

JAN 01, 2021 to MAR 31, 2021
Report Generated On: APR 16, 2021

Consult Requests
To: COMMUNITY CARE-PAIN

Req Physician	Req Service	Patient	SSN	Con Date	Status

REDACTED - 8 PAGES OF VETERAN NAMES/NUMBERS

From: [redacted]
Sent: Friday, April 16, 2021 8:08 AM
To: [redacted]
Cc: [redacted]
Subject: RE: Report of contact
Importance: High

[redacted]
Today is the deadline that you have given me to "compile the consults for COMMUNITY CARE-PAIN that refer to [redacted] Please note the following:

1. My colleagues and I did not include your name or [redacted] name on any of the consultations that were forwarded to community care pain. I have already pointed this out to you in the prior email.

2. I could not obtain the list of Community Care Pain referrals because I have no access to do so. It also appears that the AMSAs who are addressed in this email have been busy and I have received no list from them to verify.

Unless you provide me with the list or the ability to obtain it, I shall not be able to review it to verify to you whether your names are or are not present.

Since the deadline is today, you have threatened me with administrative action, you refuse to extend the deadline, my appeal up the chain of command to [redacted] on 04/14/2021, was never answered, I am now appealing up the chain of command to the Director, [redacted] for his judgement in this matter. This is absurd, it is a setup for failure. [redacted] you want me to review a list that I have no access to and you are not giving me access to obtain. You are not extending the deadline, eager to slam me with administrative action.

[redacted]
Your urgent interference and action in this matter in needed, please.

Sincerely,
[redacted]

From: [redacted]
Sent: Wednesday, April 14, 2021 7:13 AM
To: [redacted]
Cc: [redacted]
Subject: RE: Report of contact

Can any of the AMSAs and [redacted] help to obtain a list of all the Community Care Pain Consultations that were forwarded from Pain Management to community service starting 02.01.2021 and up to the end of March. This will be much appreciated, Please read below

[redacted] as you have refused to extend the deadline. I am adding [redacted] to consider this request as I go up the chain of command.

[redacted] please consider extending the deadline for this project because without thi list of referrals we are unable to locate which consultations included your name and the name of [redacted] so we may forward these to you for redaction of your names

With appreciation to all who can help us,
[redacted]

From: [redacted]
Sent: Tuesday, April 13, 2021 7:38 PM
To: [redacted]
Cc: [redacted]
Subject: RE: Report of contact

[redacted]

You will have to find another way to get these consults. The CITC staff are too busy to assist you with this.

The deadline stands.

[redacted]

From: [redacted]
Sent: Tuesday, April 13, 2021 5:26 PM

To: [redacted]
Cc: [redacted]
Subject: RE: Report of contact

Hello [redacted]
We would like to obtain a list of all the Community Care Pain Consultations that were forwarded from Pain Management to your service starting 02.01.2021 and up to the end of March. This will be much appreciated,

[redacted] please extend the deadline that you stated in the email below.

Sincerely,
[redacted]

From: [redacted]
Sent: Monday, April 12, 2021 6:18 AM
To: [redacted]
Cc: [redacted]
Subject: Re: Report of contact

I am only aware because [redacted] was alerted to this and asked me to address it.

[redacted]

[redacted]
Clinical Director, Whole Health and Integrated Health
Central Texas VA Healthcare System

From: [redacted]
Sent: Sunday, April 11, 2021 11:30:06 PM
To: [redacted]
Cc: [redacted]
Subject: RE: Report of contact

[redacted]

I do not recall that we put your names on any of the consults that were referred for community care. Please let me know if this is not the case.

<REDACTED>

From: [redacted]
Sent: Friday, April 9, 2021 5:19 PM
To: [redacted]
Subject: RE: Report of contact

[redacted]

It appears that there are additional consults that need to be checked.

You are instructed to compile the consults for COMMUNITY CARE-PAIN that refer to [redacted] If there are any other consult orders that you receive, to which you or the others may have responded to by including our names, please compile these as well.

Please submit this to me by close of business on Friday, April 16, 2021.

If these instructions are unclear, please let me know no later than 4/12/21. If there are any barriers to completing this task, please let me know prior to the deadline.

[redacted]

From: [redacted]
Sent: Wednesday, April 7, 2021 3:56 PM
To: [redacted]
Cc: [redacted]
Subject: RE: Report of contact

The list you requested is attached.

From: [redacted]
Sent: Wednesday, April 7, 2021 11:53 AM
To: [redacted]
Subject: RE: Report of contact

This email is a record of confirmation that we spoke on Friday 4/2/21 by telephone and clarified what the task assigned to you entailed. You were never asked to redact the records. You were asked to identify the records that made reference to [redacted] and myself and give me this list. The deadline remains close of business on 4/9/21.

[redacted]

From: [redacted]
Sent: Friday, April 2, 2021 3:59 PM

To: [redacted]
Subject: RE: Report of contact

We can talk now on Teams.

[redacted]

From: [redacted]
Sent: Friday, April 2, 2021 3:58 PM
To: [redacted]
Cc: [redacted]
Subject: RE: Report of contact

I am on leave on 04/05/2021. I switched SL to AL. Please go to VATAS and approve my three pending leaves.

From: [redacted]
Sent: Friday, April 2, 2021 3:53 PM
To: [redacted]
Subject: RE: Report of contact

[redacted]

I will show you how to open a chart to review the consult response, and determine whether it meets the criteria outlined below.

We will meet at noon on 4/5/21. I will send you a calendar invite. This will be an opportunity to answer any additional questions you may have.

The deadline stands.

[redacted]

From: [redacted]
Sent: Friday, April 2, 2021 2:14 PM
To: [redacted]
Cc: [redacted]
Subject: RE: Report of contact

[redacted]

I am unable to do this clerical task that you have requested. Because I do not know how and because I do not have the time to do it.

If you want me to complete this task, then please teach me how to do it, and allow me adequate time to complete it.

Sincerely,
[redacted]

From: [redacted]
Sent: Thursday, April 1, 2021 7:40 PM
To: [redacted]
Subject: RE: Report of contact
Importance: High

The request was for you to identify and compile the records in which you and the other providers made reference to [redacted] in the disposition of the consults. Instead, you gave me a list of 171 consults submitted between 2/2/21 and 3/23/21, most of which did not meet the criteria I asked for, and you did not meet the deadline. I am extending the deadline because I want to make sure that you understand my instructions.

You will have until close of business on Friday, 4/9/21, to submit the requested list, consisting ONLY of those records in which you made reference to [redacted] in the disposition of the consults. Failure to meet this deadline will be considered a failure to follow supervisory instructions.

As for your request for more administrative time, I have already told you that I need an accounting of your time to justify any additional administrative time. The duties that you are tasked with are the minimum requirements for a clinical supervisor, including certifying time cards and authorizing leave requests, which you had not been doing until now. You have been given the standard allotment of time for this purpose. You currently have 8 hours of administrative time each week, and an additional 3 hours once monthly. Judging by the scheduled appointments for your clinics, including face-to-face, VVC, and procedures, you see between three and seven patients daily.

Please provide an hour-by-hour accounting of each day of the week you spend doing VA work so that I can have a better idea of how you are using your time. This will help me understand what you may need in order to improve efficiency. You have until close of business on Friday 4/9/21, to submit this.

[redacted]

From: [redacted]
Sent: Wednesday, March 31, 2021 3:14 PM

To: [redacted]
Cc: [redacted]
Subject: RE: Report of contact
Importance: High

[redacted]

I hope you find the following satisfactory:

The fact is that you have been overwhelming me with many demands and issues but giving me no proper time to accomplish these tasks. I have requested more Admin Time on multiple occasions but that was totally ignored by you. Please see the attached email to you as being the latest of multiple verbal and written requests for adequate administrative time so I may properly fulfill my duties.

I have full clinical duties. I come 30 – 60 minutes early every day and I leave late unless, rarely, I have an appointment to go to. On 03/26/2021, I wrote to you the attached email at 5:47 PM. Although my Tour-of-Duty ends at 04:00 PM, on 03/26/2021, I left my clinic at 06:00 PM, working on the clinical and administrative issues that I listed in the attached email.

After leaving this Medical Center, I went shopping at [redacted] After that I had a motor vehicle accident at 07:30 PM. The accident was my fault. The truth is that I was thinking of you when I was shopping at [redacted] and thinking of you when I had the accident. I feel overwhelmed with the punitive clerical work that you have assigned to me without allowing me the proper time to complete. You are stressing me out with a multitude of demands, most of which are clerical and obviously setting me up for failure and discharge.

You could have easily assigned this search to a clerk who would be much more efficient at finding these medical records, because they have the keys, the knowhow and the access to do so. But you did not.

I may not agree with you on redacting the receiving statements on these consultations. I gave you the reason why. Despite that I went along with you and sent to you all the records that you required. I am unable to redact these notes. I sent them to you so you may redact the ones that you wish to redact.

I am respectfully requesting that you cease and desist from harassing me with threats and overwhelming me with clerical duties without giving me the proper time to complete them. I am requesting that you halt the hostile work environment that you have created for me and my pain management section. How are we supposed to work and serve our Veterans under such conditions.

Sincerely,
[redacted]

From: [redacted]
Sent: Wednesday, March 31, 2021 11:12 AM
To: [redacted]
Subject: Report of contact

[redacted]

On 3/19/2021 you were instructed to identify all records in which you and the other pain specialists named [redacted] for the purpose of justifying the disposition of the consults or for justifying treatment plans. You were given one week from receipt of the email to compile these records and deliver them to me.

On 3/23/2021 at 4:07 PM you had received a list of all accepted, scheduled, and completed consultations since 2/1/2021 from [redacted] in response to your request, which you submitted to me 3/29/2021. You also explained that you were unable to submit this list by the deadline because you were involved in a car accident 3/26/2021.

I reviewed of a sampling these records. A significant number of them did meet the requested criteria.

Please provide a report of contact by close of business 4/2/2021 on the following:

1. What timeframe you were involved in the car accident 3/26/2021.
2. The reason you forwarded the complete list containing all accepted, scheduled, and completed consultations since 2/1/2021, rather than compiling the list meeting the criteria I requested.

[redacted]

[redacted]
Clinical Director, Whole Health and Integrated Health Service
Central Texas VA Healthcare System

[redacted]

Reference 46

From: [redacted]
To:
Subject: [PRIVATE]
Date: Wednesday, March 31, 2021 8:20:00 AM

[redacted]

This is an **example of just one veteran** whose care has been affected by the consult template that [redacted], in his administrative role over Whole Health, has been allowed to enact with effects on:

1. Services, and ease of procurement of services, available to the veteran
2. Clinical availability and function of the Pain Management section

On the basis of [redacted] template, we have been instructed to discontinue the consult request if any answers are "no" to the template; as such, this veteran's consult request has been discontinued:

[redacted]

No / Veteran has been informed that they must take Introduction to Whole Health before they will be scheduled. Please place consult for Intro to Whole Health if patient has not yet completed this class. This is intended to optimize response to treatment - patients achieve the best results from practitioner-delivered care when they also learn and practice self-management approaches.

[redacted]

From: [redacted]
To:
Subject: [PRIVATE]
Date: Monday, April 5, 2021 10:57:00 AM

Hello [redacted]

Here is a veteran that, best I can tell, that per [redacted] recently changed consult processing instructions, I myself have just entered an Intro to Whole Health Class order for.

I have never even seen this patient.

[redacted] [redacted] [redacted]

[redacted]

From [redacted]
To
Subject: OSC investigation — veteran affected
Date: Monday, October 4, 2021 4:27:00 PM

Hello [redacted]

--- veteran affected

//////////////////////////////////

Here is a veteran that, best I can tell, that per [redacted] recently changed consult processing instructions, I myself had entered an Intro to Whole Health Class order for.

I had never even seen this patient.

[redacted]

//////////////////////////////////

Here is a veteran that, best I can tell, that per [redacted] recently changed consult processing instructions, I myself have just entered an Intro to Whole Health Class order for.

This veteran is already established with a community care pain doctor, and qualifies per drive time.

Best I can tell, per [redacted] recently consult processing instructions, the veteran required Intro to Whole Health Class also.

I also had never even seen this patient.

[redacted]

//////////////////////////////////

From: [redacted]
To:
Subject: OSC investigation — veteran affected
Date: Monday, October 4, 2021 4:28:00 PM

Hello [redacted]

Here is **clear written evidence that other staff at this facility are being instructed** as **per** [redacted] **recently changed consult processing instructions:**

This veteran is already established with a community care pain doctor. Best I can tell, per [redacted] **consult processing instructions, CITC personnel has been instructed that the veteran requires** Intro to Whole Health Class **prior** to obtaining (here, continuing, in this case) their pain management treatment.

*** Please scroll all the way down, see highlighted portions ***

//

[redacted]

Current PC Provider: [redacted]
Current PC Team: T AMB PACT GOLD 5 *WH*
Current Pat. Status: Outpatient
UCID: [redacted]
Primary Eligibility: SERVICE CONNECTED 50% to 100%(VERIFIED)
Patient Type: SC VETERAN
OEF/OIF: NO

Service Connection/Rated Disabilities
SC Percent: 100%
Rated Disabilities: TRAUMATIC BRAIN DISEASE (70%)
SLEEP APNEA SYNDROMES (50%)
MIGRAINE HEADACHES (50%)
HEMORRHOIDS (20%)
HIATAL HERNIA (10%)
ALLERGIC OR VASOMOTOR RHINITIS (10%)
LIMITED FLEXION OF KNEE (10%)
SUPERFICIAL SCARS (10%)
FACIAL SCARS (10%)
LABYRINTHITIS (10%)

LIMITED EXTENSION OF KNEE (0%)
SINUSITIS,MAXILLARY,CHRONIC (0%)
SCARS (0%)
VENTRAL HERNIA (0%)
DEFORMITY OF THE PENIS (0%)

Order Information
To Service: COMMUNITY CARE-PAIN
From Service: TEM PACT GOLD PHY5
Requesting Provider: [redacted]
Service is to be rendered on an OUTPATIENT basis
Place: Consultant's choice
Urgency: Routine
Clinically Ind. Date: May 12, 2021
DST ID:
Orderable Item: COMMUNITY CARE-PAIN
Consult: Consult Request
Provisional Diagnosis: Cervicalgia(ICD-10-CM M54.2)
Reason For Request:
INTERVENTIONAL PAIN MANAGEMENT CONSULTATION GUIDELINES:
This consultation request is for Interventional Pain Management Procedures.

1. Reason for Request: Where is the primary location of the patient's worst pain for the consultant to address?

- Back Pain Yes
- Neck Pain Yes
- Other No (please specify):

2. Controlled Substances:
- Does the patient understand that the Interventional Pain Clinic offers procedures for the management of chronic pain and does not prescribe chronic controlled substances in the management of chronic pain? Yes

3. Interventional Pain Management Procedures:
- Does the patient desire to receive interventional pain management injections for the management of Chronic Pain? Yes

4. Imaging:
- The patient needs to have advanced imaging of the area involved within the last two years. MRI is usually the preferred advanced imaging for the spine.

If MRI is contraindicated then obtain CT scan of the involved area.

If
the patient had prior surgery to the spine then please request MRI
with
and without contrast if the renal function allows it. The official
imaging report must be reviewed by pain management before the
consultation can be accepted. Please specify where the official
imaging
report is found:
(Choice of only one is accepted; may not choose more than one)
VISTA Imaging

5. Blood Thinners:
- Is the patient receiving any blood thinners such as Coumadin,
aspirin, clopidogrel, TSOACs (apixaban, dabigatran, or
rivaroxaban)
etc. No
- If the patient is on blood thinners, can the patient discontinue
that
medication for about 7 days WITHOUT ANY BRIDGING medication and
without
significant risk of developing stroke, cardiovascular insult, or
any
other problem for which the patient is receiving that medication to
prevent. Not applicable

6. Laboratory investigations:
- Is the patient Diabetic? No
- If YES, then the HGB A1C within the last three months of the date
of
the consultation needs to be less than 8.
- Please indicate the VALUE and the DATE of the last HGB A1C:

Collection DT	Specimen	Test Name	Result	Units	Ref Range
10/22/2020 13:50	BLOOD	GLYCOHEMOGLOBIN	5.7	%	4.8 - 6.0

7. The Interventional Pain Management Clinic requires responses to the
following questions regarding various modalities that may have been
used in the management of pain in this patient's pain:
a) Has the patient tried Physical Therapy or exercise within the last
year? Yes
b) Has the patient tried Acetaminophen and/or NSAIDs within the last
year? Yes
c) Has the patient tried Gabapentin and /or Duloxetine if

neuropathic pain was suspected?
Yes
d) Has the patient tried the TENS Unit be tried within the last year?
Yes
e) Has the patient tried Cognitive Behavioral Therapy (CBT) or Pain Psychology within the last year?
Yes

8. Comments:

**********NOTES**********

ALL FIELDS MUST BE FILLED OUT for the consultation to go through, just like the MRI template. The consultation will not go through if one field is not answered.

****

Inter-facility Information
This is not an inter-facility consult request.

Status: ACTIVE
Last Action: RECEIVED

Facility
Activity Date/Time/Zone Responsible Person Entered By

CPRS RELEASED ORDER 04/12/21 12:57 [redacted] [redacted]
PRINTED TO 04/12/21 12:57
CTX-PTPMRS3 (BIG)
ADDED COMMENT 04/12/21 15:03 [redacted]
Per Veteran, awaiting approval for auth cont of care with established community care provider. Veteran does not wish to be seen by VA Pain Clinic, he wants to continue care with established provider, awaiting approval to schedule procedure.

ADDED COMMENT 04/12/21 15:05 [redacted]
[redacted] please enter referral for **the Intro to Whole Health Services, as this is mandated for Veterans who desire pain mgmt.**

RECEIVED 04/13/21 14:55 [redacted]
Please schedule this patient in the Introduction to Whole Health Class before they will be scheduled in the Pain Management Consultation Clinic.

The goal of this class is to provide an orientation to holistic care that is personalized, proactive, and patient-driven, and to emphasize the importance of self-management to achieving optimal treatment outcomes. Please inform the patient that the initial visit to this Pain Clinic is a consultation appointment that may be carried out as a VA Video encounter. There will be no procedure performed during the initial consultation. If the patient is interested in the Austin VA for consultation and procedures in Austin, you may forward this consultation to the "Austin WHS Pain Management Clinic.

-You may discontinue this consultation after failed outreach attempts and/or after reaching the appropriate number of "Cancellations by Patient" or "No Shows" as per policy.

-PLEASE CONTACT ME BY EMAIL OR CALL ME AT [redacted] IF YOU HAVE ANY QUESTIONS OR CONCERNS REGARDING THE PROCESSING OF THIS CONSULTATION.

ADDED COMMENT 04/14/21 11:09 [redacted]

DST-DST ID: 403839c5-58e9-4dcd-8e32-0516a4105316
CSC-Consult stop code: 420
CSN-Clinical Service: PAIN CLINIC
CST-Consult service type: SPECIALTY CARE
DSW-DST Workflow: NEW PT
CCE-CC Eligibility Status: NO ELIGIBILITY FOUND

#COI# WAIT TIME CID:05/12/21

FORWARDED FROM 04/14/21 11:09 [redacted]
TEM WHS OUTPT PAIN MANAGEMENT
RECEIVED 04/14/21 13:36 [redacted]

SEOC - VHA Office of Community Care----------

VHA Office of Community Care - Standardized Episode of Care
Pain Management Comprehensive

CAT-SEOC CoC: PAIN MANAGEMENT
SEOC ID: MSC_PAIN MANAGEMENT COMPREHENSIVE_1.2.6_PRCT
Description: This authorization covers services associated with the specialty(s) identified for this episode of care, including all medical care listed below relevant to the referred care specified on the consult order. Medication Management including any opioid therapy should be consistent with VA/DOD clinical practice guidelines. This episode of care does not include intrathecal drug delivery (IDD) or neuromodulation device

care. Separate approval is required for IDD or neuromodulation device initiation and care.
Duration: 180 days

Procedural Overview:
1. Initial outpatient evaluation and treatment for the referred condition indicated on the consult order, including any restrictions for or against treatment options
2. Diagnostic imaging relevant to the referred condition on the consult order
3. Diagnostic studies relevant to the referred condition on the consult order including but not limited to: EMG/NCV
4. Labs including necessary drug screens and pathology relevant to the referred condition on the consult order
5. Injections including but not limited to: Medial branch blocks, epidural injections, facet injections, trigger point injections, genicular injections, joint injections
6. Procedures including but not limited to: radiofrequency ablation, vertebroplasty and spinal decompression
7. Anesthesia consultation related to a procedure
8. Pre-operative medical and cardiac clearance as indicated, to include H+P/labs, EKG, CXR, echo
9. Inpatient or observation admission for procedure, if indicated.
** Notify the referring VA of admission status to initiate and facilitate care coordination and discharge planning.
10. Inpatient admission or observation status for complications from the procedure
** Notify the referring VA of admission status to initiate and facilitate care coordination and discharge planning.
11. Follow-up visits for this episode of care
12. Physical Therapy: as indicated up to 15 visits as related to the referred condition on the consult order; Notify VA to request additional visits with supporting medical documentation
13. Occupational Therapy: as indicated up to 15 visits as related to the referred condition on the consult order; Notify VA to request additional visits with supporting medical documentation

*Please visit the VHA Storefront www.va.gov/COMMUNITYCARE/providers/index.asp for additional resources and requirements pertaining to the following
* Pharmacy prescribing requirements
* Durable Medical Equipment (DME), Prosthetics, and Orthotics prescribing requirements
* Precertification (PRCT) process requirements
* Request for Services (RFS) requirements

* DME, prosthetics and orthotics will be reviewed by the VA for provision.

SEO----------

SEV-Community Care Eligibility: Wait Time
CVA-Accept new consult, received during COVID-19 Pandemic

Scheduling prioritized during COVID-19 Pandemic
CV1-COVID-19 Priority 1
  Schedule appointment despite COVID-19 restrictions
As an alternative to a face-to-face appointment:
  TEL-Telephone Appointment may be offered to the Veteran
  THL-Telehealth Appointment may be offered to the Veteran
CAP-Community Care Approved, Program:
  Authorized/Pre-authorized Referral - 1703
ME-May discontinue if Veteran cancels/no-shows twice or fails to respond
to mandated scheduling effort.
CCH-Community Care Appt Scheduling to be handled by: Community provider
schedules directly with Veteran
Admin Screening for Care Coordination
SCD-Screening Code: 005-77-TC-A-85
  CAN Score: 85
Admin Screening=Moderate
Clinical Screening for Care Coordination
TCD-Clinical Triage Code: 040-77-TC-A
  Significant Comorbidities: no Significant Psychosocial Issues: no ADL
Support Needed: no

Clinical Triage Care Coordination: Moderate
Clinical Triage: Complete

After the appointment has been scheduled, the integrated team should
proceed to coordinate are based on the Veteran's needs.
Moderate care coordination may include:
-assistance with navigation
-scheduling
-post-appointment follow-up
-monitoring and coordination of preventative services

Recommended frequency of contact: monthly to quarterly

ICR-Initiate Community Care Referral
Community Care Coordinator:

Community Care Contact Number:

Note: TIME ZONE is local if not indicated

No local TIU results or Medicine results available for this consult
========== END ==========

From: [redacted]
To: [redacted]
Subject: [redacted] — FW: Whole Health — Intro Class — Changes to Processing
Date: Monday, January 10, 2022 4:19:00 PM

Hello [redacted]

Please see message.

[redacted]

From: [redacted]
Sent: Monday, January 10, 2022 4:00 PM
To: [redacted]
Subject: Whole Health — Intro Class — Changes to Processing

To whom it may concern

It appears that changes have occurred:

- "Whole Health is NOT a prerequisite for" the traditional and complementary treatments offered.
- Explicit statement that Whole Health Coaches cannot evaluate and/or medically clear patients OR submit consults for the traditional and complementary treatments offered.

Sincerely,

[redacted]

//

Re:

[redacted] [redacted] [redacted]

//

<EXCERPT>

Veteran only wants pain management and acupuncture care at this time.

As written this consult only pertains to scheduling an appointment with a Whole Health Coach.

Intro to Whole Health is NOT a prerequisite for chiropractic care and/or pain management and/or acupuncture therapeutic treatment.

Whole Health Coaches cannot evaluate and/or medically clear patients or submit consults for chiropractic care and/or pain management and/or acupuncture therapeutic treatment.

//

<FULL>

Current PC Provider: [redacted]
Current PC Team:
Current Pat. Status:
UCID:
Primary Eligibility: [redacted]NECTED 50% to 100%(VERIFIED)
Patient Type: SC VETERAN
OEF/OIF: NO

Service Connection/Rated Disabilities
SC Percent: 70%
Rated Disabilities: LUMBOSACRAL OR CERVICAL STRAIN (20%)
LUMBOSACRAL OR CERVICAL STRAIN (20%)
TINNITUS (10%)
LIMITED MOTION OF ANKLE (10%)
PARALYSIS OF SCIATIC NERVE (10%)
PARALYSIS OF SCIATIC NERVE (10%)
IMPAIRED HEARING (10%)
LIMITED MOTION OF ANKLE (10%)
SEPTUM, NASAL, DEVIATION OF (0%)
LARYNGITIS,CHRONIC (0%)

Order Information
To Service: TEM WHS OUTPT INTRO TO WHOLE HEALTH
From Service: ROC2
Requesting Provider: [redacted]
Service is to be rende[redacted]TIENT basis
Place: Consultant's choice
Urgency: Routine
Clinically Ind. Date: Jan 10, 2022
DST ID:
Orderable Item: TEM WHS OUTPT INTRO TO WHOLE HEALTH
Consult: Consult Request
Provisional Diagnosis: Illness, unspecified(ICD-10-CM R69.)
Reason For Request:
If you are requesting consult to the Whole Health Integrated Pain Management program for your patient to receive Acupuncture, Chiropractic or Pain Management clinic services, in addition to this Intro to Whole Health consult you must also complete the whole health integrated pain manage consult specific for the one service you are requesting. If the Veteran has already attended Intro to Whole Health, exit out of this consult and proceed as indicated.

REASON FOR REQUEST

Acupuncture

All patients involved in Whole Health should attend a one hour Introduction to Whole Health Class (Orientation) and a minimum of one WH Coaching session. Introduction to WH is offered in multiple modalities to accommodate patient needs.

Is this a STAT consult?

Inter-facility Information
This is not an inter-facility consult request.

Status: CANCELLED
Last Action: CANCELLED
Significant Findings: Unknown

Facility Activity	Date/Time/Zone	Responsible Person	Entered By
PRS RELEASED ORDER	01/10/22 11:53	[redacted]	[redacted]
[redacted]E	01/10/22 12:47		

[redacted]onsult only pertains to scheduling an appointment with a Whole Health Coach.

Intro to Whole Health is NOT a prerequisite for chiropractic care and/or pain management and/or acupuncture therapeutic treatment.

Whole Health Coaches cannot evaluate and/or medically clear patients or submit consults for chiropractic care and/or pain management and/or acupuncture therapeutic treatment.

01/10/22 12:47 [redacted]

[redacted]y Status: NO ELIGIBILITY FOUND

CVA-Accept new consult, received during COVID-19 Pandemic
ME-May discontinue if Veteran fails to respond to mandated scheduling effort.
CUR-CTB User Role: Scheduler

01/10/22 12:49 [redacted]

[redacted]y Status: NO ELIGIBILITY FOUND

C1-First call to Veteran: Left voicemail
L1-Unable to schedule letter sent by mail to Veteran.
CUR-CTB User Role: Scheduler

01/10/22 13:06 [redacted]

[redacted]to participate in the Intro to Whole Health coaching orientation session(s) at this time.

Veteran only wants pain management and acupuncture care at this time.

As written this consult only pertains to scheduling an appointment with a Whole Health Coach.

Intro to Whole Health is NOT a prerequisite for chiropractic care and/or pain management and/or acupuncture therapeutic treatment.

Whole Health Coaches cannot evaluate and/or medically clear patients or submit consults for chiropractic care and/or pain management and/or acupuncture therapeutic treatment.

Note: TIME ZONE is local if not indicated

Significant Findings: Unknown

No local TIU results or Medicine results available for this consult
==========
===
========== END
==========

Reference 47

From: [redacted]
To:
Cc:
Subject: Clarification
Date: Sunday, March 7, 2021 [redacted]
Importance: High

Team,

The following is a clarification of a prior email that I have sent to you.

1. **Regarding the Pain Management Service Agreement:** [redacted] did not approve it yet, but he agrees in principal with the agreement proposal, and [redacted] is still working on finalizing the document.

2. **Regarding the policy on Community Care**: This is not "Whole Health Service Recommendation," but is the CTX policy based on Community Care eligibility.

3. **Regarding the current pain management consultation ordering template:** Please accept patients who were approved for community care "regardless of the current ordering template." Because these patients were approved for community care at some point, i.e. met some kind of guidelines, as lax as they may have been.

Please call me if you have any questions at [redacted].

I have included [redacted] on this email for comments, approval, modification, or denial of any of the above-stated comments.

Respectfully,
[redacted]

Reference 48

From: [redacted]
To:
Cc:
Subject: RE: The Pain Management Section
Date: Monday, February 8, 2021 11:44:00 AM

Hello [redacted],

Thank you so much for addressing these concerns with us.

On the topic of practicing under a scope administratively, it need not be the focus.

Suffice it to say that we have scopes of practice that reflect our experience, expertise, practice foci, and reasons for hire and described duties.

1. I do not prescribe opioids for chronic pain.
- It is neither a part of my practice nor was this described to me at time of hiring.
- I do not believe I have prescribed an opioid for chronic pain in my outpatient practice for, at this point, probably >7 years.
- In fact, at the time of my hiring, it was described to me that we are an interventionally-focused pain clinic. We can prescribe other things such as PT and non-opioid medications for pain when we see fit, although we do not prescribe opioids.
- I was advised prior to joining that referring providers may ask our opinions or for recommendations, although it is primary care who manages opioids.
- At CTVHCS, again prior to my joining, I was also advised that we have Pain Management pharmacists who are employed in consultation, who can help the PCPs and offer advice/recommendations on opioid adjustment/tapering, etc. as the PCP desires.

2. I did not join on to treat any brand of Opioid Dependence or OUD.
- This was never a part of my job description in any fashion, and I do not agree to it.
- I did not join on to function as an Opioid taper doctor either; again, if an

individual's opioid medication is to be tapered off, then implicit in this decision is that chronic opioids are viewed as not indicated for that individual's chronic pain.

- Of note, Opioid and Benzo tapers falls to Mental Health and Primary Care per GAO document sent previously.

3. I find it grossly inappropriate and unethical for us to be forced to take the X-Waiver by [redacted]; I said this during a Pain Oversight Committee meeting and I repeat it now. **I want to make clear the conduct that has come along with this by [redacted] to cause me to say this:**

   Please note how this coercion is being used here:

   (1) Coerce us to take these classes and get the X-waiver
   (2) Enforce that coercion by changing our OPPE and Performance Pay against our will
   (3) Assure compliance by assuring our evaluations are made to count any complaints against us, not just validated ones, [redacted] actively soliciting complaints, and further, scheduling patients for us that are highly likely to complain based on the management that [redacted] is forcing others to do for him
   (4) With our careers in jeopardy because of , these solicited complaints, Letters of Counselling based on critical facts being omitted, and reprimands if we do not comply with the coercion, we will have no choice but to:
      (1) **Practice outside of both our Reasons for hire / Agreed upon job duties** and our Scope of Practice / Area of Expertise.
      (2) Wait until we are **Constructively Dismissed** or be
      (3) **Terminated** outright.

4. Please note that [redacted] coercion in clinical decision-making is apparent on different fronts, but by now has become more obvious to others as well, I believe, in how we are being forced to address Pain Management consult requests — please discuss with [redacted] as to what they see happening — and this is affecting patient care in real time:

- There are 3 of us interventional pain physicians.
- We run an interventional pain clinic.
- [redacted] has completely disregarded the fact that it is not within his purview to change our job duties.
- In consult processing, veterans are having their care blocked with [redacted] using his time in reviewing consults that are declined with the intention of having patients who require opioids scheduled with us instead of their established pain doctors.
- This serves to destabilize the pain care of these patients.
- In the meantime, every patient for opioid management that is being scheduled with us is a patient not on opioids and for intervention who is not being scheduled with us for the tasks we actually perform.
- As there are only 3 of us interventional pain doctors, these patients who are not on opioids end up being sent to the community anyway due to wait times.
- [redacted] decisions designed to force us to take over opioid management therefore has the following end effects: (1) Veteran stable on their opioid regimens with outside care providers are getting their care destabilized (2) Veterans who are not on opioids are being sent to the Community anyway, and will likely get started on opioids (3) If these changes to Community Care Pain requests are being sold as ways to get costs down and stabilize care, it is very likely to do the opposite.
- In essence, with [redacted] decision-making, the veterans are actually at greater risk, and on top of that, we are at even greater risk of being constructively dismissed or terminated as [redacted] has found a way to generate even more complaints against us.

Sincerely,

[redacted]

From: [redacted]
Sent: Monday, February 8, 2021 10:54 AM

To: [redacted]
Cc: [redacted]
[redacted]
Subject: RE: The Pain Management Section

We will talk later this morning..
But you do not practice under a scope.

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

From: [redacted]
Sent: Thursday, February 4, 2021 12:19 PM
To: [redacted]
Cc: [redacted]
[redacted]
Subject: RE: The Pain Management Section

I do not agree with this change in work conditions/duties. I will continue to provide great care to veterans as per my scope of practice/core privileges.

From: [redacted]
Sent: Wednesday, February 3, 2021 4:32 PM
To: [redacted]
Cc: [redacted]
[redacted]
Subject: FW: The Pain Management Section
Importance: High

Hello [redacted]

This is a change to our work duties.

I do not agree with it.

[redacted]

From: [redacted]
Sent: Wednesday, February 3, 2021 4:29 PM
To: [redacted]
Cc: [redacted]
Subject: The Pain Management Section

Importance: High

Dear Colleagues,

I met with [redacted] today and last Wednesday, 01/27/2021. We discussed the status and plans for the Pain Management Clinics in Temple and Austin. Please note the following:

1. Pain management at the CTVHCS is moving towards treating patients with medications (opioids) besides the interventional pain management procedures that we usually do. Surely, opioids will be prescribed only if indicated. Once we determine that the patient is stable enough, we may discharge the patient to the care of the PCP with a set of recommendations. [redacted] is working to streamline this process with Pain Management Pharmacy and with Primary Care in a comprehensive pain service agreement.

2. In this regard we need to individualize our treatment plan for every patient. For example, a patient whose chronic pain has been stable on a safe dose of chronic opioids, may remain on such if he wishes as long as he meets all the other criteria of PDMP and UDS. We may also treat the occasional patient who suffers of both, chronic pain and OUD. This will be a team approach and members of the PMT and MH/SATP will be available to help with psychosocial support besides MAT that we may have to initiate or maintain. Again, the plan here is to refer the patient back to the PCP once he is stabilized in regards to his pain and OUD.

3. For this purpose, I encourage all of us to take the MOUD Classes. Please register by speaking with [redacted]. X-Waiver Training Registration form (va.gov)

4. Regarding CITC and community care referral, [redacted] does not want patients to be sent to the community pain clinics for medications that we are able to offer at the CTVHCS. So please accept the cases to be seen at our pain clinics. [redacted] is currently trying to work out a plan with pain management pharmacy, so they may assist with these usually time consuming cases that require a lot of work and attention. In my opinion, patients who are interested in medications alone without interventional pain procedures, their consultation ought to be referred directly to "pain management pharmacy" for basic workup such as PDMP, and UDS and then sent to us for a determination regarding opioid therapy. I am adding [redacted] to this email for his opinion. Much of the work is still in progress at this time.

5. In accordance with [redacted] recommendation, patients may be referred to the community pain clinics under the following conditions:

    a. Drive Time exceeds the recommended 60 min, and the patient chooses community.
    b. Wait Time exceeds the recommended 28 days, and the patient chooses

community.

c. A pain management procedure that we do not have available at our clinic.
d. Patients who were seen at a community care pain clinic and want to renew their care at that clinic, may do so only if they have to follow-up for a procedural complication that is being treated at that community clinic, otherwise they can be seen at our clinic unless the wait time is over 28 days and that is not acceptable to them.
e. Patients recommended for a SCS need to be seen by us to make a determination whether that would be to the best interest of the Veteran or no.
f. All others are to be treated locally at our pain clinics.

6. Please note that patients may withdraw consent for a procedure at any time during the procedure. For example, if we are doing a procedure and we notice that the patient is uncomfortable and not so sure whether to proceed or not, [redacted] recommends that we say: "we are stopping this procedure, unless you instruct us otherwise."

7. We all practice patient-centered pain management. In this regard Service recovery is most important. It is highly recommended that we complete these courses before June 30, 2021:

    a. TEACH for success,
    b. Motivational Interviewing, and
    c. Whole health 102
    d. MOUD training

I am adding [redacted] on this email for comments and additions.
Best regards to all. Please let me know if you have any questions.

Sincerely,
[redacted]

Reference 49

From: [redacted]
To: [redacted]
Subject: FW: March PMT
Date: Wednesday, February 24, 2021 11:24:33 AM

FYI

From: [redacted]
Sent: Wednesday, February 24, 2021 11:05 AM
To: [redacted]
Cc: [redacted]
Subject: RE: March PMT

We will coordinate with Clinical Pharmacy, Pain Clinic, and Primary Care to serve these Veterans.

Thank you for your patience.

[redacted]

From: [redacted]
Sent: Wednesday, February 24, 2021 10:59 AM
To: [redacted]
Cc: [redacted]
Subject: RE: March PMT

Can the 4 (or 5?) patients all get started on the new/ desired pathway?

[redacted]
Associate Chief of Pharmacy, Clinical Services
[redacted]

From: [redacted]
Sent: Wednesday, February 24, 2021 10:56 AM
To: [redacted]
Cc: [redacted]
Subject: RE: March PMT

I apologize. I thought the patients we talked about on Friday were ones that we would be scheduling for PMT, but I realize now that it was not confirmed.

Because we are at an impasse on the service agreement, I think that we need to suspend the PMT for clinical appointments. The process was contributing to the problems we are facing at the

moment, rather than improving pain management or outcomes. We can use the time to discuss plans instead.

There is clearly a communication issue in that Primary Care leadership does not understand the concerns about precipitous deprescribing, nor are they willing to assume any responsibility for managing opioid prescriptions. They do not seem to understand that CITC pain management is unsustainable, and that patients are getting opioids one way or the other anyways. They also do not understand that Suboxone is not simply "opioid rotation".

With appreciation,

[redacted]

From: [redacted]
Sent: Wednesday, February 24, 2021 10:30 AM
To: [redacted]
Cc: [redacted]
Subject: RE: March PMT

I asked [redacted] earlier this week and he said there were 4 patients for March and that he was going to delegate to you and [redacted] to get them scheduled . . . ??

[redacted]
Associate Chief of Pharmacy, Clinical Services
[redacted]

From: [redacted]
Sent: Wednesday, February 24, 2021 10:08 AM
To: [redacted]
Cc: [redacted]
Subject: March PMT

Morning,

[redacted]

Patient is on [redacted] – new to pact pcp, transferee from another VA

What is the status for this patient scheduling for CARA PMT? Will he be contacted for March clinic? I do not see any patients yet scheduled for tem whs pain idt-x

Facility
Activity Date/Time/Zone Responsible Person Entered By

CPRS RELEASED ORDER 02/22/21 14:31 [redacted]
RECEIVED 02/23/21 13:52 [redacted]
This consultation is accepted on behalf of the Chairperson of the pain management team, [redacted] Notification will be sent to [redacted] and to Pain Management Pharmacy, [redacted], for processing and scheduling in the Pain Management Team clinic.

Respectfully,
[redacted]
Pain Clinical Pharmacy Specialist
[redacted]

From: [redacted]
To: [redacted]
Cc:
Subject: FW: 011-001-18 PAIN POLICY
Date: Sunday, February 21, 2021 5:34:22 PM
Attachments: 011-001-18 PAIN POLICY.docx
image001.png
OPIOID USE POLICY.docx
Charter Approved 15-12-031.docx
2018-Pain-Roadmap-Final.pdf
Informed Consent for LTOT VHA Directive 1005.pdf
1004.01(4) HK 2009-08-14.pdf
1306(1) D 20191016 (1) PDMP.pdf
Pain Champions for PACT.pdf
pmtf-final-report-2019-05-23.pdf
System-wide Implementation of Academic Detailing and Pain Program Champions.pdf
2017.07.18 CHARTER FOR CARA-PMT CEC APPROVED.pdf
9-1-20 145p Topic 3 VIP POST 2020 Topic 3 [redacted] Pain Management Teams.v7.pptx
VHA Notice 2020-30 Buprenorphine Prescribing for OUD.pdf
Pain Management VHA Directive 2009-053.pdf
Importance: High

Dear Colleagues,

I hope all of you and your loved ones made it through last week safely.

We are required to update the 2018 **Pain Management MCM** (attached) before it expires in April 2021, assuming we retain it as an MCM. The guidelines state that the National Pain Management Strategy and the ongoing work of the National Pain Management Program Office and Coordinating Committee are to be used to guide the development of local policies, but that an SOP will suffice.

If we are to retain a policy, we have been asked to submit a draft by 2/24/21. (I apologize that I did not submit this to the committee sooner for discussion. I received the email on 2/9, but I was on leave that week, and then everyone knows last week was challenging due to the disastrous weather. Still, I should have been more attentive to this.)

We will need to make a decision on which way to proceed. In either case, we will need to produce a new document. We can discuss and vote on this by email, or we can request an extension until we can discuss this at the next meeting. However we may decide to proceed, we need to work on this as a team, considering all of the stakeholders this affects. The revisions will need to address the following issues.

1. There are aspects of the local policy that are not consistent with the guidelines. For instance, the local policy refers to an "opioid agreement" rather than Informed Consent for LTOT (attached; also attached the new policy that removes the requirement for written informed consent for buprenorphine for OUD). This will need to be addressed in the local **Opioid Use Policy** as well (attached).
2. The **CARA Pain Management Team** is still not performing the responsibilities required by the National Pain Management Program, as has been detailed in the **VIP POST** meeting in September 2020 (see the attached PPT presentation from [redacted]. I have attached the existing charter as well.) One such requirement is for the PMT to follow patients longitudinally and manage and prescribe medications as needed or indicated (slide 17). This presentation also includes the expectation that the PMT and the Pain Clinic will integrate treatment of OUD in Pain Clinics and the PMT for patients with comorbid Pain and OUD or complex persistent opioid dependence (slides 31-37)
3. There have been updates to PDMP policy (attached).

4. While the **VA/DoD Clinical Practice Guidelines for Opioid Therapy** were last updated in 2017 (Management of Opioid Therapy (OT) for Chronic Pain (2017) - VA/DoD Clinical Practice Guidelines,) judging by the consults that we continue to receive for pain management, providers are not familiar with the guidelines, particularly regarding Stepped Care for Pain Management and Opioid Safety described in the 2009 VHA Directive. In particular, the latest guidelines advise against precipitous, non-consensual weaning of opioids when there is no alternative treatment plan in place, but rather recommend a Shared Decision Making Process, as was emphasized again in the **Pain Management Best Practices Interagency Taskforce Report of 2019** (attached). (**The Institute for Healthcare Improvement** offers education on the topic of Shared Decision Making in its **Open School** program: What Is Shared Decision Making? | IHI - Institute for Healthcare Improvement. I believe that this would be useful for providers to improve not just their approach to pain management but also all other aspects of care, in a manner that is consistent with Whole Health.)

5. Also, the **PACT Roadmap for Managing Pain** was updated in May 2019 (attached). This update incorporates a Whole Health orientation and describes the best practices for implementing Stepped Care for Pain Management as outlined in the 2009 VHA Directive on Pain Management, which is the objective of revising the **Service Level Agreement.** I have been working on this, but I have come to see that the difficulty coming to an agreement on this has much to do with the way PACT currently operates. I believe we need to have more discussions between Ambulatory Care, Nursing, Clinical Pharmacy, Mental Health and Whole Health before we will be able to implement some of the changes that I have proposed. We can form a workgroup to address this.

6. We will also need to discuss replacing the Buprenorphine SOP with a Service Agreement between these services in order to comply with VHA directives on Stepped Care for OUD (attached).

7. The Roadmap cites a VHA Memo from 2015 on **System-wide Implementation of Academic Detailing and Pain Program Champions** (also attached) that requires VISNs to "ensure that each facility is funding 0.25-0.5 FTEE for a Primary Care Pain Champion, and ensure that this individual is able to participate in VA and Professional association training programs to acquire primary care competencies in pain management." The memo goes on to state that "This position is critical for implementation of the OSI and safe and effective pain care for our Veterans."

   The document describes the roles and responsibilities of this Champion in depth. I have also included a one-page summary of these duties. Essentially, the Champion is a Subject Matter Expert who is "An enthusiastic PACT Pain Champion can help PACTs learn about pain care, operationalize this Roadmap, and ensure alignment with other pain care team members." (p. 13). The Roadmap also states that:

   > The local PACT Pain Champion should have adequate time to:
   > a. Serve as the Pain Roadmap navigator and guide for PACTs.
   > b. Advise PACTs (to include PACTs at your CBOCs) on how to use all available resources to provide safe and effective pain care.
   > c. Serve as liaison to other pain care resources/team members.

   At our last few meetings I raised the issue that we do not currently have such a Champion in Primary Care. [redacted] has been acting as the Ambulatory Care Service Representative, but when she had been the designated Champion she did not have the time to perform these duties, or attend the Committee Meetings.

   I would like to propose that we request hiring at least one PACT provider under Ambulatory Care who has at least 0.2S protected time to serve as this Champion. (The memo states that we may want more than one such champion, which would make sense given our geographic challenges, but we can start with requesting one such provider.) I understand that [redacted] had advocated for this in the past. This is

consistent with the strategy that has been adopted in several other facilities, including South Georgia/North Florida, with considerable success. SG/NF has several such providers, all of whom are x-waivered, who manage patients with comorbid pain and OUD or complex persistent opioid dependence using buprenorphine when indicated. We can discuss this at the next committee meeting, but please feel free to respond with your thoughts on this.

For now, I am requesting that voting members respond to the following:

1. Should we request an extension to allow further discussion on whether to abolish the policy in favor of an SOP at the next meeting?
2. If we do not request an extension, should we renew the existing policy and submit a revision after we have had time to deliberate over these issues? Realistically, we will be able to revise the policy, discuss it, and submit it by the currently deadline. Even if we do make some revisions, some of these things will require more discussion, and adding the Primary Care Pain Champion will require approval from ELT, but please let me know if anyone has other thoughts on this.
3. Are there any other updates we need to make that I have not included in this?
4. Please let me know who would be willing to be part of the workgroup described above. We need representatives from Primary Care, Behavioral Health, Nursing, Clinical Pharmacy and Whole Health/Pain Management. **Members of the workgroup do not have to be voting members**. If there are people who have not been attending the Pain Committee meetings and have an interest or expertise in these areas, please invite them to be involved. We will need to meet regularly between committee meetings. This may require asking for time for this from your supervisors, or it may require the participants to work on this outside of their regular tours.

With appreciation,

[redacted]

From: [redacted]
Sent: Tuesday, February 9, 2021 12:38 PM
To: [redacted]
Subject: 011-001-18 PAIN POLICY

The attached policy will expire on 4/24/2021. Now is the time to start the recertification process by reviewing all the documents related to this policy, updating references, getting stakeholder input and determining the correct type of local document to deliver the content (Directive, Handbook, MCP, SOP). Remember, once you have submitted the final draft to me(if it is to remain a policy), due 2/24/20, the policy will still have to be reviewed and approved by Labor Relations and the ELT. I will be following up with you routinely for status updates.

If you have any questions or concerns, please feel free to contact me between the hours of [redacted] Teams, or e-mail.

Below is verbiage from the Directive 2009-053, dated 10/28/2009. However, there is a note that an SOP would suffice if appropriate for CTVHCS needs.

****Please note the responsible program office has stated that an SOP would suffice according to local needs and that there are resources on the program SharePoint site. If you have questions about this, please reach out to the responsible program office.*

Policy: " It is VHA policy that VHA's National Pain Management Strategy and the ongoing work of the VHA National Pain Management Program Office and Coordinating Committee is to be used to guide the development of local policies related to pain management"

VISN Director: " All facilities within the VISN establish and implement current pain management policies consistent with this Directive"

Reference 50

From: [redacted]
To: [redacted]
Cc: [redacted]
Subject: RE: MEDICATION
Date: Wednesday, February 16, 2022 12:15:36 PM
Attachments: image001.jpg
STEPPED CARE MODEL FOR PAIN MANAGEMENT.pdf
Importance: High

[redacted]

I want you to know that I am in full agreement with your statement below. However, I need to make a few points clear to all:

1. When the Pain management Section was under Whole Health and [redacted] told me on several occasions that he has no control on Mental Health and that he has no control over Primary Care. [redacted] said that he has control over the Pain Management Section that was aligned under him and as such will order us to treat Opioid Use Disorder (OUD) because Mental Health/Substance Abuse Treatment Program refuse to do so, and that he will order us to treat Chronic Pain with chronic opioids because primary care at the CTVHCS refuse to do so.

2. I presented the reasonable argument to [redacted] stating the following:

    a. There are only three pain management providers who are credentialed by the CTVHCS to do interventional pain management procedures, while there are a multitude of other providers who are credentialed by the CTVHCS to prescribe chronic opioids for chronic pain.

    b. Considering that the number of pain providers has not increased over the last 10 years, and has remained at three interventionalists, and considering that the Veteran population has dramatically increased over the last 10 years and the CTVHCS opened new satellite OPCs, there is certainly an overwhelming amount of Veterans needing procedures, many of whom are now overflowing to community care pain management.

    c. It really makes no professional and no economic sense to displace the patients needing interventional procedures to community care pain, while replacing these with patients who need chronic Opioid therapy for the three interventionalists at the CTVHCS. Bad decision. Where are the multitude of the Primary Care Providers who are fully credentialed at the CTVHCS to prescribe Chronic Opioid for Chronic Pain?

    d. Why have we deviated from the VHA Stepped Care Model for Pain Management? A copy of which is attached to this email. Look at the attachment; read it carefully. This is a primary care process, I do not see any pain clinic in the stepped care model. We are a specialty clinic. [redacted] response to me has always been the same and unchanged, that he was given control over the Pain Management Section and we shall obey.

3. It is my opinion that displacing our interventional practice, in part or as a whole, with opioid management is a setup for failure not only for us but for our Veterans who are forced into community care pain with the problems that they face in the community. Also, it is a set up for failure for the pain management Section and the CTVHCS. Why? Because Primary Care and Mental health do not want to treat [redacted], so these patients are channeled over to us.

4. Moreover, [redacted] gives me the rhetoric that pain management section has a lot of support. The facts are as follows:

    a. None of us in pain management is specialized in addiction and we are not credentialed to treat OUD at the CTVHCS. We are interventional pain management providers and we are credentialed only in this capacity.

    b. Even if we decided to breach our credentials and treat OUD, MH/SATP refuse to back us up and they are not obliged to do so even for difficult cases. They are not even involved in the Pain Management Service Agreement that was authored by [redacted]

    c. Then [redacted] gives me the rhetoric that we have all the support we need to treat OUD:. He tells me that we have him, we have [redacted], the pain management pharmacists, [redacted], and the addiction specialist pharmacist, [redacted]. The fact is that none on the named was available when I needed them. Except for pain management pharmacy consultations, none of the help mentioned in this paragraph has any CPRS consultation process for their services, neither [redacted], nor [redacted], nor [redacted] has any consultation template in CPRS for their services. This is a frank breach of VHA directive 1232(3). So please, before you offer your services, establish a proper consultative process through CPRS that can be followed and scrutinized.

5. The pain management section has always provided advise regarding medication management including opioids. We have prescribed opioids when they were professionally indicated, but always the patient's PCP took over the maintenance of prescriptions and followed our advice to free our hands to capture more procedures who would have been channeled to community care pain management.

6. We see real patients at the pain management clinics, I do not know how much use I have for virtual doctors and cyber pharmacists. Please abstain from targeting the pain management providers as scapegoats for what I believe to be system failure of other services, certainly not ours. Please contact me if you have any questions, my team and I are always glad to help.

7. I believe I made myself quite clear, I shall not be responding any further regarding this topic, I have a lot of things to do and patients to attend to, so are my colleagues. This fiasco must end. If you have any comments or complaints, please contact our chief, [redacted], I have included her on this email.

With much appreciation to all,

[redacted]

From: [redacted]
Sent: Tuesday, February 15, 2022 7:36 PM
To: [redacted]
[redacted]
Cc: [redacted]
[redacted]
Subject: RE: MEDICATION

I would like to clarify for myself what is true in this message.

I have heard [redacted] say he will be prescribe opioids when indicated, so I hate to see statements in writing like "the Interventional Pain doctors refuse to write for these prescriptions". I know we are all in uncomfortable situations with what is currently going on, but we must keep the care of the veteran foremost in our minds.

I read [redacted] note. Obviously the patient has med on hand as he noted. What do you think about adding the PCPs to your notes, if you see that they have enough medication and a future follow-up with them, so the PCP knows your intentions – ie., for them to write.

We need to come together and work as a team with each other and with the patient's PCPs. We will be submitting a request for the national funding for a nurse practitioner or physician assistant to help in the pain clinic with temporary medication management along with the pharmacists.

I am open to hearing any of your suggestions.

[redacted]
Associate Chief of Pharmacy, Clinical Services
[redacted]

"You are your last line of defense in safety. It boils down to you." – [redacted]

From: [redacted]
Sent: Tuesday, February 15, 2022 4:07 PM
To: [redacted]
Subject: FW: MEDICATION

From: [redacted]

Sent: Tuesday, February 15, 2022 1:42 PM
To: [redacted]
Cc: [redacted]
Subject: RE: MEDICATION

[redacted]
As previously directed, please refill these meds until the care can be transitioned.
I will contact CITC and have them expedite these consults to the community.

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

From: [redacted]
Sent: Tuesday, February 15, 2022 11:50 AM
To: [redacted]
Cc: [redacted]
Subject: RE: MEDICATION

If I may make a comparison, what would you do with an anesthesiologist who trained before propofol was approved by the FDA, who decided that they would not adopt its use because it was "outside their regular practice?"

We have Veterans who are suffering and need help, but neither the pain specialists nor primary care providers are willing to prescribe medications that could help them maintain functioning and quality of life. In many cases, the Veterans have iatrogenic opioid dependence which has led to a reset "hedonostat," which in turn leads to dysphoria and suicidality when their opioids are stopped. This is no different really than patients who have adrenal insufficiency due to long-term steroid therapy, who will have an Addisonian crisis if their steroids are stopped.

The treatment of choice is buprenorphine, but when this fails, full-agonist opioids are indicated. This is the new standard of care, as the proposed update to the CDC guidance on long-term opioid therapy indicates. A board-certified pain specialist should be familiar with this reality based on the existing literature.

Community Care pain specialists are already doing this, but they are also doing interventions when they were not clinically justified. CTX was #1 in the country for community care for pain management, at a cost of $12 million in FY20. We reduced this to $10 million in FY21, when I started bringing Veterans back to the VA for care, and prescribing medications while implementing appropriate risk-mitigation strategies as well as integrative, holistic approaches to pain management.

If no solutions are suggested to take care of these Veterans, I will have no option other than to go to OIG myself.

Respectfully,

[redacted]

From: [redacted]
Sent: Tuesday, February 15, 2022 10:32 AM
To: [redacted]
Cc: [redacted]
Subject: RE: MEDICATION

I am newer to this whole situation. From what I can gather, the Interventional Pain doctor [redacted] force a practitioner to do something that makes them uncomfortable or is outside their regular practice (a point that is, in my opinion, the key here.) I do not know how the system has been set up so not sure where to direct these patients. I am sorry I do not have a good answer for this.

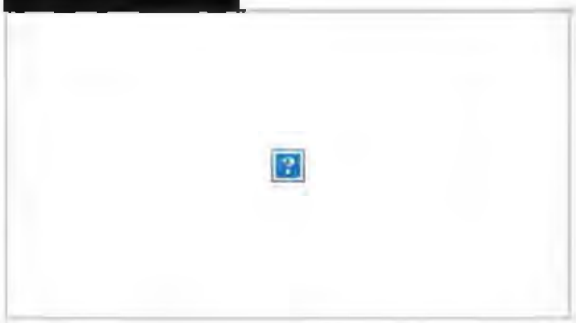
[redacted]
Chief of Anesthesia
Central Texas Veterans Health Care System
VISN 17
Temple, TX
[redacted]

From: [redacted]
Sent: Tuesday, February 15, 2022 10:22 AM
To: [redacted]
Cc: [redacted]
Subject: RE: MEDICATION

[redacted] can you weigh in on this as [redacted] is the one fielding these calls from angry vets needing their meds filled?

[redacted]
Whole Health Program Manager [redacted]
Central Texas Veterans Healthcare System
[redacted]

[redacted]



"People are fed by the Food Industry, which pays no attention to health, and are healed by the Health Industry, which pays no attention to food." - [redacted]

VISN 17 → SELF-CARE CALENDAR - Calendar (sharepoint.com)

#LiveWholeHealth

From: [redacted]
Sent: Tuesday, February 15, 2022 10:21 AM
To: [redacted]
Cc: [redacted]
Subject: RE: MEDICATION

My understanding is that I will take care of refills until the transfer of care is complete.

However, I was not advised on how to manage patients seen by the pain specialists when the pain specialist decline to continue medications.

I am waiting for guidance.

[redacted]

From: [redacted]
Sent: Tuesday, February 15, 2022 10:10 AM
To: [redacted]
Subject: RE: MEDICATION

Please advise on who to contact for pain medication refills, from my understanding the pain clinic doctors do not proscribe medications?

Thank you!

[redacted]
Central Texas Veterans Health Care System
[redacted]

From: [redacted]
Sent: Tuesday, February 15, 2022 10:05 AM
To: [redacted]
Subject: FW: MEDICATION

FYI

From: [redacted]
Sent: Tuesday, February 15, 2022 9:54 AM
To: [redacted]
Subject: FW: MEDICATION

Please advise.

[redacted]

From: [redacted]
Sent: Tuesday, February 15, 2022 9:52 AM
To: [redacted]
Subject: RE: MEDICATION

He had an appointment with [redacted] this morning and was told that the doctor does not prescribe medication.

Thank you!

[redacted]
Central Texas Veterans Health Care System
[redacted]

[redacted]

From: [redacted]
Sent: Tuesday, February 15, 2022 9:49 AM
To: [redacted]
Cc: [redacted]
Subject: RE: MEDICATION

He needs to see [redacted] about this.

[redacted]

From: [redacted]
Sent: Tuesday, February 15, 2022 9:46 AM
To: [redacted]
Subject: MEDICATION

[redacted] is asking if you can please call him regarding his pain medication, He stated that you spoke to him about increasing his dosage? [redacted]
Thank you!

[redacted]
Central Texas Veterans Health Care System
[redacted]

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Reference 51

From: [redacted]
To: [redacted]
Cc: [redacted]
Subject: Missed Opportunities Pending
Date: Wednesday, July 29, 2020 7:53:38 AM
Importance: High

AMSAs,

Unless these times are officially blocked, please fill the following empty slots in our pain clinics:

1. TEM VVC SUR PAIN MGMT: 15:00 HR, 07/31/2020
2. TEM VVC SUR PAIN MGMT2: 15:00 HR, 07/29/2020

Sincerely,
[redacted]

From: [redacted]
To: [redacted]
Cc: [redacted]
Subject: Blocking Clinics
Date: Tuesday, August 18, 2020 10:52:31 AM
Importance: High

[redacted]

Please block the open slots in the following clinics ASAP:

1. **TEM SUR PAIN MGMT,**
2. **TEM SUR PAIN MGMT2,**
3. **TEM SUR PAIN PROC, and**
4. **TEM SUR PAIN PROC2,**

For the Month of July 2020 and August 2020, and confirm.
Patients have been rescheduled from these slots per COVID-19 policy but the slots are still left open showing as pseudo "missed opportunities" that will not reflect well on the pain management section.

Thanks,
[redacted]

From:
To: [redacted]

Subject: Pain Management Section Clinics
Date: Thursday, December 3, 2020 3:31:31 PM
Importance: High

To All,

Please note that my Performance Pay Evaluation for FY2021, will be based on the following criteria among others:

1. Between 85% -115% clinic utilization aggregate at the end of the fiscal year based on the clinic utilization standardization summary (CUSS) report.
2. Meets or exceeds median productivity target per SPARQ for the fiscal year. (Meets Target = full 15%, 90% of target = 10%, 80% of target = 7.5%)

[redacted], I think that your Performance pay evaluation will most likely have similar statements.

[redacted], as I have always asked from our AMSAs, please assure that all our pain clinics are filled with patients. Please be vigilant on scheduling new consultations in empty clinic slots, especially when the patient cancels at short notice. In addition, please block our clinic slots when that is appropriately indicated such as for approved leave, or for administrative limitation that is imposed on our scheduling due to COVID-19 or other situations.

Please note that I shall send to you a "Scheduling Error" email whenever breaches are encountered such as unblocked clinics or empty slots.

I am including for your attention my clinic profile and I am requesting that my colleagues do the same.

[redacted] Clinic Schedule

	Monday	Tuesday	Wednesday	Thursday	Friday
AM	TEM SUR PAIN MGMT / TEM VVCSUR PAIN MGMT	TEM SUR PAIN MGMT / TEM VVCSUR PAIN MGMT	TEM SUR PAIN MGMT / TEM VVCSUR PAIN MGMT	TEM SUR PAIN PROC	TEM SUR PAIN PROC
PM	TEM SUR PAIN MGMT / TEM VVCSUR PAIN MGMT	TEM SUR PAIN PROC	ADMINISTRATIVE TIME	TEM SUR PAIN PROC	TEM SUR PAIN PROC

[redacted], please make sure that all of us in the Pain Management Section are properly mapped for FTEs, clinical vs. administrative and report to each of us our FTE mapping at your service.

Please let me know if you have any questions.

Sincerely,
[redacted]

From: [redacted]
To: [redacted]
Cc: [redacted]
Subject: RE: clinic utilization
Date: Thursday, December 10, 2020 5:59:51 PM
Importance: High

[redacted]

Please note that all patients that we have approved to go to the Community, may come and see us at the Pain Clinic only if they will and if we have the slots for them in our clinics.

From multiple recent experiences, I was advised that if a patient and his provider choose community, I must approve that, otherwise prepare to respond to a congressional and patient advocate complaint. With that said, **my team and I are willing to follow any policy you advise regarding approval of community care consultation requests.**

To play it safe and to lessen the stress of this issue, my advice is:

1. To follow the policy of the Mission Act and COVID-19 limits on F2F encounters, and
2. To advocate for the Veterans, keeping them satisfied and happy.

These issues need to involve the scheduling clerks since they are the ones that schedule our clinics. I keep instructing them to fill every slot. Perhaps [redacted] can supervise them and take the lead in filling our clinics vigilantly.

We are all keen on improving clinic utilization but you must realize that this is 100% dependent on our scheduling clerks and not on the providers at the pain clinic. We never refuse patients and we have an overwhelming number of patients guaranteed to overflow our clinics. Scheduling at the pain clinic is plagued with clerical scheduling errors, many of which I document and bring to the attention of the clerks who keep repeating them.

Another sure source of poor clinic utilization data is when our clinics do not get blocked when we go on leave despite several requests to do so. We may repeat our request to block our clinic and that may be approved by our supervisor, and the clinics still do not get blocked. **The fact is that the data on clinic utilization is as good as the clerks who schedule our clinics.**

I AM HOPING THAT YOU AND [redacted] would find a solution to that problem. My team and I are willing to help in any way we can.

Sincerely,
[redacted]

From: [redacted]
Sent: Thursday, December 10, 2020 10:57 AM
To: [redacted]

Cc: [redacted]

Subject: Clinic utilization

[redacted],

Please review clinic utilization and compare to the consults going to the community. Please see if we can fill open slots by bringing patients back from CITC, if they have not been seen yet. I am including [redacted], who may be able to assist you with this.

Respectfully,

[redacted]

[redacted]

Clinical Director, Women Health and Integrated Health Service

Central Texas VA Healthcare System

From: [redacted]
To: [redacted]
Cc:
Subject: RE: Pain Management Leave Calendars
Date: Friday, December 11, 2020 4:12:33 PM
Attachments: image001.png

My comments in red.

From: [redacted]
Sent: Friday, December 11, 2020 2:53 PM
To: [redacted]
Cc: [redacted]
Subject: RE: Pain Management Leave Calendars

I have some questions after digging into the data and profiles today and speaking with the front line AMSAS.

1. The front line AMSAs have been told that [redacted] only has clinic patients on Tuesdays but he actually has Proc slots open from 8-12pm and clinic from 1-4pm. They have only offered clinic slots on Tuesday since being told this. The clinic slots are in the VVC clinic and are currently booked out into February. Is there support of nursing, etc to have procedures on this day and if so why is it not being utilized?

[redacted] **is building his clinic. He has to see more new patients is whatever slots available to generate procedures. For now, he is utilizing the procedure clinic to get more new patients for procedures. AMSAs need to work along with doctors. It is unfortunate that we could not be at full capacity for many months due to the limitations that were imposed by COVID-19.**

2. The AMSA were also told to only book in VVC clinics unless patient is adamant and wants a f2f visit. My understanding is this should be patient driven and that F2F is only limited to the 75% capacity. The patients have all voiced that they want F2F. Can the AMSAs be told to offer F2F from here on out? [redacted] first appt for a F2F clinic slot would be 2/18@3pm, [redacted] 1/26@8-12pm.

There are many advantages to the VVC clinic. To say the least, there are no administrative limitations imposed by the COVID-19. This is a provider preference, and is highly recommended to develop by the VHA. No patient is ever denied a F2F consultation. I am including [redacted] **in the email. My preference is VVC for consultations, every provider can state their preference.**

3. [redacted] does not have a VVC clinic to be found anywhere in VSE. It says Tem on this schedule but that clinic does not exist either. I will put in for a clinic to be built for him as it doesn't sound like he has been using one.

I will be switching all these clinics to WHS from SUR but the slots and current

standing appts will all stay the same. I'm aiming for January for them to make that switch. Just putting this out right now as FYI as it is coming.

[redacted]
Whole Health Program Manager [redacted]
Central Texas Veterans Healthcare System
[redacted]

"People are fed by the Food Industry, which pays no attention to health, and are healed by the Health Industry, which pays no attention to food." - [redacted]
"Let food be thy medicine and medicine be thy food"-[redacted]

From: [redacted]
Sent: Friday, December 11, 2020 1:28 PM
To: [redacted]
Cc: [redacted]
Subject: RE: Pain Management Leave Calendars

Re-attached with phone numbers as well.

From: [redacted]
Sent: Friday, December 11, 2020 9:29 AM
To: [redacted]
Cc: [redacted]
Subject: RE: Pain Management Leave Calendars

Thank you. I've attached the document. THX

From: [redacted]
Sent: Friday, December 11, 2020 9:01 AM
To: [redacted]
Cc: [redacted]

Subject: FW: Pain Management Leave Calendars
Importance: High

I am resending "Approved" Pain Management Providers Leave Calendar again.

AMSAs,

- Please fill all our Pain Management clinics to capacity, in accordance with the administrative limitation/recommendations for the COVID-19.
- Please block our Pain Management clinics when we are on "approved" leave. Please see the attached "CLINIC SCHEDULES_PAIN SECTION" to know what clinics to block. Please note that the VVC clinics are daily clinics for each provider even if they do not show as daily on the attached schedule. These need to be blocked also so we do not inconvenience our Veterans.

[redacted],
Kindly fill in your portion of the attached, "CLINIC SCHEDULES_PAIN SECTION" and send to me for distribution to all.

We must be vigilant to improve our Clinic Utilization data. Please let me know if you have any questions or corrections.

Sincerely,
[redacted]

Pain Management Clinic Provider Schedules:

From: [redacted]
Sent: Tuesday, November 24, 2020 7:34 AM
To: [redacted]
Subject: Pain Management Leave Calendars
Importance: High

Good morning,

I am attaching a Pain Management Section Leave Calendar for December 2020 and for the whole 2021. All approved leave has been entered. It is color-coded. Please note the following points:

1. I based the calendars on the information that you sent to me. Please review and correct me if entries are incorrect.

2. Plan ahead for your leave for 2021. Send to me your "Approved" leave so I may update this calendar.
3. Per [redacted], one of us three ought to be available at work on all work-days.
4. Leave may not be approved for a third person off on the same date unless it is a sick leave, an emergency, or approved by [redacted]
5. The only day when the three of us are off simultaneously is 12/24/2020, Christmas Eve. [redacted], if that is not okay by you, I shall have to cancel my leave on that date. Please let us know.
6. Please note that approval for clinic blocking by [redacted] must precede approval for Annual Leave on VATAS. Exceptions apply for Sick Leaves and Emergencies.
7. Please read the emails below for more information.

You may call me if you have any questions or suggestions about the attached calendars.

Sincerely,
[redacted]

From: [redacted]
Sent: Friday, November 20, 2020 8:47 AM
To: [redacted]
Cc: [redacted]
Subject: RE: Leave Requests

Thank you, sir.

One modification – leave requests should go to [redacted] unless he is on leave, in which case they should come to me. Please wait for approval before canceling clinics.

With appreciation,

[redacted]

From: [redacted]
Sent: Friday, November 20, 2020 8:11 AM
To: [redacted]
Cc: [redacted]
Subject: Leave Requests
Importance: High

Dear Colleagues,

Per the email below and the attached email by the chief of our service, [redacted], please note the following regarding leave requests:

1. I shall be managing your time and leave requests.
2. Kindly, submit to me a calendar of your currently approved leave (annual and sick) so I may assure that for future leave requests there is always one of us available to cover for the group as per [redacted]. All currently approved leave remains.
3. Please plan ahead for your leave, because, "we are required to give 45 days' notice for annual leave to reschedule patients, to minimize disruption to patient care and access. Any shorter notice requires approval from Chief of Staff."
4. "each of you (us) are able to cover for anyone who is on leave... at least one of you (us) are on duty when others are on leave."
5. "Going forward, please contact me [redacted] before canceling any clinics for sick leave or annual leave."

Please let me know if you have any questions. I am adding [redacted] on this email for guidance and for corrections, if any.

Sincerely,
[redacted]

From: [redacted]
Sent: Thursday, November 19, 2020 1:59 PM
To: [redacted]
Cc: [redacted]
Subject: FW: (Updated) How to obtain VATAS Roles
Importance: High

[redacted]

As the section chief for pain management, you are expected to manage time and leave requests for [redacted]

If all of you are requesting leave for the same days during the holidays, Seniority can be invoke on only one occasion per year. Please explain this to the others.

Please complete the training described in the attachment and let me know when you have completed this.

Respectfully,

[redacted]

From: [redacted]

Sent: Thursday, April 30, 2020 3:28 PM
To: [redacted]
[redacted]
Subject: [Updated] How to obtain VATAS Roles
Importance: High

The attached document contains updated links for both the VATAS SharePoint Portal and our LEAF site. Please keep for future reference. Please share as needed. Thank you.

Respectfully,
[redacted]
Payroll Supervisor
Central Texas VA
[redacted]

To better assist you and to allow us the opportunity to complete the necessary research of your payroll requests and concerns, please click here: CTX LEAF Homepage to enter a LEAF request.

From: [redacted]
To: [redacted]
Cc:
Subject: RE: scheduling follow up visits
Date: Tuesday, January 12, 2021 3:20:43 PM

Given these guidelines, COVID testing will not be required before procedures are scheduled – patients will need to be screened by telephone 1-2 days prior to their appointments instead. [redacted] – can we get assistance with these screening calls from nursing?
Any Procedure slots that are not filled 24-48 hours prior can be used for VVC or clinic visits, but if there are patients seen in clinic who would be appropriate for a procedure, assuming they have all appropriate workup in place, should be offered the next available appointment.
Please check in daily with the MSAs to see what your next available appointments are so that you may inform your patients before they leave their visit.
With appreciation,
[redacted]

From: [redacted]
Sent: Sunday, January 10, 2021 3:18 PM
To: [redacted]
Cc: [redacted]
Subject: RE: scheduling follow up visits
Since these are not Aerosol Generating Procedures(AGP) COVID testing is not required. The patients need to be screened 1-2 days prior to see if they are symptomatic. If not symptomatic the patient is treated like any other visit.
We have been doing paracentesis in PACU and cystoscopies in the GU clinic since reopening following these guidelines.
Respectfully
[redacted]
Acting DNE
[redacted]

From: [redacted]
Sent: Saturday, January 9, 2021 5:58 PM
To: [redacted]
Cc: [redacted]
Subject: Re: scheduling follow up visits
Just to update - [redacted] pointed out that we cannot utilize procedure slots with less than 2 days advanced planning due to the requirement for COVID testing.
Slots that are not filled 2 days out can be used for non-procedure clinics. If there are Monday

slots unfilled on Friday, they may be used for non-procedure visits.
We will monitor utilization and adjust the grids if necessary. Under-utilization of procedure clinic slots for procedures may require closer review.
With appreciation,
[redacted]

From: [redacted]
Sent: Friday, January 8, 2021 10:16 AM
To: [redacted]
Cc: [redacted]
Subject: scheduling follow up visits

Dear colleagues,
It has come to my attention that patients are being scheduled for VVC follow up during times that are blocked for procedures.
This has the affect of decreasing access for procedures. Follow up visits would be appropriate after procedures or medication changes, but not for pending test results. If tests must be done before a procedure can be scheduled, please schedule the patient only after you have the results, when you have a treatment plan in mind.
If, going forward, we find that there is a problem with access, or if the procedure slots are underutilized, we can discuss changing the grid to reflect the actual clinic use.
With appreciation,
[redacted]
Clinical Director, Whole Health and Integrated Health Service
Central Texas VA Healthcare System
[redacted]

References 52 and 53

From: [redacted]
To:
Subject: RE: Whole Health
Date: Tuesday, March 8, 2022 4:29:00 PM

Hello [redacted]

I am surprised [redacted]

I have definitely **NOT** told [redacted] is "not to follow directions from my supervisor because I no longer belong to Whole Health."

I do not know how [redacted] such a claim. I do not believe anyone else said such a thing either.

Regarding her request "Please clarify that I am still part of the Whole Health Team and that I am able to follow the instructions given to me by my supervisor [redacted]?" ... I can tell you that [redacted] stopped me on Friday while I was at the front desk area and advised me that she had been instructed to [redacted] mostly being put onto mine. I was, of course, irritated to hear this. And I asked who gave this instruction. [redacted] showed me a copy of a printout on the same matter. I stated to [redacted], that if this came from [redacted], she knows that she is not to be making clinical decisions, and these are not established patients with me. At that point, [redacted] expressed confusion, and a colleague at the front desk who heard us speaking, affirmed to [redacted] that she was doing the right thing by following the orders given to her. **Right then and there, I also affirmed to [redacted] that she did the right thing by following the instructions given to her through her chain of command, that she should follow instructions, AND that she did nothing wrong.** I confirmed with her that she did what she was supposed to do.

I did reiterate that [redacted] is not allowed to make clinical decisions, however --- these are not our established patients --- and if something like this is being requested, she should let [redacted] know.

At **NO** time, did I indicate to [redacted] that she is not to follow the instructions of her supervisory chain or that she no longer belongs to Whole Health.

[redacted]

From: [redacted]
Sent: Tuesday, March 8, 2022 4:15 PM
To: [redacted]

Cc: [redacted]
Subject: RE: Whole Health

I am adding my colleague, [redacted], to see if he ever told [redacted] that statement below.

[redacted], read below, the question by [redacted] and comment.

Thanks,
[redacted]

From: [redacted]
Sent: Tuesday, March 8, 2022 12:51 PM
To: [redacted]
Cc: [redacted]
Subject: RE: Whole Health

[redacted]

That is not true. Absolutely false statements.

Why does [redacted] put such a statement, when she has explicitly refused to follow my orders stating that [redacted], her supervisor, told her otherwise.

This morning, [redacted] came into my clinic to explain to me why my clinic was not booked this morning. Also, she told me that she is getting conflicting orders from [redacted], her supervisor, and from us. I told her clearly and I repeated that to her at least twice, that she is supposed to obey her supervisor and follow her supervisor's orders in case of any conflicting requests from us.

I cannot even imagine that any of my colleagues would state anything like what she wrote below.

If [redacted] was serious about what "pain management" said, she would get it from us in writing. There is absolutely nothing from any of us to this regard.

[redacted] does not know who his or her supervisor is, or when that supervisor changes. I believe this is one of [redacted] is her supervisor and can order her to say and to do what she wants. Besides shouldn't [redacted] contact **her supervisor**, up the chain of command, with this question? or was she directed to contact **my supervisor** to put me down and make my supervisor think negative about me. I find it difficult to believe that [redacted] is not involved in that.

This is the type of harassment that I have to put up with, when I am trying my best to take care of my Veterans. I have overbooked my 13:00 HR Procedure clinic with a patient who needs care right away. I have to attend to two patients with procedures at 13:00 HR. I shall start working on her in a few minutes. Unfortunately, I have to respond to this false allegation, and delay completing my charting and other clinical activities. This harassment MUST stop. We cannot function this way.

Sincerely,
[redacted]

From: [redacted]
Sent: Tuesday, March 8, 2022 12:09 PM
To: [redacted]
Subject: FW: Whole Health

[redacted]
Is this correct? Please advise.
Thanks,
[redacted]

[redacted]
Chief of Anesthesia
Central Texas Veterans Health Care System
VISN 17
Temple, TX
[redacted]

Good afternoon, I am hoping that someone would be able to clarify that [redacted] is still my supervisor and that [redacted] is still my lead? I have been told by the pain management doctors that I am not to follow directions from my supervisor because I no longer belong to Whole Health? Please clarify that I am still part of the Whole Health Team and that I am able to follow the instructions given to me by my supervisor [redacted]

Thank you!

[redacted]
Central Texas Veterans Health Care System
[redacted]

From: [redacted]
To: [redacted]
Subject: FW: Clinic face to face reduction - Everyone, please Read Entire Email.. Thanks
Date: Thursday, January 14, 2021 3:54:52 PM
Attachments: [redacted]

Thank you!

[redacted]
Central Texas Veterans Health Care System
[redacted]

From: [redacted]
Sent: Thursday, January 14, 2021 1:39 PM
To: [redacted]
Cc: [redacted]
Subject: RE: Clinic face to face reduction - Everyone, please Read Entire Email...Thanks

[redacted]' guidance on procedures was that it is a matter of what the inpatient staffing needs are. I am working with [redacted] on this Pain Management is considered a foundational service and thus should be provided so long as we can staff the clinic.

50% F2F would be acceptable for clinic visits, but not for procedure clinic

Please do not reschedule procedures at this time.

[redacted]

From: [redacted]
Sent: Thursday, January 14, 2021 1:05 PM
To: [redacted]
Cc: [redacted]
Subject: RE: Clinic face to face reduction - Everyone, please Read Entire Email...Thanks

[redacted], I believe [redacted] was at the COVID-19 meeting when [redacted] announced Temple & Waco campuses were regressing to phase 2, seeing 50% of patients F2F. I have inserted [redacted] email below...thank you

From: [redacted]
Sent: Friday, January 8, 2021 1:30 PM
To: [redacted]
Subject: Phase Regression in Temple and Waco Campuses

Service Chiefs, ACNs and AOs

Most are already aware but I wanted to remind all that effective Monday, January 11, **Temple and Waco campuses** will be going back to modified phase 2 care. This translates to reducing outpatient face to face appointments to 50% or less and increasing virtual modalities to 50% of more of pre-covid encounters. The phase regression is modified phase 2 as follows

1. GI procedures will continue as currently constituted (no regression)
2. Cardiac catheterizations will continue as currently constituted (no regression)
3. Surgical procedures have already been curtailed for several weeks to allow for emergency and urgent surgeries only (regressed further than phase 2)

Again, this phase regression is limited to **Temple and Waco** campuses only. Other care sites remain in phase 3

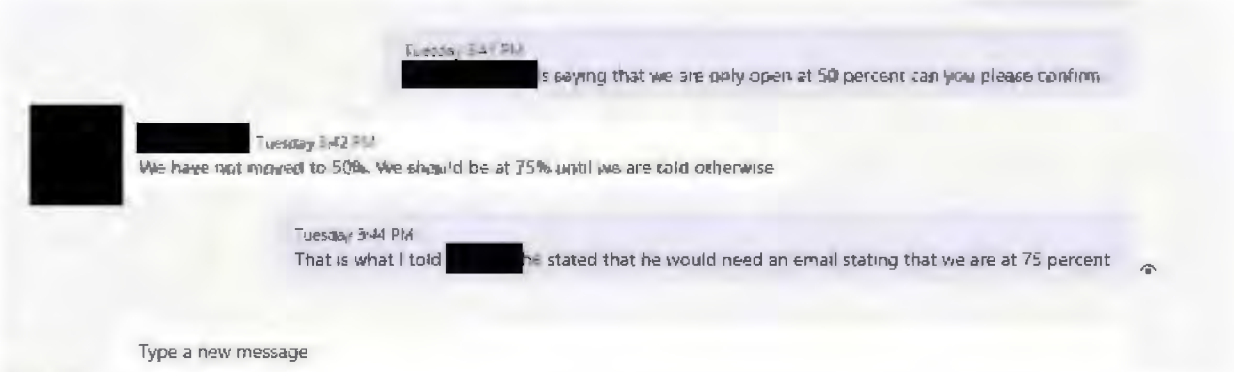
Thank you and have a good weekend

[redacted]
DCOS/CTVHSC
Austin, Texas

[redacted]
Administrative Officer, Surgical Service
Central Texas Veterans Health Care System
[redacted]

From: [redacted]
Sent: Thursday, January 14, 2021 12:38 PM
To: [redacted]
Subject: RE: Clinic face to face reduction - Everyone, please Read Entire Email. Thanks

[redacted], I just want to confirm per our conversation on Tuesday @ 1542 you stated that we are at 75%, per the email below we are suppose the be at 50% starting on 01/11/21 , I just want to clarify and if we are 50% do I need to reschedule all the patients that are already scheduled?



Thank you!

[redacted]
Central Texas Veterans Health Care System
[redacted]

From: [redacted]
Sent: Thursday, January 14, 2021 11:25 AM
To: [redacted]
Subject: RE: Clinic face to face reduction - Everyone, please Read Entire Email. Thanks

Greetings Team Surgical,

[redacted] and I are being notified that very few surgical clinics are reducing clinical face-to-face visits to 50% as you all were instructed. As you know, Temple and Waco have reverted back to phase 2 and must see only 50% of their regular workload based on their clinic profiles. The other 50% of the workload must be scheduled to be seen by other modalities such VVC, Telephone and Telehealth clinics. Please comply. Leadership is monitoring all clinics for compliance. **MSA Supervisors, please work with the providers to get on top of this mandate.** Also, ENT and Urology have been cited for running procedures at the regular volume and need to reduce procedures.

Thank you kindly

From: [redacted]
Sent: Thursday, January 14, 2021 10:26 AM
To: [redacted]
Cc: [redacted]
Subject: Clinic hours of face reduction

Good morning,

a calling number) for next week from tomorrow we are seeing little reduction in face to face visits in some of the surgical clinics. Can you please help in continuing the provision the need to reduce clinic staff Level within the NHS/WHC recommends. Also still running procedures at same volume as normal is going to affect multiple areas. Can you please discuss this more as reduce procedures in ENT and Oral specialty. WE is having to slowly come on their staff as well as the outstanding clinics were reducing to 50%

Thank you,

[redacted]

Nurse Manager Surgical Specialty Clinics

[redacted]

CTVHCS FY 2021 STAFF PHYSICIAN PERFORMANCE PAY CRITERIA

Name: [redacted]	Service/Section: Whole Health - Pain Section

FISCAL YEAR 2021	Met	Not Met	N/A	% of Perf. Pay Max	% Perf. Pay Earned	Comments	Peformance Goals
GOAL 1: PRODUCTIVITY/EFFICIENCY/QUALITY				50.0%			
Between 85% -115% clinic utilization aggregate at the end of the fiscal year based on the clinic utilization standardization summary (CUSS) report	X			25.0%	25%	Clinic-121% Proc-57% Ave-89%	[redacted]
Meets or exceeds median productivity target per SPARQ for the fiscal year. (Meets Target = full 15%, 90% of target = 10%, 80% of target = 7.5%)	X			25.0%	25%	112% per SPARQ	[redacted]
GOAL 2: PATIENT EXPERIENCE and CLINICAL CARE	Met	Not Met	N/A	50.0%			
No greater than 3 documented complaints from staff or patients during the fiscal year	X			25%	25%	3 complaints	
Institute patient satisfaction improvement program based on Whole Health principles and document positive results (20%, 10% each for program and results)	X			25%	25%		
TOTAL PERFORMANCE PAY EVALUATION:				100%	100%		

"I understand the target goals and am aware of the need to maintain my license to practice. Actions jeopardizing my license would prevent me from receiving pay for performance. In addition, my conduct and being subject to disciplinary action might affect my ability to receive pay for performance. I have reviewed these pay for performance goals, understand the criteria to meet the goals, and have had the opportunity to ask questions. My signature indicates my understanding of this."

Employee Signature (Communication of Goals):

7/23/2021

X [redacted]

Service Chief Signature (Communication of Goals):

X [redacted]

Clinical Director, Whole Health & Integrated Hea...

Service Chief Signature (Review of Achievements):

X [redacted]

Clinical Director, Whole Health & Integrated Hea...

Employee Signature (Communication of Achievements):

X [redacted]

From: [redacted]
To: [redacted]
Cc: [redacted]
Subject: [redacted]
Date: [redacted]

Hi [redacted]

I think the **overriding mentality/approach** →

Should be that *unless the physician you are scheduling for is unavailable* (meeting/committee time, admin time leave, patient already in the slot), **fill the schedule's slots.**

If you keep this thought process in the back of your mind, when such situations arise, you can think on it again, with the question:

> **Now that I have moved a patient from a slot:**
>
> Where/when does *that patient* go?
>
> - AND -
>
> What happens to *that slot*"

The patient needs an appointment AND the slot needs to be filled (unless the slot is to be closed).

[redacted]

From: [redacted]
Sent: Monday, July 27, 2020 2:21 PM
To: [redacted]
Subject: RE: URGENT — RE: Scheduling error

I did not realize that he wanted the patients switched from one doctor to the other, I rescheduled the patient to Friday and he was ok with that.

From: [redacted]
Sent: Monday, July 27, 2020 2:02 PM
To: [redacted]
Cc: [redacted]
Subject: URGENT — RE: Scheduling error

For whatever it is worth, I **can see the new patient right now.**

[redacted]

From: [redacted]
Sent: Monday, July 27, 2020 2:00 PM
To: [redacted]
Cc: [redacted]
Subject: Scheduling error
Importance: High

[redacted]

I spoke with [redacted] and he stated that he told you to switch the 2pm patients from his clinic and [redacted] clinic. He stated that you brought it up to him that [redacted] 2pm for today was an established patient and should be seeing [redacted] and [redacted] 2pm for today was a new consult. The instruction given was to switch the two patients. Put the [redacted] 2pm in place of [redacted] 2pm and Vise versus. Because [redacted] was pushed back to a later date and we have a missed clinic utilization time. Please explain why this wasn't done as requested.

V/R

[redacted]
Supervisory Medical Support Assistant
Surgical Service
[redacted]

From: [redacted]
To: [redacted]
Subject: RE: Clinic schedule — 08/04/2020
Date: Monday, August 3, 2020 2:49:00 PM

Thank you. Keep it up!

I will read the notes by [redacted]

Take care,

[redacted]

From: [redacted]
Sent: Monday, August 3, 2020 2:44 PM
To: [redacted]
Subject: RE: Clinic schedule — 08/04/2020

[redacted] I am trying my best to keep the slots for appointments full, did you read the notes That [redacted] put in CPRS? Concerning this patient?

From: [redacted]
Sent: Monday, August 3, 2020 2:35 PM
To: [redacted]
Cc: [redacted]
Subject: Clinic schedule — 08/04/2020

Hello [redacted]

I believe [redacted] is in clinic tomorrow **08/04/2020 in the afternoon.**

Please fill [redacted] TFM VVC SUR PAIN MGMT afternoon schedule for tomorrow.

(Appropriately, his schedule and mine are blocked off for **IDT-X tomorrow morning** and I am off tomorrow afternoon, so that is blocked too — nothing to do for these portions of the schedule)

Thank you,

[redacted]

From: [redacted]
To: [redacted]
Subject: RE: schedule
Date: Wednesday, August 5, 2020 8:07:00 AM

It looks like yes, for today. I appreciate you asking; it is even more helpful if you can address on/before the day prior.

But I see 1130 is not filled. Please try to fill it.

Please be mindful about filling those 30 minute slots that are not filled; please review [redacted] and my schedules.

[redacted]

From: [redacted]
Sent: Wednesday, August 5, 2020 7:58 AM
To: [redacted]
Subject: schedule

[redacted] can you please tell me if you have received all the emails for the VVC appointments on the schedule for today? Please let me know so if not I can resend it. Thank you

From: [redacted]
To: [redacted]
Cc: [redacted]
Subject: RE: [redacted] s Email is CONFIRMED: The AOPC ONLY is Re-opening to Phase 1 on Aug 17th - Pls Read
Date: Wednesday, August 5, 2020 3:48:05 PM

[redacted],

I believe that this applies to the Pain Management procedures as well. I am adding [redacted] to confirm if true.

Sincerely,
[redacted]

From: [redacted]
Sent: Wednesday, August 5, 2020 3:27 PM
To: [redacted]
Subject: RE: [redacted] Email is CONFIRMED: The AOPC ONLY is Re-opening to Phase 1 on Aug 17th - Pls Read

Hello [redacted]

I was assuming the below applies to Pain Procedure clinic as well, but my team wanted me to confirm because it's not included in the list below. It is your understand that Pain Procedure clinic is reopening on Aug 17 at 25%?

THANKS

From: [redacted]
Sent: Wednesday, August 5, 2020 11:04 AM
To: [redacted]
Subject: [redacted] Email is CONFIRMED: The AOPC ONLY is Re-opening to Phase 1 on Aug 17th - Pls Read

Greetings Team Surgical (Specifically AOPC),

The COVID-19 conference call ended close to 4 pm today and [redacted] confirmed that the AOPC is starting phase 1, beginning Aug 17, 20.
This means AOPC clinics will begin seeing 25% of face-to-face (F2F) patients including routine patients Aug 17th. Guidelines are in the attachment and I also cut and pasted them below.

Also, I need you to complete the table below AFTER you have read the guidelines. I have to turn this in Thursday. If I don't get your info, I will call you, so please be able to respond to the items in the table below. I will need you to verify the day you will actually see your first routine patients…change the dates I have below if they are not correct. My scheduler supervisor will need this information. REMEMBER TO READ THE GUIDELINES BELOW THOROUGHLY BEFORE COMPLETING THE TABLE BECAUSE IF YOU DON'T HAVE DIFFERENT PLANS FOR SOCIAL DISTANCING AND ENVIRONMENTAL, JUST PUT SEE GUIDELINES IN THE TABLE FOR THESE. IF YOU WANT TO ADD SOMETHING TO THE GUIDELINES, LET ME KNOW.

Please call me if you have questions. [redacted]. Thanks a bunch!

Specialty	Actual Start Date	Number of Days Clinic will see patients per week	Number of F2F Appointments per Day (Not more than 25%)	Number of Providers on Duty per Day	Number of Scheduler Staff on Duty Per Day	Amount of time between each patient Appointment	Social Distancing Plan for waiting room	Environmental Care Plan within Clinic/Exam Room
Audiology	Aug 17, 20							
Gen Surgery	Aug 17, 20							

Optometry	Aug 17, 20							
Ophthalmology	Aug 17, 20							

Wound	Aug 17, 20							
Orthopedic	Aug 17, 20							
Podiatry	Aug 17, 20							
Urology	NA	Vacant						

Guidelines for Clinical Operations During COVID-19 Reduction in Capacity
(This is in addition to the Service Re-opening Standard Operating Procedure)

Must have items:

- Masks,
- Gloves
- Face Shields (Optional upon request)
- Disinfectant wipes (Those approved by Infection Control)
- Hand Sanitizer
- Providers may use gowns if you prefer (not mandated)

Instructions to Providers for seeing patients:

- Please communicate your patient workload with your AMSA's (schedulers) to ensure your clinic is not scheduled to full capacity. **This is a must.** AMSA's should schedule no more than 25% of your clinic capacity for "face-to-face" visits.
- AOPC AMSA scheduler Supervisor are [redacted] and Lead MSA is [redacted]. Both are also available by SKYPE and Outlook. Please contact either for scheduler/scheduling issues.
- Schedule only 25% of your regularly scheduled patient workload/elective surgery cases Face-to-Face, the remaining 75% should be seen via Telehealth, Telephone, VA Video Connect (VVC). For example: If your regular clinic capacity is 20 slots, you should see no more than 5 patients "face-to-face" and the remainder through non-contact means as stated above.
- Procedures/Surgery – Triage cancelled cases and begin to schedule higher priority elective @ 40% capacity; transition from specialty reservations of OR.
- Space clinic appointments throughout the day so you don't have a lot of patients in the facility at once. (Meaning don't do back to back appointments 30 min, 45 min or 1hr intervals may be appropriate)

Limit Staff on Station:

- Please continue to limit the number of staff on station as much as possible. Rotating staff on telework is encouraged as well as compressed tour where feasible.
- Providers may rotate on telework to reduce the number of clinicians on station. For example: If there are normally two providers in the clinic, one may telework while the other works on station to accommodate the 25% patient workload, if practical.
- Advanced medical support assistants (AMSA's) may continue to rotate on telework as much as possible, while ensuring sufficient AMSA's are on station to check-in patients and provide clinical administrative support to the providers.

Requirements for Being in the Facility:

- Everyone entering the facility must have on a face covering (mask), this includes all employees, patients with appointments and authorized visitors.
- Visitors are not allowed in the facility unless accompanying a patient that requires assistance.
- Social distancing is mandated where feasible (provider-patient contact may be necessary to provide treatment and care during the medical appointment). Personal Protective Equipment (Masks, gloves, gowns, face shields, etc., may be worn by the provider. The patient must wear a face covering).
- Staff and patients who are physically able, are encouraged to use the stairs instead of the elevators. If the elevator is utilized, do not enter a crowed elevated.

Environmental Care:

- Providers are to disinfectant-wipe exam areas between patients
- EMS staff will thoroughly clean exam rooms and clinic areas (work order not required)
- EMS will terminally clean exam rooms at the end of each day after clinic closes (work order not required)
- Hand sanitizers are placed throughout the facility. Please call Environmental Management Service when empty or expired.

Thank you kindly, be safe and stay well.

[redacted]
Administrative Officer, Surgical Service
Central Texas Veterans Health Care System
[redacted]

[12/21/20 1:05 PM] [redacted]
there seems to be quite a few changes in our schedule, If there is anything you need changed please let me know?

[12/21/20 1:31 PM] [redacted]
will do.
let me know if you catch anything

[12/21/20 1:32 PM] [redacted]
Yes sir

[12/29/20 10:40 AM] [redacted]
Just want to let you that your VVC appointments are going in to March

[12/29/20 11:02 AM] [redacted]
I may end up converting more mondays back to VVC. We will see.

[12/29/20 11:03 AM] [redacted]
Ok, thank you

[12/29/20 11:03 AM] [redacted]
You do have openings in the procedure clinic

[12/29/20 11:04 AM] [redacted]
thanks for letting me know

[12/29/20 11:05 AM] [redacted]
you are so welcome, I don't want to see openings in the schedule that are not filled, let me know if I need to do anything to help fill the schedule

[12/29/20 11:06 AM] [redacted].
Actually, if you can keep me advised when there are procedure dates that are coming up soon and not filled...

[12/29/20 11:06 AM] [redacted]
yes sir, I can keep you up to date on the schedule

[12/29/20 11:27 AM] [redacted]
Monday February 1st procedure clinic is empty

[12/29/20 11:28 AM] [redacted]
Can we put VVC in the clinic for that day?

[12/29/20 11:28 AM] [redacted]
Sure.

1/12/21 9:32 AM] [redacted]

I spoke to [redacted] yesterday and he informed me, I can forward an email.

[1/14/21 10:15 AM] [redacted]
Good morning, On February 17th, we have opening for procedures. We only have three patients scheduled for that day. I did not know of you wanted to add more patients on that day?

[1/14/21 1:11 PM] [redacted]
I think probably you will end up using such free slots due to the drop to 50% F2F change?
Wait that might not make sense.
I have to look at it again...

[1/14/21 2:50 PM] [redacted]
Now I am being told the the procedures will not go to 50% only the F2F visits

[1/14/21 2:51 PM] [redacted]
Huh?
I dont know how that works
Who is telling you that?

[1/14/21 2:52 PM] [redacted]
I am very frustrated right now

[1/14/21 2:52 PM] [redacted]
Hang in there
Will keep working on clarification.
We all need to
Who told you that

[1/14/21 2:53 PM] [redacted]
yes sir, thank you
I am going to forward the last email I got from [redacted]

[1/14/21 2:54 PM] [redacted]
ok

[1/14/21 2:58 PM] [redacted]
May I mark the 8:00 F2F as a No-Show

[1/14/21 2:59 PM] [redacted].
Oh yes.
Definitely.
Good catch.

[1/14/21 2:59 PM] [redacted]
Yes sir

[1/14/21 3:05 PM] [redacted]
Well.

[1/14/21 3:06 PM] [redacted]
Thats clear though.
[redacted] order, I think.
Some back and forth
But you know what the most recent instruction from him is.

[1/14/21 3:06 PM] [redacted]
Yes I agree, Things just keep changing

[1/28/21 2:45 PM] [redacted].
[redacted] seemingly does not want this done.

[3/1/21 11:29 AM] [redacted]
This may be a function of not scheduling follow-ups any more?

[8/20/21 8:12 AM] [redacted]
please contact [redacted] and ask for further guidance.

[9/20/21 11:53 AM] [redacted]
thank you

[9/20/21 1:54 PM] [redacted]
If that slot is open for tomorrow, and you did not already fill it, go ahead and fill it

[9/20/21 1:56 PM] [redacted]
I filled the slot

[9/20/21 1:57 PM] [redacted].
ok

[9/27/21 9:01 AM] [redacted]
I did rreschedule the 8:00 to [redacted], I was told to schedule the proc patients of [redacted] in to your proc clinic. Please refer to [redacted]

[10/19/21 8:57 AM] [redacted].
[redacted] is indicating to go ahead. [redacted] is saying to go ahead.

From: [redacted]
To: [redacted]
Subject: RE: schedule
Date: Wednesday, August 5, 2020 8:44:39 AM

Yes I am

From: [redacted]
Sent: Wednesday, August 5, 2020 8:44 AM
To: [redacted]
Subject: RE: schedule

[redacted] as directed?

[redacted]

From: [redacted]
Sent: Wednesday, August 5, 2020 8:42 AM
To: [redacted]
Subject: RE: schedule

Yes sir, I have been struggling with the schedule, the 30 minute follow up's are setting the schedule off, because they have to coincide with the 1 hour appointments, that makes it difficult to keep your schedule on the time fame needed.

From: [redacted]
Sent: Wednesday, August 5, 2020 8:36 AM
To: [redacted]
Cc: [redacted]
Subject: FW: schedule

Hello [redacted]

Anticipating at some point we will be re-opening (and doing injections and return visits together, with each patient scheduled for 1 hour total), maybe it is more efficient for you to schedule my already scheduled follow-ups that are 30 minutes for a full hour.

If you have two of my patients back to back scheduled for 30 minutes, **leave it as is.**

If you have a 30 minute follow-up with me that has a 30 minute empty slot before/after it (looking at hourly slots), just **make the existing 30 minute visit a full hour.**

Please don't move patients to do this.

[redacted]

From: [redacted]
Sent: Wednesday, August 5, 2020 8:24 AM
To: [redacted]
Subject: RE: schedule

Your 11:00 is a 30 minute follow up per your order, I do not have another 30 minute follow up to put in the 11:30 time slot, most of your follow up appointments go out for a month. Please advise

Thank you

From: [redacted]
Sent: Wednesday, August 5, 2020 8:08 AM
To: [redacted]
Subject: RE: schedule

It looks like yes, for today. I appreciate you asking; it is even more helpful if you can address on/before the day prior.

But I see 1130 is not filled. Please try to fill it.

Please be mindful about filling those 30 minute slots that are not filled; please review [redacted] and my schedules.

[redacted]

From: [redacted]
Sent: Wednesday, August 5, 2020 7:58 AM
To: [redacted]
Subject: schedule

[redacted] can you please tell me if you have received all the emails for the VVC appointments on the schedule for today? Please let me know so if not I can resend it. Thank you

Reference 55

From: [redacted]
To: [redacted]
Cc: [redacted]
Subject: RE: Pain Management Leave Calendars
Date: Friday, December 11, 2020 4:43:23 PM
Attachments: image001.png

Dear colleagues,
Because pain management referrals to the community is the highest in the facility and is costing $5.5 million, [redacted] has ordered that we must schedule F2F and procedures to 75% capacity immediately. The remaining 25% will be VVC. Telephone will only be for veterans who cannot use VVC due to lack of internet connectivity.
Telework for the Pain Section will have to be revoked.
We also need to change profiles to add appointments. We need to add slots for Wednesday morning in [redacted] clinic and for Friday afternoons for and [redacted] clinic, as well as the full day on Friday for [redacted]
With appreciation,
[redacted]

From: [redacted]
Sent: Friday, December 11, 2020 4:13 PM
To: [redacted]
Cc: [redacted]
Subject: RE: Pain Management Leave Calendars
My comments in red.

From: [redacted]
Sent: Friday, December 11, 2020 2:53 PM
To: [redacted]
Cc: [redacted]
Subject: RE: Pain Management Leave Calendars
I have some questions after digging into the data and profiles today and speaking with the front line AMSAS.

1. The front line AMSAs have been told that [redacted] only has clinic patients on Tuesdays but he actually has Proc slots open from 8-12pm and clinic from 1-4pm. They have only offered clinic slots on Tuesday since being told this. The clinic slots are in the VVC clinic and are currently booked out into February. Is there support of nursing, etc to have procedures on this day and if so why is it not being utilized?

[redacted] **is building his clinic. He has to see more new patients is whatever slots available to generate procedures. For now, he is utilizing the procedure clinic to get more new patients for procedures. AMSAs need to work along with doctors. It is unfortunate that we could not be at full capacity for many months due to the limitations that were imposed by**

COVID-19.

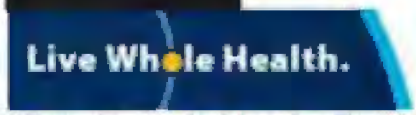
2. The AMSA were also told to only book in VVC clinics unless patient is adamant and wants a f2f visit. My understanding is this should be patient driven and that F2F is only limited to the 75% capacity. The patients have all voiced that they want F2F. Can the AMSAs be told to offer F2F from here on out? [redacted] first appt for a F2F clinic slot would be 2/18@3pm, [redacted] 1/26@8-12pm.

There are many advantages to the VVC clinic. To say the least, there are no administrative limitations imposed by the COVID-19. This is a provider preference, and is highly recommended to develop by the VHA. No patient is ever denied a F2F consultation. I am including [redacted] in the email. My preference is VVC for consultations, every provider can state their preference.

3. [redacted] does not have a VVC clinic to be found anywhere in VSE. It says Tem on this schedule but that clinic does not exist either. I will put in for a clinic to be built for him as it doesn't sound like he has been using one.

I will be switching all these clinics to WHS from SUR but the slots and current standing appts will all stay the same. I'm aiming for January for them to make that switch. Just putting this out right now as FYI as it is coming.

[redacted]
Whole Health Program Manager [redacted]
Central Texas Veterans Healthcare System
[redacted]



"People are fed by the Food Industry, which pays no attention to health, and are healed by the Health Industry, which pays no attention to food." [redacted]
"Let food be thy medicine and medicine be thy food"-- [redacted]

From: [redacted]
Sent: Friday, December 11, 2020 1:28 PM
To: [redacted]
Cc: [redacted]
Subject: RE: Pain Management Leave Calendars

Re-attached with phone numbers as well.

From: [redacted]
Sent: Friday, December 11, 2020 9:29 AM
To: [redacted]
Cc: [redacted]
Subject: RE: Pain Management Leave Calendars

Thank you. I've attached the document. THX

From: [redacted]
Sent: Friday, December 11, 2020 9:01 AM
To: [redacted]
Cc: [redacted]
Subject: FW: Pain Management Leave Calendars
Importance: High

I am resending "Approved" Pain Management Providers Leave Calendar again.

AMSAs,

- Please fill all our Pain Management clinics to capacity, in accordance with the administrative limitation/recommendations for the COVID-19.
- Please block our Pain Management clinics when we are on "approved" leave. Please see the attached "CLINIC SCHEDULES_PAIN SECTION" to know what clinics to block. Please note that the VVC clinics are daily clinics for each provider even if they do not show as daily on the attached schedule. These need to be blocked also so we do not inconvenience our Veterans.

[redacted]

Kindly fill in your portion of the attached, "CLINIC SCHEDULES_PAIN SECTION" and send to me for distribution to all.

We must be vigilant to improve our Clinic Utilization data. Please let me know if you have any questions or corrections.

Sincerely,

[redacted]

Pain Management Clinic Provider Schedules:

From: [redacted]
Sent: Tuesday, November 24, 2020 7:34 AM
To: [redacted]
Subject: Pain Management Leave Calendars
Importance: High

Good morning,

I am attaching a Pain Management Section Leave Calendar for December 2020 and for the whole 2021. All approved leave has been entered. It is color-coded. Please note the following points:

1. I based the calendars on the information that you sent to me. Please review and correct me if entries are incorrect.
2. Plan ahead for your leave for 2021. Send to me your "Approved" leave so I may update this calendar.
3. Per [redacted] one of us three ought to be available at work on all work-days.
4. Leave may not be approved for a third person off on the same date unless it is a sick leave, an emergency, or approved by [redacted]

5. The only day when the three of us are off simultaneously is 12/24/2020, Christmas Eve. [redacted], if that is not okay by you, I shall have to cancel my leave on that date. Please let us know.
6. Please note that approval for clinic blocking by [redacted] must precede approval for Annual Leave on VATAS. Exceptions apply for Sick Leaves and Emergencies.
7. Please read the emails below for more information.

You may call me if you have any questions or suggestions about the attached calendars.

Sincerely,

[redacted]

From: [redacted]
Sent: Friday, November 20, 2020 8:47 AM
To: [redacted]
Cc: [redacted]
Subject: RE: Leave Requests

Thank you, sir.

One modification – leave requests should go to [redacted] unless he is on leave, in which case they should come to me. Please wait for approval before canceling clinics.

With appreciation,

[redacted]

From: [redacted]
Sent: Friday, November 20, 2020 8:11 AM
To: [redacted]
Cc: [redacted]
Subject: Leave Requests
Importance: High

Dear Colleagues,

Per the email below and the attached email by the chief of our service, [redacted], please note the following regarding leave requests:

1. I shall be managing your time and leave requests.
2. Kindly, submit to me a calendar of your currently approved leave (annual and sick) so I may assure that for future leave requests there is always one of us available to cover for the group as per [redacted] All currently approved leave remains.
3. Please plan ahead for your leave, because, "we are required to give 45 days' notice for annual leave to reschedule patients, to minimize disruption to patient care and access. Any shorter notice requires approval from Chief of Staff."
4. "each of you (us) are able to cover for anyone who is on leave... at least one of you (us) are on duty when others are on leave."
5. "Going forward, please contact me [redacted] before canceling any clinics for sick leave or annual leave."

Please let me know if you have any questions. I am adding [redacted] on this email for guidance and for corrections, if any.

Sincerely,

[redacted]

From: [redacted]

Sent: Thursday, November 19, 2020 1:59 PM
To: [redacted]
Cc: [redacted]
Subject: FW: (Updated) How to obtain VATAS Roles
Importance: High

[redacted]

As the section chief for pain management, you are expected to manage time and leave requests for [redacted]

If all of you are requesting leave for the same days during the holidays, Seniority can be invoke on only one occasion per year. Please explain this to the others.
Please complete the training described in the attachment and let me know when you have completed this.
Respectfully,

[redacted]

From: [redacted]
Sent: Thursday, April 30, 2020 3:28 PM
To: [redacted]

[redacted]

Subject: (Updated) How to obtain VATAS Roles
Importance: High

The attached document contains updated links for both the VATAS SharePoint Portal and our LEAF site. Please keep for future reference. Please share as needed. Thank you.

Respectfully,

[redacted]

Payroll Supervisor
Central Texas VA

[redacted]

To better assist you and to allow us the opportunity to complete the necessary research of your payroll requests and concerns, please click here: CTX LEAF Homepage to enter a LEAF request.

Reference 56

From: [redacted]
To:
Subject: OSC investigation --- veteran affected
Date: Tuesday, October 5, 2021 8:28:00 AM

Hello [redacted]

Here is a conversation/chat I just had with a colleague regarding a referral request.

I can see this consult being processed in different ways; I don't believe there is one "right way" on this one. As it had already been processed according to orders, I discontinued it.

The thing I really wanted to point out with this is that the **referring provider had no idea that the Whole Health Clinical Director is even involved in our consult processing.**

This all takes time out of the day to clarify...

[redacted]

//////////////////////////////////////

<Excerpt>

[12:53 PM] [redacted]
The referral was submitted after it was already previously forwarded to Neurolgy from Pain management on yesterday. Neurology consult notes requested Pain management referral so that vet can get CITC for botox injections with Pain Mgmt. **I am not sure why this would go to [redacted] for Whole Health?**

//////////////////////////////////////

<Transcript>

[12:45 PM] Unknown User [redacted] added [redacted] and [redacted] to the chat.

[12:45 PM] [redacted]
Good afternoon [redacted], regarding patient [redacted]. This patient was seeing CITC Neurology

at [redacted] for botox injections. [redacted] moved botox injections to pain management. Referral was submitted to Pain Mgmt with request and was then forwarded to Neurology for 3rd time. Neurology has agreed that patient can go to BSW Pain Mgmt for botox injection and referral was submitted for the 3rd time to Pain Management. Can you please review the consult notes from VA Neurology regarding necessity for Pain mangement referral for botox injections for CITC?

[12:49 PM] [redacted]
Hello [redacted], to my understanding, I have processed this consult according to instructions passed down to us via the chain of command.

[12:50 PM] [redacted]
I saw that you had submitted this ATTN: [redacted]

[12:50 PM] [redacted]
Have you reached out to discuss with him?

[12:50 PM] [redacted]
I do not know who [redacted] and did not submit to his attention

[12:51 PM] [redacted]
Aha. ok

[12:51 PM] [redacted]
Order Information to Service: TEM WHS OUTPT PAIN MANAGEMENT Attention: [redacted]

[12:51 PM] [redacted]
I pulled that from the order that was placed.

[12:51 PM] [redacted]
I wonder if it simply prepopulates it.

[12:51 PM] [redacted]
[redacted] is the Whole Health Clinical Director

[12:52 PM] [redacted]
As it stands, the Pain Management section is under Whole Health.

[12:52 PM] [redacted]
Perhaps your service chief and [redacted] may discuss together?

[12:52 PM] [redacted]
From my standpoint, I have processed the consult per the instructions given to me; I am not sure I can do anything else on this one.

[12:53 PM] [redacted]
The referral was submitted after it was already previously forwarded to Neurolgy from Pain management on yesterday. Neurology consult notes requested Pain management referral so that vet can get CITC for botox injections with Pain Mgmt. I am not sure why this would go to [redacted] for Whole Health?
Edited

[12:53 PM] [redacted]
Yes, I understand.

[12:53 PM] [redacted]
At some point, the Pain Management section was realigned under Whole Health

[12:53 PM] [redacted]
This was in October 2020.

[12:54 PM] [redacted]
It was not long after that that consults were processed as per the instructions [redacted] passed down to us.

[12:55 PM] [redacted]
I started here in December 2020. My concern is that the patient care is being delayed with forwarding referral care to Neurology as Neurology has stated pt may receive care in the CITC for Pain mgmt for botox injections. How can we resolve this for patient centered care?

[12:57 PM] [redacted]
I understan

[12:58 PM] [redacted] hority to process this otherwise, and I am sorry for that.
(1 liked)

[12:58 PM] [redacted]
I am thinking that your request to [redacted] may be a fruitful approach.
(1 liked)

[1:04 PM] [redacted]
Okay, thank you for your response. Hopefully [redacted] can assist and this patient may have care resumed
(1 liked)

[1:08 PM] [redacted]
Yes madam

[1:09 PM] [redacted]
Be well

From: [redacted]
To:
Subject: [redacted] wants to redact the part
Date: Tuesday, April 6, 2021 9:57:05 AM

[redacted]

Facility
Activity Date/Time/Zone Responsible Person Entered By

CPRS RELEASED ORDER 02/05/21 17:19 [redacted] [redacted]
PRINTED TO 02/05/21 17:19
CTX-PTPMRS3 (BIG)
DISCONTINUED 02/08/21 08:21 [redacted] [redacted]
Per my understanding: per [redacted], continuity of care for chronic pain only applies to follow-up for a procedural complication that is being treated at that community clinic or a procedure we do not do. Please discuss this consult request directly with [redacted] and CITC.

I could not locate the MRI C-/L-Spine within the last two years. Please obtain an MRI C-/L-Spine and then re-consult after the official report is available for review. If
the patient had prior surgery on his C-/L-Spine, then obtain an MRI C-/L-Spine
with and without contrast; unless contraindicated.

PRINTED TO 02/08/21 08:21
CTX-PTPMRS3 (BIG)

Note: TIME ZONE is local if not indicated

No local TIU results or Medicine results available for this consult

========== END ==========

Reference 57

VHA Handbook 1907.01 – Health Information Management and Health Records, March 19, 2015.

INTRODUCTION

Reference 58

Tuesday, February 18, 2014 7:22 AM

This Health Information Management (HIM) Guidebook provides direc ion and illustra ion for how to make corrections in Veterans Health Information Systems and Technology Architecture (VistA), Computerized Patient Record System (CPRS), and VistA Imaging (VI). Data entered in one location may send that data to multiple locations within the system. You must be aware of all of he locations data is sent and make corrections as appropriate. There are a variety of references that have been used as he basis for these corrections and you will find them located at the bottom of each subject. This comprehensive guide details op ions and scenarios for making edits or corrections where all the data resides. You can locate the appropriate reference either by tabbing through or using the 'find' feature and searching for a key term.

[redacted]

There may also be situa ions when a request to amend a record would be inappropriate, such as when someone requests a note be deleted (retracted) from the health record, when the documentation appears to be accurate, relevant and timely for the patient care that was provided. For example, Provider A is asked to remove a note by a supervising provider concerning withholding medications. When querying Provider A on the justification for removing the note, Provider A stated they could not give an explanation of why the note needed to be removed. After reviewing the content of the documentation, it appears the documentation accurately reflects the justification of withholding the medication. In these instances, a second review should be conducted by the Facility Patient Safety Manager, the Risk Manager, or other designee who can provide guidance on the possible impact that the removal of he specific documentation could have on patient care. In rare circumstances, it may be appropriate to contact your Regional Council after coordinating though your local chain of command.

Health information that has been received from external sources may need to be corrected. Per VHA Handbook 1907.01, Health Informa ion Management and Health Records, 19.b., a request to amend an external source document must be referred back to the original source. This includes Non-VA Purchased Care, Compensation and Pension examinations provided by contracted Non-VA providers, and data received through the VLER eHeal h Exchange. See also [redacted]

[redacted]

ADMINISTRATIVE CORRECTIONS OR AMENDMENTS TO CONSULT FIELDS

Tuesday, February 18, 2014 7:33 AM

Making corrections or amendments to the consult fields should be an infrequent occurrence. Prior to making any corrections, the Chief, Health Information Management or Privacy Act Officer must be notified. Per VHA Handbook 1907.01: An **administrative correction** is "remedial action by administrative personnel with the authority to correct health information previously captured by, or in, error. Administrative corrections include factual and transient data entered in error or inadvertently omitted. Administrative corrections are not initiated by the Veteran." And, an **amendment** is "the alteration of health information by modification, correction, addition, or deletion at the request of the patient or Veteran. A request to amend any data contained in VHA health records must be submitted in writing to the facility Privacy Officer, or designee, by the Veteran stating explicitly what information is in contention and why, i.e., inaccurate or erroneous, irrelevant, untimely, or incomplete". See VHA Handbook 1907.01, Health Information Management and Health Records, for further guidance.

Consult Comments, Reason for Consult, and other related fields do not have amendment functionality. FileMan write access to the REQUEST/CONSULTATION file (#123) is needed. Each of the consult activities is stored there so the individual making the correction will need to locate the field within the file to find the date/time this data was entered.

Amendment requests must be maintained by the Privacy Officer in accordance with specified retention requirements. Edits not related to amendment requests are also maintained with the before and after edits to the Consult fields, including who performed the edit and a justification of why the edit was made.

[redacted]

Reference 59

The most recent issuance of the VHA Directive 1230, on June 1, 2022 adds Stop Code 674 “Administrative Patient Activities” as exempt; this issuance rescinds the prior version published on July 15, 2016; it seems that “Administrative Patient Activities” refers to interactions that are “not an encounter and not requiring independent clinical judgment in the overall diagnosing, evaluating, and treating the patient's condition(s).” and are non-count interactions.

Reference 60

From: [redacted]
To: [redacted]
Subject: RE: [redacted] — The Assignment under Whole Health — Concepts and Programmatic Components
Date: Thursday, December 16, 2021 1:54:00 PM
Attachments: image001.png
image002.jpg
image010.jpg
image012.jpg
image013.jpg

Hello [redacted].

Well.

I think the issue — the one of confounding - - is one that characterizes this concerning approach thus far.

To be clear, I have no problem with the concepts of Whole Health. Separately, I don't have strong feelings about many of the CIH care modalities.

But how good is the science, the statistics?

I reviewed the Whole Health System of Care Evaluation – A Progress Report on Outcomes of the WHS Pilot at 18 Flagship Sites from 2/19/2020 some months ago.

I was struck by several observations. I include below charts/writing from the document with my queries below.

Here are the 2 broad categories defined:

Now, what determines what makes something a CIH?

If the treatments are not diagnosis-based, could a CIH not be anything someone feels increases their wellness?

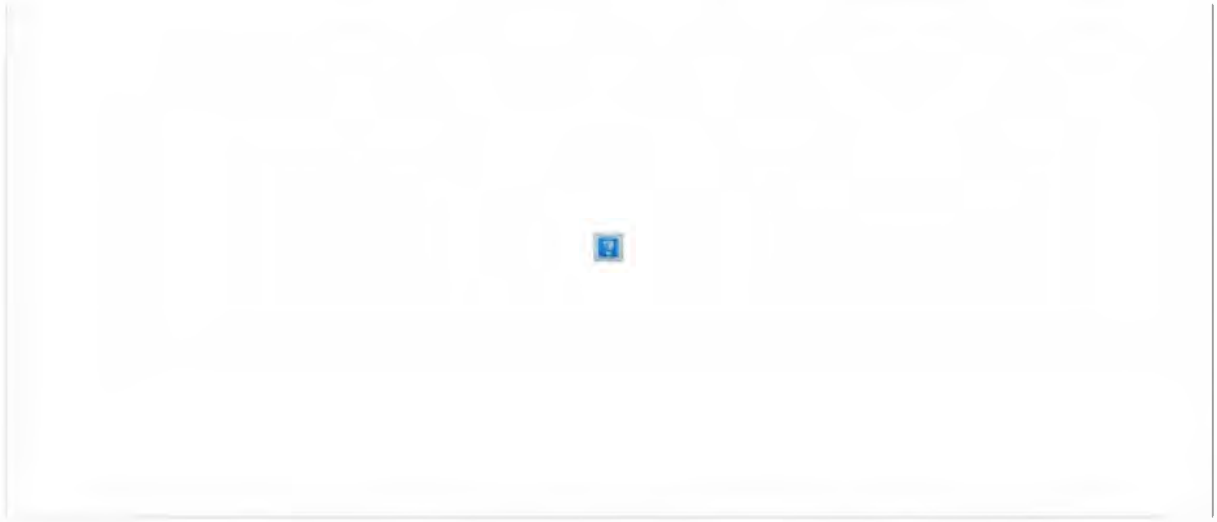
The question comes up: Could we achieve the same (wellness) goals in a more cost-effective manner if the services included on List 1 were instead made up of:

Alternate List 1

[redacted]

And could we achieve those goals more cost-effectively, re; new hires, clinic space required, scheduling personnel, repeat appointments, etc?

I am not posing the question facetiously. Instead I am pointing out a very real question that begs a real answer.



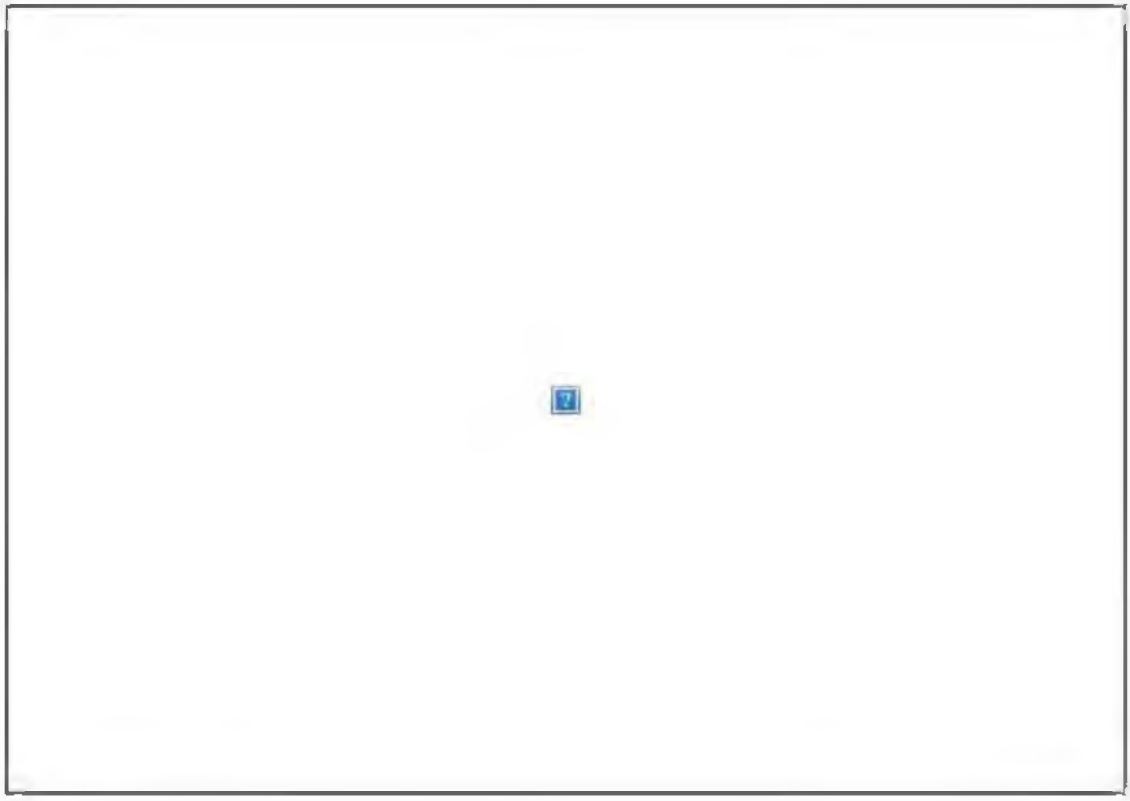
My question re: the above is: What is the value in double-counting re; the categories being overlapping. Granted, it is a survey to begin with, and we know it's not very statistically sound, but does this not skew the numbers and apparent success?
I don't think the fact ">=2" or ">=4" or ">=8" is arbitrary... is it?

If the selection of those numbers / set-points was not arbitrary, then one would assume this report would also showcase the **absolute numbers of visits.**

Was there a correlation with outcome or desired outcome simply with number of encounters or total time spent for all encounters for each veteran? Is it that the number of (?non-stressful) visits is actually the variable of interest, while these one/more other categories (which exhibit sewn-in collinearity or confounding amongst themselves) are actually the confounders?

It one would reasonably want to know the answer to that, then it should have been presented in the information.

Also, does this not insert a potentially spectacular degree of confounding between the (concept) and the (programmatic components) of Whole Health?



Let's look at the above:

No use – 141,361 unique veterans
Any 2+ WHS – 6,182 veterans (likely encompassing all of the numbers/categories listed below it as well due to use of overlapping categories)
Comprehensive – 583 veterans … that's all… (literally 0.4% of the no use category)…
If one feels comfortable concluding there was a practical change in pharmacy costs … well … I don't feel comfortable with that.
If anything, if one actually were to have disallowed the overlapping nature of the categories, "Any 2+ WHS" use either **correlated or probably correlated with increased pharmacy costs** compared to "No use" when the numbers were run; this concept begs the question:

- Are CIH List 1 (programmatic) components responsible for even any of the potential desirable change in pharmacy costs, or is any actual/potential desirable change in pharmacy costs **only due to "Core Whole Health" – – the concept** — and not at all to the CIH List 1 modalities (programmatic).
- Do the potential benefits boil down simply to a correlation with the number of those or even any visits (all counted)?

Same question:

- Do the potential benefits boil down simply to a correlation with the number of visits (all counted)?
- To be clear, as this was a survey, and per the report: "WHS service use or non-use may be associated with several factors, including an individual decision by a Veteran" --- also known as **Self-Selection bias.** If Whole Health is being sold as a way to decrease one's opioid usage, and one wants to decrease one's opioid usage, and therefore one chooses Whole Health, have we simply found a way to identify those veterans and take credit for their reduction, which itself may have been accomplished with the Alternate List 1 I presented earlier? Or perhaps Whole Health helped, but it was only the Core (concept) portion of it?

From 7.0 Conclusions:

"Implementation of the WHS is complex and takes time. Yet, the early findings from this evaluation demonstrate that when Veterans engage in WHS services, improvements in perceptions of care, engagement in care, and well-being are possible.

Critical to addressing the primary goal of CARA legislation, we observed a meaningful lower use of opioids amongst the most intensive WH users. **Although there may be other reasons for this decrease, it might be associated with the intended outcomes of WH: having better experiences with their providers, increasing engagement in care and improved self-management of their pain**. While we expect to see more meaningful outcomes over time, even these small improvements in pain are notable in this short time period – as are the improvements in self-reported physical and mental health."

It looks like the author(s) of the study recognized the potential importance of the confounding in the approach that they selected...

I am not asking these questions to take away from the (concept) or the (programmatic components) of Whole Health. (I myself refer folks for Yoga and Acupuncture), but I am pointing out that the confounding between the concept and the programmatic components is potentially

- Misleading.
- Very, very expensive... precooly millions and millions of dollars... more and more over time.
- A reason for why we may overlook the possibility that the value in Whole Health may simply be in having an increased number of human interactions/visits which are perceived to be "non-judgmental" or "non stressful"?
- A reason to further limit physicians' allowance to make these same in-roads with patients when it comes to scheduling? Instead of giving physicians the time to have positive human interactions/visits with patients, we simply keep pushing physicians for higher numbers while creating a section that offers Whole Health services while not being held to the same requirements as physicians (E-SSRS, med reconciliations, etc). In this way, Whole Health becomes a positive interaction for the patient, the physician interaction continues to suffer from what was taken from physicians long ago re: administrative approach to physicians (?managed care, etc), more and more numbers.
  - [redacted]
  - I (we) and others I've (we) have **being associated with Whole Health here at CTVHCS has been the single most stressful thing we have encountered in our careers**, after having lost weight when I joined on, I personally have gained over 20 lbs and become fairly depressed just trying to survive Whole Health here.

I am traditional medicine specialist.

I offer/d patient-centered care here well before I came aboard.

Branding patient-centered care as Whole Health does not change things for me.

But being under the Whole Health Service here at CTVHCS has been absolutely brilliant.

Sincerely,

[redacted]

From: [redacted]
Sent: Thursday, December 16, 2021 12:08 AM
To: [redacted]
Subject: RE: [redacted] – The Employment under Whole Health – Concepts and Programmatic Components

[redacted]

[redacted]

[redacted]

Suicide Prevention is Everyone's Business. *#BeThere*

From: [redacted]
Sent: Wednesday, December 15, 2021 8:33 AM
To: [redacted]
Subject: OSC — The Realignment under Whole Health — Concepts and Programmatic Components

Hello [redacted]

Recently, here is an MHV / veteran message to the Pain section. It is worth reviewing.

Of note,

1. I think there are potential benefits to the concept of patient-centered care which is supposed to characterize "Whole Health" (concept) and its incorporation into healthcare.
2. There are, in existence, complementary modalities ("programmatic components"), which are to be housed under a "Whole Health" (programmatic) section/service.
3. There is, in existence, traditional medicine, which, in my opinion, is NOT to be housed under complementary care... by definition and by being diagnosis-led (programmatic).
4. Number (2) should NOT be made to seem as if it has greater claim to (1) than does (3). Complementary care modalities (programmatic) are by no means more patient-centered (concept) than traditional medicine (programmatic).

Now, here is the message from the veteran below. It is all interesting to read ... I suppose there can be folks that have allergies to egg or dairy, at least... in any case... I am curious as to the lab standards where the veteran had her labwork done...

I have also attached a publication --- what appears to be a position statement "Approved by the Executive Committee of the American Academy of Allergy and Immunology" ... from 1986...

The confounding of the Whole Health concept with the Whole Health programmatic components is misleading and in my opinion dangerous. Sometimes confounding also causes us to repeat mistakes of the past.

Please see attached and below...

Sincerely,

[redacted]

Sent: [redacted]
From: [redacted]
To:
Message ID#:
Subject: [redacted]

Hello,

I am starting a new whole health program [redacted]

Based on my lab results, [redacted]

Also, I would benefit from the following supplements [redacted]

Clean gut probiotic

[redacted]

Vitamin D

[redacted]

magnesium citrate powder [redacted]

[redacted]

Estrogen Balance

[redacted]

Daily Nutritional support vanilla [redacted]

[redacted]

Full spectrum magnesium

[redacted]

Activated b complex

[redacted]

Gluco support

[redacted]

Finally, I'm to avoid the following foods for up to 6 months.

[redacted]

[redacted] (avoid these foods for 6 weeks)

[redacted] (avoid these foods for 12 weeks)

[redacted] (avoid these foods for 6 months)

[redacted] if any of their suggestions I'm unable to move forward with. Also, [redacted] time and collaboration as I start this new journey.

[redacted]

Reference 61

VHA Directive - 1137 Provision of Complementary and Integrative Health (CIH)

Reference 62

From: [redacted]
To:
Subject: OSC investigation — Whole Health Clinical Directorship and Realignment as a backdoor
Date: Tuesday, October 5, 2021 8:33:00 AM

Hello [redacted],

Did the CTVHCS facility Director and CoS comply with:

VA HANDBOOK 5005/1 PART II APPENDIX H1

"If the candidate is board certified in an appropriate specialty or specialties, the Chief of Staff or designee discusses the proposed selection with the appropriate VA Central Office program official who may provide comments or recommendations concerning the proposed selection within 5 working days. For candidates who are not board certified or who are certified in a specialty or specialties not appropriate to the proposed assignment, the Chief of Staff or designee will forward the candidate's curriculum vitae, employment application and credentialing/privileging information to the **Office of Patient Care Services** (11), which will provide comments concerning the proposed selection **within 15 working days**.

- [redacted] the Clinical Director of Whole Health Services, is **not** Board Certified in Pain Management and has been holding himself out to staff and colleagues here as someone who offers "State of the Art" (his own words) Pain Management.

Did the assignment of [redacted] to the Clinical Directorship of Whole Health Services **with the Realignment of the Pain Management Section under the Whole Health Service** function to allow facility leadership to backdoor a new Pain Management Service chief into the position?

[redacted]

From: [redacted]
To:
Subject: OSC investigation --- Whole Health clinical control over Pain Management
Date: Tuesday, October 5, 2021 8:30:00 AM
Attachments: Viruses__Buprenorphine Increases HIV-1 Infection In Vitro but Does Not__2021.pdf

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Hello [redacted]

I wanted to pass along this article; please see attached.

I want to highlight:

"**Conclusions:** our results suggest that buprenorphine, in contrast to morphine or methadone, increases the in vitro susceptibility of leukocytes to HIV-1 infection but has no effect on in vitro HIV reactivation. These findings contribute to our understanding how opioids, including those used for MAT, affect HIV infection and reactivation, and can help to inform the choice of MAT for people living with HIV or who are at risk of HIV infection."

I have not reviewed this article for accuracy of statistical analysis and/or robustness, methodologies, etc; this may be better left to member(s) of the OMI team, although that exercise itself is not the point.

I want to put this forth as a Proof of Concept –- I am not saying that this result strictly translates from the "bench to the bedside":

- When discussing MAT for OUD in those who are at risk for HIV infection, is the choice of Buprenorphine over Methadone clear cut? Or could it maybe even be riskier to the patient in certain circumstances?

- When discussing the treatment of Chronic Pain, is the choice of Buprenorphine over Methadone or Morphine clear cut? Or could it maybe even be riskier to the patient in certain circumstances?

The Pain Management section was realigned under Whole Health Services with coercion of the Pain Management specialists as a key reason for the realignment — did those individuals in the supervisory chain above my 1st line

supervisor understand the ramifications of what they were coercing with their approach to Buprenorphine and to us?

Has CTVHCS treated the Veteran right?

Was the Veteran placed first here, or last?

Sincerely,

[redacted]

From: [redacted]
To: [redacted]

Subject: OMI — The Realignment under Whole Health — Concepts and Programmatic Components
Date: Wednesday, December 15, 2021 8:34:00 AM
Attachments: Candidiasis Hypersensitivity Syndrome _ 1986.pdf

Hello OMI team,

Recently, here is an MHV / veteran message to the Pain section. It is worth reviewing.

Of note,

1. I think there are potential benefits to the concept of patient-centered care which is supposed to characterize "Whole Health" (concept) and its incorporation into healthcare.
2. There are, in existence, complementary modalities ("programmatic components"), which are to be housed under a "Whole Health" (programmatic) section/service.
3. There is, in existence, traditional medicine, which, in my opinion, is NOT to be housed under complementary care... by definition and by being diagnosis-led (programmatic).
4. Number (2) should NOT be made to seem as if it has greater claim to (1) than does (3). Complementary care modalities (programmatic) are by no means more patient-centered (concept) than traditional medicine (programmatic).

Now, here is the message from the veteran below. It is all interesting to read ... I suppose there can be folks that have allergies to egg or dairy, at least... in any case... I am curious as to the lab standards where the veteran had her labwork done...

I have also attached a publication — what appears to be a position statement "Approved by the Executive Committee of the American Academy of Allergy and Immunology" ... from 1986...

The confounding of the Whole Health concept with the Whole Health programmatic components is misleading and in my opinion dangerous. Sometimes confounding also causes us to repeat mistakes of the past.

Please see attached and below...

Sincerely,

[redacted]

Sent: [redacted]

From: [redacted]

To:

Message ID#:

Subject: [redacted]

Hello,

I am starting a new whole health program [redacted]

Also, I would benefit from the following supplements [redacted]

Clean gut probiotic

[redacted]

Vitamin D

[redacted]

magnesium citrate powder [redacted]

[redacted]

Estrogen Balance

[redacted]

Daily Nutritional support vanilla [redacted]

[redacted]

Full spectrum magnesium

[redacted]

Activated b complex

[redacted]

Gluco support

[redacted]

Finally, I'm to avoid the following foods for up to 6 months.
[redacted]

[redacted] (avoid these foods for 6 weeks)

[redacted] (avoid these foods for 12 weeks)

[redacted]
(avoid these foods for 6 months)

[redacted] if any of their suggestions I'm unable to move forward with. [redacted] time and collaboration as I start this new journey.

[redacted]

From: [redacted]
To: [redacted]
Subject: OMI — FW: Whole Health Implementation — Service Lines
Date: Tuesday, August 10, 2021 12:29:00 PM
Attachments: WH ImplementationGuide_March2019_Version3_FinalA.pdf

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From: [redacted]
Sent: Wednesday, February 24, 2021 4:31 PM
To: [redacted]
Subject: Whole Health Implementation — Service Lines

Hello,

None of the following mentions establishing Whole Health to take over an existing service line.

//

3.2.2 Service Line to Support Whole Health

The Whole Health System and the term 'Whole Health' includes the entirety of the healthcare system (i.e., every encounter the VA makes with the Veteran)

- • The concept of Whole Health should not be isolated to one specific service line but instead is the transformation of care in every service line within a VA facility

The Whole Health System *does* have programmatic components, including Pathway programming and Well-Being Programming, often staffed by many CIH and Well-Being roles (e.g., Whole Health partners/peers, health coaches, well-being class facilitators, and CIH providers). Additionally, the transformation of an entire organization into the Whole Health culture requires concerted effort from leaders and administrative staff dedicated to support the Whole Health transformation. When hiring Whole Health leaders (e.g., Whole Health clinical director, Whole Health program manager, etc.), Whole Health administrative staff, and CIH and well-being providers, it is up to the facility to decide the appropriate organizational structure for these new staff members. Options for consideration:

- • **Option 1: Utilize Established Service Line(s):** Whole Health leaders, Whole Health administrative staff, Pathway staff and Well-Being Program staff **could be housed within an established service line (e.g., PACT, PM&R), especially if the service line leadership is supportive and willing to share resources.** Whole Health leaders would not only supervise Pathway and Well-Being Program staff but also lead the Whole Health transformation across the organization. Additionally, Pathway and Well-Being Program staff could provide CIH and well-being approaches within these programs and could be deployed across the organization to provide these approaches in other service lines as well.

- • **Option 2: Create a New Service Line:** Whole Health leaders, Whole Health administrative staff, Pathway staff, and Well-Being Program staff could be **housed within a new service line. Possible service line names include: CIH & Well-being, Well-being, or Whole Health Operations**. Regardless of the name, it is essential that the intention of this service line is not only to house the programmatic pieces of the Whole Health System (i.e., Pathway and Well-Being

programming and staff) but also to support the rest of the organization in its

• Whole Health transformation. Thus, Whole Health leaders would not only supervise Pathway and Well-Being Program staff but also lead the Whole Health transformation across the organization. Additionally, Pathway and Well-Being Program staff could provide CIH and well-being approaches within these programs and could be deployed across the organization to provide these approaches in other service lines as well. • The following considerations may be helpful in deciding which option is best for your facility: ▪ It is not mandatory to have a new service line in order to fully implement the Whole Health System.

• ▪ Whole Health leaders, Whole Health administrative staff, Pathway staff and Well-Being Program staff could be initially housed within an established service line and then move into a new service line when the site determines the need for extra infrastructure and administrative oversight for Whole Health staff.

• ▪ A new service line to support Whole Health transformation provides administrative oversight and mentorship to Whole Health staff.

- ▪ As described above, ideally, if creating a new service line to support Whole Health transformation, staff would not only provide care within that service line but also be deployed across the enterprise to support Whole Health activities in other service lines (similar to nursing services and OI&T). o For example, a yoga instructor from the new service line could provide a yoga class within the pain clinic versus the pain clinic hiring a yoga instructor within their service line to provide this class.
- o There is a cost benefit to implementing CIH and well-being services this way. The cost per encounter decreases in this scenario because these services do not assume the more expensive overhead costs of other service lines. For example, healing touch within palliative care can have a high cost per encounter because of the overhead cost associated with palliative care. However, if a well-being provider was to be deployed from the new service line to provide healing touch in this instance, a different overhead cost would be associated with the encounter and the cost per encounter would decrease.
-
-
-

From: [redacted]
To:
Cc:
Subject: OMI --- Progression of Events
Date: Monday, August 16, 2021 8:51:00 AM
Attachments: VHA_NOTICE_2020_30_Buprenorphine_Prescribing_For_Opioid_Use_Disorder.pdf
PAIN MANAGEMENT BEST PRACTICES_PMTF_final_report_2019-05-23.pdf

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[redacted]

Please see attached **VHA Notice 2020-30 Buprenorphine Prescribing for OUD.**

Please see attached (non-VA document) **PAIN MANAGEMENT BEST PRACTICES INTER-AGENCY TASK FORCE REPORT FROM 2019**:

- Please note the following excerpt/recommendations from the PMTF 2019 document:

"

Barriers include lack of coverage and reimbursement for buprenorphine as well as the lack of education and training on the proper usage of buprenorphine. There has been a lack of access to buprenorphine treatment for chronic pain.

• RECOMMENDATION 4A: Make buprenorphine treatment for chronic pain available for specific groups of patients, and include buprenorphine in third-party payer and hospital formularies.

• RECOMMENDATION 4B: Encourage CMS and private payers to provide coverage and reimbursement for buprenorphine treatment, both for OUD and for chronic pain. Encourage primary use of buprenorphine rather than use only after failure of standard mu agonist opioids such as hydrocodone or fentanyl, if clinically indicated.

• RECOMMENDATION 4C: Encourage clinical trials using buprenorphine for chronic pain to better understand indication, usage, and dosage.

"

I am sure that I do not have to point out that the juxtaposition of "Encourage primary use of buprenorphine" with "Encourage clinical trials using buprenorphine for chronic pain to better understand indication, usage, and dosage" serves as a point of curiousness.

Which is it? Should it be encouraged for primary use, or do we need to know more about the basics?

An independent provider could and should consider Buprenorphine as an option for opioid treatment for whatever diagnosis is made, if within the spectrum of what is indicated, true, but whether prescribing this particular medication should be forced on any provider is a question that comes up. An ongoing concern of mine is that what is going on here at the

facility level, which differs from that delineated in the afore-mentioned documents:

Coercion of the (specific) pain providers to prescribe specific opioids ... with an undetermined indication or someone else's personal interest/preference, no less ... and further, this is enacted via the Whole Health Service.

Please note the following progression:

1. [redacted] has kept his clinic grid closed from the beginning of his employment here, even though multiple providers asked him about this and even though multiple providers asked him how to consult him via CPRS. One of our very first questions to [redacted] when we met him for the first time in 2020 was "How do we consult you?"

2. Furthermore, even though our CoS, [redacted], has been aware of this for many months now, only recently has [redacted] seemingly taken any action to cause [redacted] to open his grid.

3. Despite the above, [redacted] has seemingly been performing unrequested consultations on veterans, of his own choosing. Some he billed/coded encounters for, some he didn't.

4. [redacted] billed/coded such self-consultations on veterans who had administrative requests, some of which were generated by [redacted] own actions of denying them community care requests which were made on their behalf for their best medical interest by their clinical care team(s).

5. Solicitation of Complaints: [redacted] has used the administrative requests and concerns of veterans to not only perform these self-consultations, but to generate complaints against me, as he is aware that I am a whistleblower.

6. Performance Pay for 2021 altered from its prior-to-[redacted] requirements, by [redacted], on 12/28/2020 to indicate:
   a. "Obtain X-waiver and manage 5 patients with concurrent chronic pain and complex persistent opioid dependence using appropriate medications" — to obtain 20% of the bonus (which I overtly disagreed with).
   b. "No greater than 3 documented complaints from staff or patients during the fiscal year" --- to obtain 10% of the bonus.

7. OPPE changes: In spite of the fact that [redacted] cannot simply change my job description, he has now made it part of the OPPE that we are to prescribe opioids; throughout this past year, he has made it clear on numerous occasions to numerous colleagues that the only

opioid he would really consider is Buprenorphine; so not only do we lose Performance Pay for not allowing him to practice through our hands, but we lose our jobs. In fact, by creating certain clinical situations, or even by simply choosing to view matters in a predetermined, negative fashion, [redacted] can have someone else, beknownst or unbeknownst to such a 3rd party, perform FPPEs on us at his behest, so that he does not appear to be responsible... and then we lose our jobs.

8. Performance Pay for 2021 altered from [redacted] 12/28/2020-issued document, by [redacted], on 7/20/2021 to indicate:
   a. Removal of "Obtain X-waiver and manage 5 patients with concurrent chronic pain and complex persistent opioid dependence using appropriate medications" --- which I have reason to believe is a direct result of ongoing investigation occurring because of me; — (to obtain 0% of the bonus).
   b. Change to "No greater than 2 documented complaints from staff or patients during the fiscal year" --- to obtain 25% of the bonus; which is a %increase from prior.

9. Performance Pay for 2021 altered from [redacted] 7/20/2021-issued document, by [redacted], on 7/22/2021 to indicate:
   a. Removal of "Obtain X-waiver and manage 5 patients with concurrent chronic pain and complex persistent opioid dependence using appropriate medications" --- which I have reason to believe is a direct result of ongoing investigation occurring because of me; — (to obtain 0% of the bonus).
   b. Change to "No greater than 2 documented complaints from staff or patients during the fiscal year" --- to obtain 25% of the bonus.
   "No greater than 3 documented complaints from staff or patients during the fiscal year," although keeping the percentage increase for that parameter at 25%. (Thus far, [redacted] has only held any complaints against me, not the other Pain Management section physicians).

10. [redacted] has been forcing consults to come to Whole Health via the Realignment of the Pain Management section under Whole Health. Using his position, he has inserted himself into the care and even performed/completed consults that are requested of the Pain Management section, even though, to my best understanding, he has not met the hiring criteria for Pain Management specialists here at CTVHCS; he has not been held to the same standard. Nonetheless, he has used consult requests to our section to generate Pain Management treatment plans, billing/coding for the interaction and closing/completing the consult in doing so.

11. In performing consultation in this fashion, [redacted] is coming up with the treatment plan, and functioning as the medical-decision maker. By not being diligent in his follow-through and follow-up, his treatment plan may well be forced onto other independent providers, without their agreement, when the veteran shows up for a follow-up appointment. That way, if the veteran gets mad/complains/becomes hostile/violent to themselves or to other providers, the providers will feel coerced to enact [redacted] plan/preference for management, or receive complaints, discipline, or other harm.

Soon after the Pain Management section was realigned under the Whole Health Service, [redacted] instructed me to meet with him. He denied me the presence of my 1st-line supervisor for the meeting. On the day that I had met with [redacted], 10/23/2020, [redacted] stated to me that our Chief of Staff, [redacted], made the decision to move the Pain Management section under Whole Health, but that before finalizing the decision, he pulled the service chiefs.

The decision to realign the Pain Management section was done without the input of any of the Pain Management section physicians here at CTVHCS. This decision was forced upon our section, even though we are obvious stakeholders. It was not afterwards that [redacted] began to exhibit the peculiar behavior of implying clinical skill deficits on my part, soliciting complaints against me, and changing our Performance Pay criteria. It is accurate to state that [redacted], a federal employee, has offered federal monies to the Pain Management section physicians, also federal employees, to provide opioids to veterans for the non-covered service of treating the non-validated entity "Complex Persistent Opioid Dependence," a proposed entity that is cited in **only 2 citations** out of over **32 million citations** for biomedical literature catalogued within Pubmed — an entity which we were not hired to treat and which I do not agree with.

At some point, thereafter, he put changes into our OPPE, that in conjunction with his own agenda regarding usage of Buprenorphine, coerce us to distribute opioids for his indication and belief set. He has already stated his desire to request an FPPE on me, and he has indicated a desire to utilize OPPEs to generate FPPEs. In the meantime, [redacted] has used and is using his position as the Whole Health Clinical Director (over the Pain Management section), and the chairmanships of the Pain Oversight Committee and the Pain Management Team, given to him by our CoS, to alter facility policy to match his clinical opinions and to force them upon CTVHCS medical providers; simultaneously, he has misrepresented the Pain Management section providers to our provider colleagues, causing us to look worse in our profession and to our colleagues, at times, having provided himself a scapegoat for the actions that he has undertaken here at CTVHCS. I have already had providers communicate blame to me in regards to how consults were being processed; strained relations between the Pain Management section providers and the other providers here is a predictable endpoint.

Failing the above, our section continues to be presided over by [redacted] who states to veterans his plan/preference for management; should he not follow through or follow-up, his management is then forced through our hands, lest we receive complaints, discipline, or other harm, all the while, our veterans will be experiencing frustration, anger, and resentment.

I think about the chart redactions, and how [redacted] has indicated that these were instructed by our CoS, [redacted], on the topic of consult processing, and bringing veterans back from the community, and how said consult processing affected veterans care so as to destabilize it -- whether they had been on opioids or receiving interventional procedures, or both/other.

When I think about all of the above, I cannot help but think back to when I first met [redacted] prior to the realignment, indicating to him that it was great to meet him. And I think to when my 1st-line supervisor expressly asked him how we can consult him, and how [redacted] answered that his clinic had not been set up yet. I consider now that the plan of our CoS, even then, may well have been to never have had a separate clinic set up for [redacted], and that this is why our CoS relayed no disagreement and took no action to have [redacted] open up even small portions of his clinic grid for scheduling until more recently.

The actions taken above seem to support the notion that the supervisory chain above my 1st line supervisor sought from the start to act through our hands and wipe away any trace of it -- as if it never happened. This does not seem right to me, and it does not seem right to our veterans.

Sincerely,

[redacted]

From: [redacted]
Sent: Friday, July 30, 2021 3:45 PM
To: [redacted]
Subject: FW: [EXTERNAL] Fwd: Autoimmunity class replay and downloads (links inside)

From: [redacted]
Sent: Friday, July 30, 2021 3:42 PM
To: [redacted]
Subject: [EXTERNAL] Fwd: Autoimmunity class replay and downloads (links inside)

[redacted]

Begin forwarded message:

From: [redacted]
Date: July 30, 2021 at 2:08:58 PM CDT
To: [redacted]
Subject: Autoimmunity class replay and downloads (links inside)
Reply-To: [redacted]

[redacted]

Holy smokes! We had over 3,400 people attend the class I offered last night, [redacted] **Natural Remedies for Autoimmunity**, and the feedback has been incredible.

I want to be sure that all of you—not just those who attended live—have a chance to watch this session, because it truly has the potential to change your life if you have an autoimmune condition.

You can watch the full replay until this Sunday, August 1, at **midnight Pacific Time**.

[redacted].

Given the huge turnout last night, it's clear that there's a pressing need for a more holistic and effective approach to autoimmune disease. I'm so grateful for the opportunity to share my Functional Medicine perspective on treating autoimmunity with you.

Here's your link once again: [redacted]

In health,

[redacted]

P.S. Remember, the replay will be available only until [redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted] My Top 3 Natural Remedies for Autoimmunity with [redacted]

What if you could partner with, and heal, your autoimmune condition – *instead of fighting an endless uphill battle?*

Whether you've been diagnosed recently with an autoimmune disease (AID) or have been struggling with one for a while, chances are you're

- **Confused**, overwhelmed, or uncertain about what to do
- **Frustrated** with the lack of support
- **Concerned** about the side effects and risks of the medications you're taking
- **Looking** (and looking) for alternatives to treat your condition more naturally

..Chances also are that your doctor doesn't know how to do that—and believes drugs are your only option

What's wrong with the conventional approach?

Not only are conventional treatments ineffective; they're often dangerous.

The most common—powerful steroids and biologic drugs—simply suppress the symptoms without addressing the underlying causes, all of which carry serious side effects and risks.

What this translates to:

A lifetime of multiple medications. Endless hours in the doctor's office. Not to mention —helplessness, frustration, and despair.

If this sounds like you, you're not alone.

[redacted]

[redacted]

of functional medicine and ancestral health. Its mission is to provide the next generation of functional health practitioners and coaches with the skills, tools, and training they need to turn the tide of chronic disease—and change the future of medicine.

[redacted] offers two signature programs—[redacted]

[redacted]

The [redacted] represents a collaborative model of care that integrates Functional Medicine with an ancestral, evolutionary perspective, allowing practitioners and coaches to:

- **Prevent and reverse** chronic disease, instead of just managing it
- **Offer a vital (and often missing) layer of support** to help your patients or clients make lasting diet, lifestyle, and behavior changes
- **Play a part in reducing healthcare costs** for governments, organizations, and individuals
- **Work as part of a collaborative network** of practitioners, health coaches, and allied healthcare providers who support your goals
- **Embrace and build** an inspiring, meaningful, rewarding career

To date, [redacted] has trained more than 7,000 health professionals around the world, serving clinicians and health coaches who want to *truly* make a difference in the lives of their patients and clients—and play a pivotal role in shifting from outmoded, conventional methods to a new paradigm that draws on the following two pillars:

- **Functional Medicine**, which seeks to treat the underlying cause of disease, rather than simply suppressing symptoms
- **Ancestral nutrition and lifestyle**, which resolves the mismatch between our genes, our biology, and our modern environment
- **Health coaching**, which seeks to support and empower people to make sustainable lifestyle and behavior changes
- **A collaborative practice model** that links health coaches with licensed providers to better serve patients and create more sustainable practices

Our comprehensive virtual training courses are presented by [redacted] along with his faculty of world-renowned team of clinicians, coaches, and other health professionals, all of whom deliver insights into how to build and manage an effective practice or coaching career while integrating Functional Medicine and ancestral health. Graduates of [redacted] don't just learn a set of skills, but join an interconnected and vital community of practitioners and health coaches who have been trained in the same paradigm.

Together, we can reinvent healthcare and turn the tide of chronic disease [redacted] Our video itself a critical force in helping mission-inspired health professionals become part of the revolution — and change the face of modern medicine.

Faculty

Our faculty consists of experts and thought leaders in functional medicine, health coaching, behavior change, motivational interviewing and evidence-based medicine among other fields. To see the full list of faculty members and learn more about their background and expertise please visit this page.

Creator and Executive Director

Program Director

Faculty Member

Faculty Member

Reference 63

From: [redacted]
To: [redacted]
Subject: RE: pain clinic
Date: Wednesday, November 3, 2021 12:47:41 PM
Attachments: image002.gif

You are welcome. Yes I thought Pain MDs needed to be informed to what was going on as it will impact you at some level

[redacted]

From: [redacted]
Sent: Wednesday, November 3, 2021 12:41 PM
To: [redacted]
Subject: RE: pain clinic

Thanks for letting us know [redacted]

If not for your informing us, we would have been left to guess as to the disposition of those veterans' appointments which had been scheduled with you...

I am not sure what [redacted] FY21 ECF has to do with you having been assigned duties you were not hired/trained for? I had to re-read this a few times to make sure I understood.

Be well

[redacted]

From: [redacted]
Sent: Tuesday, November 2, 2021 2:16 PM
To: [redacted]
Subject: FW: pain clinic

FYI

From: [redacted]
Sent: Tuesday, November 2, 2021 2:15 PM
To: [redacted]
Cc: [redacted]
Subject: RE: pain clinic

Perhaps a Whole Health Integrative Medicine Clinic should have been established to address pain from a more comprehensive approach which would have been outside the realm of interventional pain procedures? Perhaps a different clinic with a different consult?

[redacted]

From: [redacted]
Sent: Tuesday, November 2, 2021 2:04 PM
To: [redacted]
[redacted]
Cc: [redacted]
Subject: pain clinic

PSB met today.

It was decided that, because the consult order is currently set up specifically as an interventional pain management consult, even though we have been stuck with this order due to multiple obstacles to implementation of changes intended to address the needs of Veterans with chronic pain from an interdisciplinary, holistic approach (which was the task assigned to us in the FY21 ECF), [redacted] was assigned duties that [redacted] was not trained for, i.e.: the evaluation of patients for interventional procedures.

As [redacted] is transferring back to the Ambulatory Care Service on 11/29/21, we will not have time to provide [redacted] more training to do this before [redacted] leaves.

Because of this, any new consults on [redacted] schedule need to be rescheduled with other providers. [redacted] can continue to see patients for follow up for non-interventional pain management until [redacted] leaves. Future follow up will need to be with other providers.

[redacted]
Clinical Director, Whole Health and Integrated Health Service
Central Texas VA Healthcare System

[redacted]

From: [redacted]
To: [redacted]
Cc: [redacted]
Subject: Re: Privilege Concerns
Date: Thursday, October 21, 2021 10:53:29 AM

Thank you [redacted] for clarifying that I will no longer be filling the role of Specialty Pain NP and will not be seeing new patient consultations for Pain Clinic – since the consultation form clearly states that those patients are expecting to be evaluated for consideration for pain interventional procedures and they are expecting to be seen by a Pain Specialty provider and not a Whole Health/ General Practitioner NP. I believe that is exactly what you said below; I am not credentialed to work as a Pain Specialty NP and that is not the position I was hired for.

[redacted]

From: [redacted]
Sent: Tuesday, October 19, 2021 4:52 PM
To: [redacted]
Cc: [redacted]
Subject: Re: Privilege Concerns

The privileges that were requested are for the Whole Health NP position. We are not requiring you to do interventional pain management procedures. What is expected is simply the evaluation of patients with chronic pain from a holistic perspective, and which can be done by any patient-centered generalist. The only thing different is the BFA. I was not aware of the fact that this was still pending until I logged into VetPro for another provider, so I signed off it when I saw it.

[redacted]

[redacted]
Clinical Director, Whole Health and Integrated Health
Central Texas VA Healthcare System

From: [redacted]
Sent: Tuesday, October 19, 2021 4:17 PM
To: [redacted]
Cc: [redacted]
Subject: RE: Privilege Concerns

Just to clarify, the BFA privileges that I completed my documentation and requirements for in July was just signed by [redacted] on Oct 8, 2021 so I still am not privileged for BFA?

And also, I was not hired as a Pain Specialist NP and am not requesting these privileges. I want to function in the job I was hired for in Whole Health.

Thank you,

Reference 64

VA-OIG REPORT #21-03339-208 - Deficiencies in Facility Leaders' Oversight and Response to Allegations of a Provider's Sexual Assaults and Performance of Acupuncture at the Beckley VA Medical Center in West Virginia, July 26, 2022.

Reference 65

Department of Veterans Affairs

Memorandum

Date: JUL 05 2017

From: Co-Chairs, Whole Health Experience Committee (10NE)

Subj: Complementary and Integrative Health Approach Recommendations (VAIQ 7811817)

To: Acting Under Secretary for Health (10)

1. The Department of Veterans Affairs (VA) is shifting the current culture of health care from problem-based "sick care" to "whole health care," which engages and inspires Veterans to their highest level of health and well-being. The Office of Patient Centered Care & Cultural Transformation (OPCC&CT) and the Whole Health Experience Committee (WHEC) have worked with Veterans Health Administration (VHA) leaders and clinical champions across the system to work towards this transformative goal. One aspect of this mission includes the promotion of complementary and integrative health (CIH) approaches within the VA health care system. CIH approaches promote self-healing and complement conventional (or allopathic) medical approaches to support Veterans on their path to health and well-being.

2. The WHEC is requesting your review and approval of our recommendations for the following CIH approaches to be considered appropriate for use as part of a Veteran's plan for treatment or for general health and well-being. These recommendations are based on review by the Integrative Health Coordinating Center (IHCC) Advisory Workgroup which concluded that the CIH approaches below are safe, and have sufficient evidence of benefit to be recommended as appropriate components of care for the Veteran population. For a list of previously approved approaches, please see SharePoint link here: [redacted]

3. This approval will allow the following approaches to be added to list 1 of VA approved approaches per VHA Directive 1137, *Provision of Complementary and Integrative Health*. This list of CIH approaches must be made available to Veterans across the system, either within a VA medical facility or in the community. Until the new Community Care contract is in place any CIH approaches provided by non-licensed providers will only be available through the facility or via telehealth, not through Community Care. IHCC will continue to work closely with the WHEC to set clear standards regarding specific indications, frequency, and duration of treatment for these CIH approaches. To download VHA Directive 1137, please see SharePoint link here: [redacted]

4. The following are the recommendations from the WHEC regarding specific CIH approaches in the VHA:

a. Biofeedback is an appropriate therapy for use in the VHA setting if recommended, and delivered, by a licensed health care provider who is trained in the clinical use of biofeedback, as part of a Veteran's treatment plan.

Complementary and Integrative Health Approach Recommendations (VAIQ 7811817)

b. Hypnosis is an appropriate therapy for use in the VHA setting if recommended, and delivered, by a licensed health care provider who is trained in the clinical use of hypnosis, as part of a Veteran's treatment plan.

c. Guided Imagery is an appropriate therapy for use as part of a Veteran's plan for health and well-being, and should be delivered by a trained professional. Guided imagery may also be used as part of a Veteran's treatment plan for specific health conditions if provided under the supervision of a licensed health care provider.

d. Massage is an appropriate therapy if recommended by a licensed health care provider as part of a Veteran's treatment plan. Examples of areas of potential utility include, but are not limited to, low back pain and neck pain.

5. Your approval of this memo will support CIH implementation across VHA. The IHCC serves as the lead in this work, expanding on existing efforts and with active partnerships across the organization, and is the point of contact for implementation of CIH approaches across VA.

6. Upon receiving your approval, the IHCC will provide guidance to the field and other program offices on the approved CIH approaches. Thank you for your consideration of this request.

[redacted] [redacted]

Attachments

Approve/Disapprove

[redacted]

8/3/17
Date

Attachment 1:

Issues to Consider

A. Adjustments to VHA business processes will be required to provide infrastructure of CIH service delivery across VHA. Additionally, CIH services may need to compete for resources with existing VHA programs. These processes have begun and will be reinforced by the clarification provided by this memo.

B. VHA Directive 2247 is critical to ensure eligible Veterans have consistent access to a standard set of CIH services. Further, a regulatory change will help to fully support application of the VHA Directive.

C. The Healthcare Analysis and Information Group conducted a survey to evaluate and report on the current state of CIH services across the VA Health Care System. The information from this report will be used to identify strategic initiatives and programmatic directions that may be addressed by the OPCC&CT and the recently established IHCC. Notably, 93 percent of VHA facilities are currently providing one or more CIH service and therefore the clarification that CIH services are within the Medical Benefits Package is critical at this time. The data is available through the following link:

[redacted]

Attachment 2

The Vetting Process

The Vetting process and criteria for CIH services to be recommended for inclusion in the medical benefits package are outlined below.

Similar to the evaluation process for conventional modalities, CIH services that will be recommended for integration into VHA care must show evidence of safety and, at a minimum, promising or potential benefit. Once approved, the IHCC will serve as the entity which will provide guidance to the field regarding CIH modalities that are suitable for inclusion in VHA care. The IHCC will also field requests for evaluation of CIH modality suitability for inclusion within VHA care.

The Policy Working Group developed a set of criteria to be used in making a case for CIH services. The criteria include the following factors:

- Clinical evidence – In 2005, the Institute of Medicine "Complementary and Alternative Medicine Committee" recommended that the same principles and standards of evidence of treatment effectiveness apply to all treatments, whether currently labeled as conventional medicine or CAM. Implementing this recommendation requires that investigators use and develop as necessary common methods, measures, and standards for the generation and interpretation of evidence necessary for making decisions about the use of CAM and conventional therapies. The Committee acknowledges that the characteristics of some CAM therapies—such as variable practitioner approaches, customized treatments, "bundles" (combinations) of treatments, and hard-to-measure outcomes— are difficult to incorporate into treatment-effectiveness studies. These characteristics are not unique to CAM, but they are more frequently found in CAM than in conventional therapies.
- Licensing and credentialing
- Clinical practice guidelines, current evidence, community standards, and potential for harm
- Veteran demand (although the clinical need and appropriateness of any treatment is based on the clinical judgment of the provider and services are not provided solely at the request or preference of the patient)
- Supports transformation of health care delivery

Reference 66

From: [redacted]
To:
Subject: FW: Pain Procedure Room Staffing
Date: Friday, January 15, 2021 7:06:35 AM
Importance: High

From: [redacted]
Sent: Wednesday, January 13, 2021 3:11 PM
To: [redacted]
Cc: [redacted]
Subject: Pain Procedure Room Staffing
Importance: High

[redacted]

On Friday, January 8, 2021, you called me at ~ 17:00 Hr. and mentioned that you were planning to exchange our current RN for an LVN to work at the pain management procedure room in Temple. As you well know this topic was the subject of discussion in the past. There are multiple genuine reasons that support having an RN and not an LVN to assist in the Pain Management Procedure Room.

It is important to have an RN because an RN does not require supervision by another health care provider for RN practice and can function as a co-leader in the procedure suite, by delegating tasks, contributing specialized judgement and skill, and performing comprehensive nursing assessments. An RN can give IV medications and use the ACLS crash cart that is stationed outside the Procedure Room, while an LVN cannot do so.

In addition, the Pain Management Section in Temple needs to open up the Post-Procedure Recovery Room (1C-16). This room was established for this purpose but we were not able to utilize it for such because of the unavailability of nursing to staff this room. We need a second RN to staff the Post-Procedure Recovery Room (1C-16) so we may be able to offer conscious sedation that would help capture more patients from Community Care Pain referrals.

I shall be glad to talk more about this subject with you, but I feel that replacing the RN with an LVN at the Pain Management Procedure Suite is a breach in patient safety and is a significant risk of imminent harm to our Veterans. Kindly consider and respond

Respectfully,
[redacted]

From: [redacted]
To: [redacted]
Subject: ONI — FW: Follow-up / Documents — Meeting#1 with the Pain Management section and the Union
Date: Tuesday, August 10, 2021 12:26:00 PM
Attachments: VHA_documents_and_Literature_List_MentalHealth_PrimaryCare_Pharmacy.docx
VHA_MEMO_EDM_03042020.pdf
Mund_2018_Buprenorphine_MAT_as_an_Imperfect_Fix.pdf
NIDA_marijuana-research-report.pdf

From: [redacted]
Sent: Monday, February 1, 2021 9:57 AM
To: [redacted]
Cc: [redacted]
Subject: Follow-up / Documents — Meeting#1 with the Pain Management section and the Union

Hello [redacted],

Thank you very much for allowing us the opportunity to meet with you regarding our concerns, both clinical and administrative, as it pertains to the treatment of our veterans as well as the treatment to which we feel we have been subject.

Please see the attachments.

You will find the information you had requested contained within the attached Word document; with the exception of the *Note* on Page 12 of 13, everything is **directly quoted**. The document highlights and references the documents and literature that we discussed on 1/29/2021 during our MS Teams meeting with our Union representation, [redacted], and my pain physician colleague, [redacted]. Best I can tell, Interventional pain is not involved in any of these apparently successful models; interventional pain physicians remain ready as consultants. The term "pain clinic" does not always mean what it once did; now, the term often means Primary Care pain clinics and Mental Health / Primary Care collaborative pain clinics as well.

I implore/beseech you to consider and reconsider all matters that have been brought before you: the realignment under Whole Health, the coercion that we feel to treat OUD/opioid dependence, and our clinical and administrative association with [redacted].

I would also note the below points that deserve comment:

(1) The VA and GAO's mutual agreement on key outcomes citing both:
   a. The organizational improvement re: the designated organizational alignments within the ICCs as per the VHA Modernization Lanes of Effort (see Word document)
   b. The responsibilities and jurisdiction assigned to Mental Health as the designated department to implement the Whole Health delivery system as well as other tasks (see Word document)

(2) The presence of chronic pain does not interfere with the success of MAT and the potential benefit of more intensive treatment of OUD and co-occurring conditions in SUD specialty care settings (some of this is from the Va/DOD Guidelines):
   a. According to Lin et al (2020), and this study examined the topic in the VHA. "In FY 2017, 41% OUD only; 22.9% OUD + 1 SUD; 35.9% had OUD + >= 2 SUDs", which means in ~60% of patients with at least OUD, it less likely that simply prescribing suboxone after taking an 8 hour class will be sufficient management.
   b. According to Hser et al (2017), "Most OUD patients (64.4%) had chronic pain conditions, and among them 61.8% had chronic pain before their first OUD diagnosis."
   c. According to Greene et al (2015), "The topic of diagnoses of Opioid Dependence (DSM-IV) vs. Opioid Use Disorder (DSM-V) seems to have been a point of contention for some members of the Mental Health Department; it should be noted that: of lifetime OUD in those with LTOT has been shown to be virtually the same if

using DSM IV or DSM V criteria."

d. According to Dennis et al (2015), Pain has no impact on outcomes for patients on buprenorphine or combination buprenorphine-naloxone.

e. Patients and their treating clinicians may be concerned that treatments proven effective in different OUD populations may not be effective for patients with chronic pain, or may not be necessary for patients who have become addicted to prescription opioid analgesics. This concern has been unfounded and was addressed by Weiss and colleagues in the Prescription Opioid Abuse Treatment Study (POATS).

(3) The matter is not simply that opioids have significant risks associated with them. It is more than that. We simply do not have good data to support chronic opioids, including buprenorphine, for chronic pain in typical situations. On the topic of the opioid, buprenorphine, for pain:

a. Buprenorphine must be used with caution in patients with **respiratory, liver, or renal insufficiency,** conditions of which many of our veterans suffer.

b. Those using buprenorphine can experience euphoria with it. It is abusable. It has been nicknamed "prison heroin" in some circles.

c. It is **not clear** whether Buprenorphine has a ceiling effect to analgesia as was once reported.

d. It is **not clear** as to what degree the addition of naloxone to buprenorphine fundamentally changes the effects and/or side-effects of the drug/combination.

e. Buprenorphine can **still very much be associated** with respiratory depression and death in children and the opioid-naïve as well as other vulnerable patients.

f. The **concomitant usage** of buprenorphine and other substances, including benzodiazepines, alcohol, stimulants, and/or anti-depressants, may change the perceived risk profile of the drug from a practical standpoint.

g. Buprenorphine has a long half-life; with its apparent lesser euphoria and its likely lesser risk from some standpoints, it has been found to be a good medication treatment option for some patients who suffer from Opioid Use Disorder. However, these same qualities may also make Buprenorphine/products the perfect gateway opioid. **If we are not careful** to approach the use of Buprenorphine with the same caution that we now know all other opioids warrant, what we know today as an opioid crisis may well become a far more pervasive state, with buprenorphine and related products as ubiquitous as alcohol, tobacco, and marijuana --- with society predictably seeing greater morbidity and mortality.

The above facts highlight the importance of the need for more research on the topic of Buprenorphine for pain, and this also highlights the importance of Mental Health's jurisdiction and leadership, in conjunction with Primary Care, in proper evaluation, diagnosis, and treatment of OUD. Additionally, I do not believe that I should be coerced into prescribing Buprenorphine for any proposed reason, and I believe my colleagues in the Pain Management section feel the same way; yet, that is exactly what is happening. Please confirm any claims in this document with [redacted], as per your desire. Further, our OPPE and Performance Pay should not be altered as they have been so as to simultaneously punish and compel us to prescribe buprenorphine products as per [redacted] wishes. [redacted] behavior towards us has been characterized by and coupled with actual / repeated threats of counselling/reprimand/discipline with clear aim to constructively dismiss and/or terminate one or more of us. Both clinically and administratively, [redacted] has omitted critical facts with the end effects of those actions predicated on his desired goals. These omissions have caused:

- Material changes to veterans' care.
- Unwarranted Letters of counselling, built on deception, aimed at me, at minimum, coupled with transparent threats to my employment here.
- Alterations of how colleagues understand serious subject matter(s).

Please take action to immediately reverse our alignment under Whole Health and [redacted]; to reverse all adverse actions and alterations to employment,

duties, privileges, and professional evaluation that [redacted] has undertaken and is undertaking towards each of us physicians in the pain management section; to reverse and put a halt to [redacted] coercion to achieve his own identified clinical and administrative goals.

Sincerely,

[redacted]

Reference 68

From: [redacted]
To: [redacted]
Subject: OMI — FW: Follow-up / Documents (Addendum #3) — Meeting#1 with the Pain Management section and the Union
Date: Tuesday, August 10, 2021 12:27:00 PM
Attachments: EDM Whole Health Implementation_Signed_08092019.pdf

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From: [redacted]
Sent: Wednesday, February 3, 2021 2:00 PM
To: [redacted]
Cc: [redacted]
Subject: Follow-up / Documents (Addendum #3) — Meeting#1 with the Pain Management section and the Union

Hello [redacted]

Please see ***attached, earlier EDM*** regarding Whole Health Implementation, signed 8/9/2019:

"Within the VHA Modernization Plan, **Whole Health is aligned with Mental Health as a Lane of Effort**"

And

"each VISN support Whole Health Implementation **as a consistent and committed strategy** throughout the VHA"

And

"consistent approach to funding and infrastructure will minimize variations across VHA in outcomes and, more importantly, in services that are available to Veterans. **By not supporting this recommendation, VISNs and medical center leadership will be left to determine individually the funding and infrastructure committed to Whole Health, ultimately leaving an inconsistent approach to the quality, quantity, and ultimately services available to Veterans nationally. Most importantly, it would be doing a disservice to the Veterans** that we serve each day"

Thank you sir for all of your continued consideration.

[redacted]

Reference 69

From: [redacted]
To:
Subject: OSC Investigation --- Consults and Patient Care under Whole Health
Date: Monday, November 22, 2021 8:12:00 AM

Hello [redacted],

Regarding the CTVHCS / [redacted] attempt to force **Whole Health on the Pain Clinic's patients by causing the consult requests to be scheduled with Whole Health practitioners** in spite of the reason for consultation, I have just seen a veteran who was absolutely furious about it.

Re:

[redacted]

- I listened to the veteran as she described the course of events.
- She indicated that the first time she was referred to the Pain Clinic, she was, unbeknownst to her, being scheduled with [redacted]
- [redacted]
- However, she said she wasn't looking or asking for Whole Health.
- She was irritated because she expected to see a Pain Management specialist and did not.
- She said some other doctor said that she would get injections same day. I don't know who this referred to, but I
- Recently, the PSB met and seemingly agreed that it was not proper for our Whole Health NP seeing these patients for New Patient Pain Management consultations.
- I ended up seeing her as a new consultation as new consults were on the chart as requested but discontinued due to not scheduling (but very obviously on my schedule…) as best I could tell, I was doing a New Patient Pain Management consultation for the veteran.
- I apologized for the flow / sequence of events.
- The veteran described it as "Piss poor planning" on our parts.
- I related that I was sorry for her experience and the decisions regarding

flow were out of my hands / above my level.

I didn't prompt any of this.

The veteran thought she was getting a pain procedure today.
She did not have an MRI ready for review.
She did not have a driver.
By our own PSB, best I can tell, it is agreed that the Whole Health NP evaluation does not suffice for a Pain Management specialty evaluation.

I hope the OSC investigation highlights how dysfunctional, confusing, and frustrating this has been for the veterans and the Pain Management section alike.

Is this all going the way it should to benefit our veterans, or **is the unique alignment of Whole Health here at CTVHCS proving to be a disservice to our veterans**?

Sincerely,

[redacted]

From: [redacted]
To: [redacted]
Subject: OMI — Is Pain Management under Whole Health a setup for failure?
Date: Monday, November 15, 2021 1:03:00 PM

Hello OMI team,

Regarding the CTVHCS / [redacted] attempt to force **Whole Health on the Pain Clinic's patients by causing the consult requests to be scheduled with Whole Health practitioners** in spite of the reason for consultation, I have just seen a veteran who was absolutely furious about it.

Re: [redacted]

- I listened to the veteran as she described the course of events.
- She indicated that the first time she was referred to the Pain Clinic, she was, unbeknownst to her, being scheduled with [redacted]
- [redacted]
- However, she said she wasn't looking or asking for Whole Health.
- She was irritated because she expected to see a Pain Management specialist and did not.
- She said some other doctor said that she would get injections same day. I don't know who this referred to, but I
- Recently, the PSB met and seemingly agreed that it was not proper for our Whole Health NP seeing these patients for New Patient Pain Management consultations.
- I ended up seeing her as a new consultation as new consults were on the chart as requested but discontinued due to not scheduling (but very obviously on my schedule...) as best I could tell, I was doing a New Patient Pain Management consultation for the veteran.
- I apologized for the flow / sequence of events.
- The veteran described it as "Piss poor planning" on our parts.
- I related that I was sorry for her experience and the decisions regarding

flow were out of my hands / above my level.

I didn't prompt any of this.

The veteran thought she was getting a pain procedure today.
She did not have an MRI ready for review.
She did not have a driver.
By our own PSB, best I can tell, it is agreed that the Whole Health NP evaluation does not suffice for a Pain Management specialty evaluation.

I hope the OMI team can see how dysfunctional, confusing, and frustrating this has been for the veterans and the Pain Management section alike.

Is this all going the way it should to benefit our veterans, or **is the unique alignment of Whole Health here at CTVHCS proving to be a disservice to our veterans**?

Sincerely,

[redacted]

From: [redacted];
To: [redacted]
Subject: OSC investigation --- Patient Care under Whole Health
Date: Monday, November 22, 2021 8:12:00 AM

Hello [redacted]

I seem not to have gotten anywhere here at the facility by bringing up the VHA documents/memos, etc, regarding **Whole Health's intended alignment with Primary Care and Mental Health**, so I thought I may as well convey to you the key points from a discussion that I had with a patient recently in my clinic.

Re:

[redacted] [redacted] [redacted]

- I listened to the veteran as I asked him questions that arose from my review of his intake form; he described to me several things which might be stressful, some things which might be depressing.
- As we came to the latter part of our visit, I was discussing options for care, and I discussed how it seemed like Whole Health might be an option that interested him.
- As I started that discussion, he interrupted me, stating that he already said yes to it, and they went to schedule it, but because he was in the middle of an [redacted]
- One attempt was then made to contact him, apparently, following that, and then the consult for Intro to Whole Health was cancelled per protocol / mandated scheduling effort.
- As we went over that progression, he indicated that he didn't know if I could understand how frustrating that is for a veteran.
- **The veteran indicated that he had understood that Whole Health was to have been a part of Mental Health, taking care of veterans' well-**

being (this did not come from me), and yet instead, he felt it was addressed in such a way that those veterans who are exactly interested in pursuing it and yet may have things on their plates which require their attention --- things which themselves may be stressful and/or depressing --- are the very veterans who are going feel even more discarded and mistreated by the handling of it. He indicated being very upset by this.

- I didn't get into the topic of the unique alignment situation regarding Whole Health here at CTVHCS …
- He was agreeable to my resubmitting a consult request to Intro to Whole Health and I referred the veteran to Mental Health as well with his agreement as well.

The way it went for this veteran, who outright stated his desire to do Whole Health, **was it efficient, effective, and veteran-centric** for the veteran?

Was this an efficient use of my skillset for the veterans? The appointment ended up going for an extra 30 minutes beyond the scheduled appointment duration…

Would Whole Health's roll-out here at CTVHCS be more efficient, effective, and veteran well-being-centric **if indeed Whole Health were placed within Mental Health as was intended by VHA leadership**?

I am happy to have done something to try to help this veteran, but is this all going the way it should to benefit our veterans, or **are these losses of intended efficiencies and the unique alignment of Whole Health here at CTVHCS proving to be a disservice to our veterans**?

Sincerely,

[redacted]

From: [redacted]
To: [redacted]
Subject: OMI — Would Whole Health be more successful here under Mental Health?
Date: Friday, November 5, 2021 11:34:00 AM

Hello OMI team,

I seem not to have gotten anywhere here at the facility by bringing up the VHA documents/memos, etc, regarding **Whole Health's intended alignment with Primary Care and Mental Health**, so I thought I may as well convey to you the key points from a discussion that I had with a patient today in my clinic.

Re: [redacted]

- I listened to the veteran as I asked him questions that arose from my review of his intake form; he described to me several things which might be stressful, some things which might be depressing.
- As we came to the latter part of our visit, I was discussing options for care, and I discussed how it seemed like Whole Health might be an option that interested him.
- As I started that discussion, he interrupted me, stating that he already said yes to it, and they went to schedule it, but because he was in the middle of [redacted]
- One attempt was then made to contact him, apparently, following that, and then the consult for Intro to Whole Health was cancelled per protocol / mandated scheduling effort.
- As we went over that progression, he indicated that he didn't know if I could understand how frustrating that is for a veteran.
- **The veteran indicated that he had understood that Whole Health was to have been a part of Mental Health, taking care of veterans' well-**

being (this did not come from me), and yet instead, he felt it was addressed in such a way that those veterans who are exactly interested in pursuing it and yet may have things on their plates which require their attention --- things which themselves may be stressful and/or depressing --- are the very veterans who are going feel even more discarded and mistreated by the handling of it. He indicated being very upset by this.

- I didn't get into the topic of the unique alignment situation regarding Whole Health here at CTVHCS …
- He was agreeable to my resubmitting a consult request to Intro to Whole Health and I referred the veteran to Mental Health as well with his agreement as well.

The way it went for this veteran, who outright stated his desire to do Whole Health, **was it efficient, effective, and veteran-centric** for the veteran?

Was this an efficient use of my skillset for the veterans? The appointment ended up going for an extra 30 minutes beyond the scheduled appointment duration…

Would Whole Health's roll-out here at CTVHCS be more efficient, effective, and veteran well-being-centric **if indeed Whole Health were placed within Mental Health as was intended by VHA leadership**?

I am happy to have done something to try to help this veteran, but is this all going the way it should to benefit our veterans, or **are these losses of intended efficiencies and the unique alignment of Whole Health here at CTVHCS proving to be a disservice to our veterans**?

Sincerely,

[redacted]

[redacted]

---

fyi

From: [redacted]
Sent: [redacted]
To: [redacted]
Subject: RE: [redacted]

Consult based off c[redacted] recommendation. This patient appears to have already been seen by pain CPS. So may have already met the criteria of being evaluated by 2 PMT members.

I'm forgetting the name of the pain psychologist.

[redacted]

From: [redacted]
Sent: [redacted]
To: [redacted]
Subject: RE: [redacted]

These consults should be forwarded to pain clinic and the clinical pharmacists for now. After these evaluations, other members of the team can be consulted. After at least 3 team members have seen the patient, we can discuss the case at the IDT. This is how interdisciplinary care should operate. A single conversation on a patient that has never been seen in anyone's clinic does not count as interdisciplinary care.

We do not need a new consult process to start doing this at this time, but I would like some assistance to write a new charter for the PMT that reflects this. Unfortunately I have been pulled into too many directions to be able to adequately address any given project.

The major task I was given was to create a single consult pathway for pain management that integrates CIH with conventional pain management approaches. This needs to integrate the pain clinic, clinical pharmacy, and the PMT. I am working with [redacted] on the final wording of this. However, we still do not have concurrence from Primary Care on the Service Agreement, nor do we have any counter-proposals from them to address the issues that the proposed agreement is trying to address. I am still waiting for guidance from [redacted].

We can try to meet before the next scheduled PMT meeting to collaborate on the charter.

I appreciate your patience during this challenging transition.

[redacted]

From: [redacted]
Sent: [redacted]
To: [redacted]
Subject: RE: [redacted]

We need some kind of plan for this patient if not going to PMT.

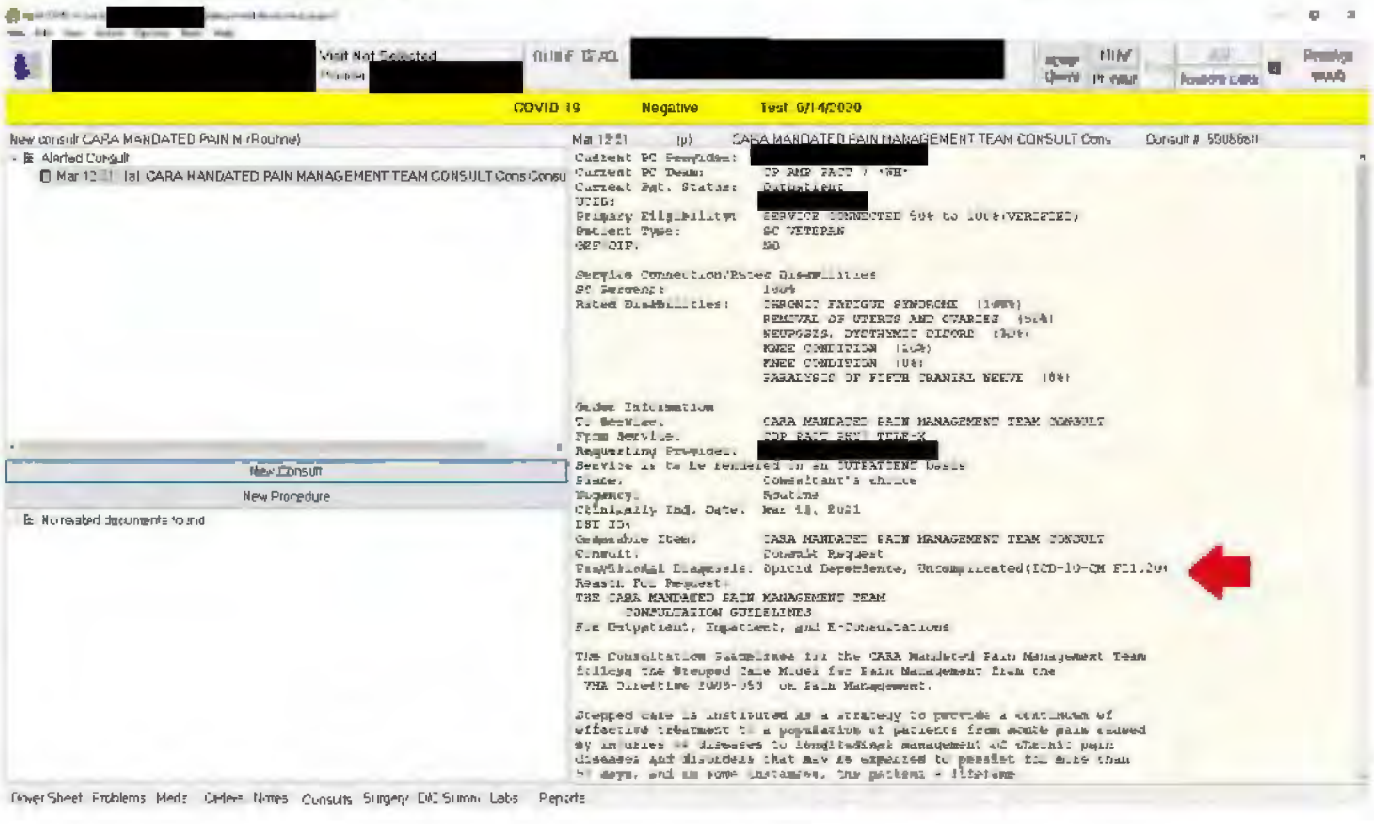
We should inactivate that consult if we will not be using it.

Where are we at with having a different consult build?

[redacted]

From: [redacted]
Sent: [redacted]
To: [redacted]
Cc: [redacted]
Subject: Delay Aged Case
Importance: High

This consultation is accepted on behalf of the Chairperson of the pain management team, [redacted]. Notification will be sent to [redacted] and to Pain Management Pharmacy, [redacted] for processing and scheduling in the Pain Management Team clinic.



From: [redacted]
To: [redacted]
Subject: RE: Patient with ?CRPS
Date: Wednesday, April 7, 2021 10:20:11 AM

I have some anxiety and fear of the same thing

From: [redacted]
Sent: Wednesday, April 7, 2021 9:59 AM
To: [redacted]
Subject: RE: Patient with ?CRPS

That is my concern.

What is worse is that I don't even know how to approach this question.

I'm deathly afraid of being tagged by [redacted] for doing it "wrong" and then being tagged for "competence or conduct."

[redacted]

From: [redacted]
Sent: Wednesday, April 7, 2021 8:12 AM
To: [redacted]
Subject: RE: Patient with ?CRPS

I guess his statement that pt should see WH before us would entail that there is a potential delay for veteran seeing us, if I understand it correctly.

From: [redacted]
Sent: Tuesday, April 6, 2021 4:30 PM
To: [redacted]
Subject: RE: Patient with ?CRPS

I am concerned that having to do the Whole Health class may delay the veteran's getting seen, or am I getting confused as to when the requirement must be fulfilled by?

[redacted]

From: [redacted]
Sent: Tuesday, April 6, 2021 4:27 PM
To: [redacted]
Subject: RE: Patient with ?CRPS

Thank you both.

Will do.

[redacted]

From: [redacted]
Sent: Tuesday, April 6, 2021 4:24 PM
To: [redacted]
Subject: RE: Patient with ?CRPS

[redacted] in trouble if there are ANY complaints against our section, so in that light, I would accept the consult. Potential sympathetic block or even SCS may be options?

From: [redacted]
Sent: Tuesday, April 6, 2021 4:20 PM
To: [redacted]
Cc: [redacted]
Subject: RE: Patient with ?CRPS

Yes, please accept him. We treat CRPS at our clinics. Thanks.

From: [redacted]
Sent: Tuesday, April 6, 2021 12:59 PM
To: [redacted]
Cc: [redacted]
Subject: Patient with ?CRPS

Hello [redacted]

I received a consultation request, dated 4/5/21, on veteran:

[redacted]

The veteran either has a history of CRPS or there is concern for it.

The consult template has “No” for some of the accessions. However, my inclination is to accept the consult request if there is a concern for CRPS.

Please advise.

[redacted]

From: [redacted]
To:
Subject: RE: pt with possible cprs
Date: Thursday, July 22, 2021 3:06:00 PM

What other imaging would you recommend, mris of shoulder, upper arm, radius and ulna? Thanks

From: [redacted]
Sent: Thursday, July 22, 2021 3:05 PM
To: [redacted]
Cc: [redacted]
Subject: RE: pt with possible cprs

Yes.

Would recommend not delaying on account of not having other imaging.

Please put on consult request that you are concerned for CRPS.

Be well,

[redacted]

From: [redacted]
Sent: Thursday, July 22, 2021 3:01 PM
To: [redacted]
Subject: pt with possible cprs

[redacted]

I have a [redacted] with possible CRPS of her right are. Xrays, ncvs, inflammatory markers, heavy metal screens, rheum evals normal.
[redacted] has had xrays. I know you saw another pt will possible CRPS in Anesthesia block. Will VA pain mgmt see this pt for right arm pain?

thanks

Reference 72

President's Commission on Combating Drug Addiction and the Opioid Crisis established by Executive Order, 2017.

Reference 73

From: [redacted]
To: [redacted]
Cc: [redacted]
Subject: RE: Case of OUD Referred to MH/SATP
Date: Thursday, May 19, 2022 12:48:43 PM
Importance: High

Colleagues,

This issue is clear cut. [redacted] cannot misdirect the encounter to solicit the responses that they so desire. I am surprised that [redacted] had to call the patient before seeing him at their clinics. Why is that so? When we consult [redacted], that means we need the help of experts on substance abuse. Our consultations should not be denied. Based on our consultation, the patient should be properly seen by MH/SATP, and a definitive and responsible note should be written. This is the least expected at the HRO Medical Center that we are. This said, we are not telling MH/SATP how to conduct their business, what we are saying is, write a responsible note after you see the patient in a full proper encounter.

Not long ago, and to the hearing of several providers, a psychiatrist at MH said the [redacted] will diagnose OUD if she does not have to prescribe Suboxone, otherwise [redacted] will not diagnose OUD if she has to prescribe Suboxone. This is not the professional way that should be. Talking this way is demeaning to the profession. Trying to solicit responses to discontinue consultation, or create gray areas where OUD can never be diagnosed by MH/SATP is even much worse.

MH/SATP should be engaged in the management of OUD. Whether the patient suffers of chronic pain or not should never be an obstruction.

If, however, the patient chooses not to go to MH/SATP, because he denies having OUD, why then would pain management be obliged to treat him with MAT/Suboxone for OUD? Or falsely calling MAT/Suboxone as a treatment for his chronic pain, when we have more effective and much safer modalities available to us to treat his chronic pain. We do not usually treat chronic pain with Suboxone, not even with other opioids. We have come a long way from chronic opioid management with more effective Modalities in the management of chronic pain. If I cannot give insulin to a patient who does not have DM, then why should I give MAT/Suboxone to a patient who does not have OUD?

A patient cannot come to the clinic and ask me to prescribe a medication that is not indicated, not to mention a controlled substance. That would be the function of a street vendor, and not of a professional MD. We are professionals and we prescribe controlled substances professionally. Let be clearly known to all, we do not prescribe to appease, to please, to engage with, etc. We prescribe only when a medication is professionally indicated in the management of the patient. This professionalism will not change and is not up for bargaining.

In this and in other similar situations of patients with OUD, who deny having it, I see no reason to prescribe MAT/Suboxone. We cannot force the treatment of OUD on

patients who do not want it. However if they admit to having OUD, then they should get the whole treatment for it including MAT. I expect MH/SATP to engage and to lead the way by example, and make all staff feel supported in this matter and not alienated.

Sincerely,
[redacted]

From: [redacted]
Sent: Wednesday, May 18, 2022 4:33 PM
To: [redacted]
Cc: [redacted]
Subject: RE: Case of OUD Referred to MH/SATP

Hello [redacted]

My concern on review of the charting is that pain seemed to be mentioned quite a bit by the MH staff while I cannot say that I recall any meaningful discussion of current/prior diagnoses of Opioid Dependence/OUD between the MH staff and the veteran --- even though alcohol usage was discussed. I repeat that I specifically discussed that I was placing the consult request and the consult request reason with the veteran. I can also say that the veteran denied any prior diagnosis of Alcohol use disorder / dependence to me, and yet, that became a focus of the MH staff discussion with the veteran.

One might consider the impact of such an approach as reflected by the MH staff charting.

Would the veteran have pursued the treatment had the focus of the interactions between the MH staff and the veteran been accurate to the consult request that was placed? MH staff know better than I that denial can be powerful in individuals suffering of substance use disorders, and a misdirected focus during interactions runs the risk of causing the veteran to not want substance abuse treatment.

Again, I believe the case is worth reviewing.

[redacted]

From: [redacted]

Sent: Wednesday, May 18, 2022 4:11 PM
To: [redacted]
Cc: [redacted]
Subject: RE: Case of OUD Referred to MH/SATP

[redacted], ultimately the issue for this Veteran is that he did not want substance abuse treatment. He was contacted, and it was documented in the chart. Nothing was mentioned by the providers about not take the patient due to pain. I would like for us to be very clear about the situation when statements are made that MH is not willing to take patients who have pain. There may be examples of this issue, and if so, I am happy to review them. However, this is not one of them.

[redacted]
ACOS , Mental Health & Behavioral Medicine

How was my service today? We value your feedback – please click on the link to take the MHMB Leadership Quick Card Survey [redacted]

From: [redacted]
Sent: Wednesday, May 18, 2022 3:54 PM
To: [redacted]
Cc: [redacted]
Subject: RE: Case of OUD Referred to MH/SATP

I do not recall immediately if the (any) MH staff that left notes on the patient chart after the initial consult was requested, charted anything substantial on the topic of prior diagnoses or current diagnoses of Opioid Dependence/OUD, or if such charting was instead characterized by references to pain... it may be worth reviewing.

[redacted]

From: [redacted]
Sent: Wednesday, May 18, 2022 3:48 PM
To: [redacted]
Cc: [redacted]
Subject: RE: Case of OUD Referred to MH/SATP

The issue is not whether he could have benefitted but whether he was actually willing to engage in services. If someone declines services, we cannot force them to engage. This was given to me as an example of MH refusing to treat pain patients. I just wanted us all to be clear that we did not refuse him.

[redacted]
ACOS , Mental Health & Behavioral Medicine

How was my service today? We value your feedback – please click on the link to take the MHMB Leadership Quick Card Survey. [redacted]

From: [redacted]
Sent: Wednesday, May 18, 2022 3:43 PM
To: [redacted]
Cc: [redacted]
Subject: RE: Case of OUD Referred to MH/SATP

For this veteran, the consult request was very specifically discussed with the veteran at the time of placement.
This is a veteran that went on to attempt suicide with one or more substances, if I recall correctly.

It seemed to me that he would have benefited from SATP…

[redacted]

From: [redacted]
Sent: Wednesday, May 18, 2022 3:40 PM
To: [redacted]
Cc: [redacted]
Subject: RE: Case of OUD Referred to MH/SATP

Thank you for the opportunity to clarify what happened with this Veteran's care. MH never refused to treat this Veteran because of pain. He was initially consulted on 3/4/21 as a stat consult. [redacted] was asked to resubmit this consult as routine as this was not a "stat" issue. [redacted] resubmitted the consult on 3/8/21. MH did reach out to the Veteran who said he was not aware he was being referred for substance use disorder treatment and does not believe he has a substance use disorder. He reported he was taking his medications as prescribed and not abusing any substances. Veteran declined treatment and was not scheduled for care. Treatment is voluntary and relies on the patient's willingness to address the issue. This is the exact scenario that we see very frequently with patients. However, I want to make it clear that MH did not refuse to treat this patient.

[redacted]
ACOS , Mental Health & Behavioral Medicine

How was my service today? We value your feedback – please click on the link to take the MHMB Leadership Quick Card Survey. [redacted]

From: [redacted]
Sent: Wednesday, May 18, 2022 1:53 PM
To: [redacted]
Subject: RE: Case of OUD Referred to MH/SATP

Hello [redacted]

As per your request:

[redacted]

[redacted]

From: [redacted]
Sent: Wednesday, May 18, 2022 1:22 PM
To: [redacted]
Cc: [redacted]
Subject: Case of OUD Referred to MH/SATP

Hello [redacted]

Kindly supply us with the name and number of the case of OUD that you referred to MH/SATP. [redacted], plans to investigate this case.

Thanks,
[redacted]

Reference 74

Systematic Review on Opioid Treatments for Chronic Pain_ Surveillance Report 3

Reference 75

From: [redacted]
To: [redacted]
Subject: OSC investigation --- Patient Care under Whole Health
Date: Friday, November 19, 2021 4:29:00 PM

Hello [redacted]

Re:

[redacted]

Here are the transcripts from my communications with:

[redacted] --- AMSA for the Pain Management section
[redacted] --- Whole Health Program Manager
[redacted] --- PMRS physician

Was this an efficient use of my time?

Sincerely,

[redacted]

From TEAMS below…

//

[redacted]

[7:46 AM] [redacted]

I have a patient of [redacted] that needs to be seen, can I put him on your schedule

[8:22 AM] [redacted]
If [redacted] has a patient, he/she should really be scheduled with him; we do not perform the same ev[redacted]ns or treatments.

[8:22 AM] [redacted]
You may discuss further with [redacted] re: other thoughts

[8:33 AM] [redacted]
[redacted] is s[redacted]t the patient of [redacted] with you

[8:34 AM] [redacted]
I dont have any open slots. The veteran will most likely be best served with following with [redacted]
Please discuss with [redacted]

[8:35 AM] [redacted]
I had one at 0800 but that is past.

[8:35 AM] [redacted]
I didnt see your message until later...

[8:35 AM] [redacted]
The 10:00 canceled so may I put the patient on the scheduled

[8:36 AM] [redacted]
Please discuss with [redacted]

[8:36 AM] [redacted]
I dont do what [redacted] and vice versa. Is this a new patient?

[8:36 AM] [redacted]
Or a follow-up?

[8:39 AM] [redacted]
Also, what is the purpose of the appointment? What is the veteran's goal of the appointment?

[8:39 AM] [redacted]
this is going to be a new patient

[8:39 AM] [redacted]
I will need to review the chart; please discuss with [redacted] also.

[8:40 AM] [redacted]
Name/number?

[8:40 AM] [redacted]

[8:40 AM] [redacted]

I will review and get back with you; however, please also discuss with [redacted]

[8:49 AM] [redacted]
I don't see any actual pain consult request on the chart.

[8:50 AM] [redacted]
It looks like [redacted] intended to re-see the veteran to discuss Whole Health options

[9:11 AM] [redacted]
[redacted] is requesting that you see the patient

[9:11 AM] [redacted]
im communicating with her

[9:11 AM] [redacted]
thanks

//

[redacted]

[8:49 AM] [redacted]
We put [redacted] in your 10am slot since he was so upset with his appt being canceled today. I realize he is not your patient but please see him as you had an opening and apologize for his provider being out. Thank you.

[8:50 AM] [redacted]
I don't see any actual pain consult request on the chart.
It looks like [redacted] intended to re-see the veteran to discuss Whole Health options.

[8:54 AM] [redacted]
[redacted] last note was that pt was to bring in records from the community and then develop a treatment plan. I think this may be one that had a PATS-R complaint for not getting chiro anymore if I am reading the notes correctly. Can you see any of his records in Vista imaging? I realize this isn't ideal but if a pt presents and is that upset and we have an opening we need to make it correct somehow. See what if anything you can offer him.....

[8:55 AM] [redacted]
I don't believe I have jurisdiction to help unless one of his established care providers submits a new pain consult request; otherwise, it looks like the veteran would most likely follow with a Whole Health clinician/evaluator.

[8:55 AM] [redacted]
I am not sure.

[8:55 AM] [redacted]
I have no problem seeing the veteran.

[8:55 AM] [redacted]
But it doesnt look on my review that it is actually for what I "do". It looks like this encounter between [redacted] and the veteran were talking re: chiropractic services...

[8:56 AM] [redacted]
Thoughts?

[8:56 AM] [redacted]
can you se

[9:00 AM] [redacted]
I'm asking [redacted] his advice on what to do... stay tuned.

[9:00 AM] [redacted]
Ok thanks

[9:01 AM] [redacted]
This is literally a followup that generated from the veteran being denied chiropractic care.

[9:01 AM] [redacted]
I get that.

[9:01 AM] [redacted]
Which doesnt seem to involve me at all

[9:01 AM] [redacted]
Ok

[9:02 AM] [redacted]
To be clear, the veteran is not already here, correct?

[9:02 AM] [redacted]
he saw PM [redacted] n your 10am

[9:02 AM] [redacted]
I see

[9:03 AM] [redacted]
so he is still on campus

[9:03 AM] [redacted]
Ok, he shouldnt leave

[9:03 AM] [redacted]
no he is waiting to be seen

[9:04 AM] [redacted]
ok good

[9:09 AM] [redacted]

If he wants an actual pain consult, I would bet that [redacted] from PMRS would have no issue requesting the consult.

[9:09 AM] [redacted]
Another th[redacted]alk" to him about Whole Health options generally if that helps with his upsetness.

[9:10 AM] [redacted]
yes i think [redacted] let me see what [redacted] says after morning report

[9:10 AM] [redacted]
Ok my 0900 was just put in a 30 minute slot... should have been a 60 minute slot... I will likely be delayed...

[9:10 AM] [redacted]
Either way... please let me know

[9:10 AM] [redacted]
will do

[9:23 AM] [redacted]
I have communicated with [redacted]; if the veteran actually wants a pain management consult, [redacted] is ok to issue the request. If the veteran does not want that, and it is as per [redacted] note as to why they communicated, then this should likely be dispositioned via an alternate pathway.

[9:24 AM] [redacted]
Re: Whole Health clinical staff/other discussing Whole Health paradigm/pathway, etc... or other / unclear to me...

[9:24 AM] [redacted]
ok can you talk to him then and hand him off via consult to chiro, acupuncture, yoga, health coach, etc?

[9:24 AM] [redacted]
I cannot predetermine that unfortunately.

[9:29 AM] [redacted]
what did PMRS offer/do with him today?

[9:29 AM] [redacted]
trial of PT

[9:30 AM] [redacted]
for his low backpain?

[9:30 AM] [redacted]
unclear gotta go

[9:33 AM] [redacted]
[redacted] said to see the patient.....thank you.

[9:34 AM] [redacted]

ok

//

[redacted]

[9:11 AM] [redacted]
Hello?

[9:11 AM] [redacted]
hello. How are you [redacted]

[9:11 AM] [redacted]
I am well s

[9:11 AM] [redacted]
And you?

[9:11 AM] [redacted]
doing wel u with?

[9:12 AM] [redacted]
There is a patient [redacted]

[9:12 AM] [redacted]
I believe y

[9:12 AM] [redacted]
I sure did.

[9:12 AM] [redacted] about his chiropractic care being discontinued

[9:12 AM] [redacted]
We set him up for PT

[9:12 AM] [redacted]
Ok

[9:12 AM] [redacted]
That is all he really wanted to talk about.

[9:12 AM] [redacted]
My understanding is that he may or may not want to see a pain doctor

[9:12 AM] [redacted]
Ahh ok.

[9:13 AM] [redacted]
I am communicating with Whole Health admin to try to understand this situation better

[9:13 AM] [redacted]
I told him my department is no longer involved in chiro care. Whole health now controls this.

[9:13 AM] [redacted]
If he wants to see a pain doctor, would you have any issue requesting the consultation to our clinic?

[9:13 AM] [redacted]
(I understand re: what you noted just now.)

[9:14 AM] [redacted]
We didn't discuss international procedures at all. He just wanted passive therapies like chiro and massage therapy but was ultimately agreeable to a trial of PT.

[9:14 AM] [redacted]
ok.

[9:15 AM] [redacted]
But I guess I am asking if it gets back to me from Whole Health admin that he does want to see a pain doctor, would you have any issue issuing the consultation request?

[9:15 AM] [redacted]
that should say "interventional" procedures.

[9:15 AM] [redacted]
Haha. yes.

[9:16 AM] [redacted]
I could but he has no MRI which y'all typically require and I don't see why he would need an MRI at this point as he hasn't trialed PT in the recent past.

[9:17 AM] [redacted]
No need. If this is what is communicated via Whole Health admin to me, then you would simply issue the consult (don't worry about the questions, etc) and I can accept immediately.

[9:17 AM] [redacted]
I will get b hat they say.

[9:17 AM] [redacted]
I am currently waiting on their reply.

[9:18 AM] [redacted]
I have no so to speak. Just want to make sure the veteran is actually being set up with what he was seeking (as long as is reasonable).

[9:19 AM] [redacted]
What he appeared to be seeking was more chiro care and or massage therapy. Both are generally not reasonable long term treatments as they are passive but that is up to whole health at this point.

[9:20 AM] [redacted]
That's my sense as well, but if it is communicated to me that the individual wants to see a pain doc to discuss those and/or other options, I will get back with you if you would submit the consult request. If

he really does not want to see a pain doctor and is looking just for that, then no need.

[9:20 AM] [redacted]
I really dont know for sure. Im getting commmunicated with about this really just now...

[9:22 AM] [redacted]
Sounds good. Let me know and I will submit a consult if needed. Thanks

[9:22 AM] [redacted].
ok thanks

[10:15 AM] [redacted]
Ok sir. I have spoken to the patient; yes, he would like to see me. Can you submit the consultation request? Don't worry about the answers, etc. Just the template submitted is fine.

[10:18 AM] [redacted].
a temple pa nsult has been placed. thanks

[10:20 AM] [redacted]
Thanks!

//

Reference 76

From: [redacted]
To: [redacted]
Subject: RE: [redacted] Supplies update
Date: Thursday, July 15, 2021 11:13:00 AM
Attachments: image001.png
image002.png

I have some of the needles.

I have not had the syringes needed for several months at this point, and I still don't.

[redacted]

From: [redacted]
Sent: Thursday, July 15, 2021 10:33 AM
To: [redacted]
Subject: RE: [redacted] Supplies update

At this point, I have stopped offering Cervical epidural steroid injections.

[redacted]

From: [redacted]
Sent: Friday, June 18, 2021 9:07 AM
To: [redacted]
Subject: FW: [redacted] Supplies update

Supplies under Whole Health...

From: [redacted]
Sent: Thursday, June 17, 2021 11:31 AM
To: [redacted]
Subject: FW: [redacted] Supplies update

To whom it may concern:

[redacted] did come to my office, [redacted]

[redacted] that the needle I had requested was in the system all along.

So, I waited all this time, without these needles, for no good reason, other than we were moved under Whole Health.

[redacted]

From: [redacted]
Sent: Thursday, June 17, 2021 9:40 AM
To: [redacted]
Cc: [redacted]
Subject: RE: [redacted] Supplies update

[redacted],
Per our conversation this morning. Please reply your justification on why your choice of needle(s) is the Non-Prime Vendor one. Again, it is so that Logistics has justification to VISN on why they ordering Non-Prime Vendor vs Prime Vendor.

I truly appreciate your time this morning on getting this done.

Thank you,

[redacted]
Program Support Assistant
Whole Health Service
Central Texas Veteran Healthcare System
[redacted]

From: [redacted]
Sent: Wednesday, June 16, 2021 8:39 AM
To: [redacted]
Cc: [redacted]
Subject: RE: [redacted] Supplies update

Good Morning [redacted]
These items have now been ordered through CTXSupplyTech. I have requested both items (needles & syringes) be stocked monthly in your area.

Thank you,

[redacted]

From: [redacted]
Sent: Monday, June 14, 2021 3:54 PM
To: [redacted]
Cc: [redacted]
Subject: RE: [redacted] Supplies update

80 of each.

[redacted]

From: [redacted]
Sent: Monday, June 14, 2021 3:54 PM
To: [redacted]
Cc: [redacted]
Subject: RE: [redacted] Supplies update

How many needles and syringes do you want right now?

From: [redacted]
Sent: Monday, June 14, 2021 3:39 PM
To: [redacted]
Cc: [redacted]
Subject: RE: [redacted] Supplies update

Hello [redacted],

Yes to both.

Please order these ASAP.

If you can order the Tuohy needles in the 19 and 18 Gauge sizes as well, I would appreciate it.

If that is too complex for the system in terms of ordering, I will await the needles and syringes you have planned to order as per prior communications.

I thought these were already ordered?

[redacted]

From: [redacted]
Sent: Monday, June 14, 2021 3:07 PM
To: [redacted]
Cc: [redacted]
Subject: RE: [redacted] Supplies update

[redacted]

I can now order your syringes. Logistic is asking do you want these stocked in your area (Supply closet)? Also, you mentioned too, if your needles could be ordered monthly. Would you like the needles and syringes stocked in your area (supply closet)? Please advise.

Thank you,

[redacted]

From: [redacted]
Sent: Monday, June 14, 2021 9:49 AM
To: [redacted]
Cc: [redacted]
Subject: RE: [redacted] Supplies update

Hello [redacted]

I am writing to request an update on the Green LOR syringes I requested back in 10/2020 or 11/2020.

To date, I have not received these.

Please let me know.

Be well,

[redacted]

From: [redacted]
Sent: Friday, March 26, 2021 9:16 AM
To: [redacted]
Cc: [redacted]

[redacted]
Subject: RE: [redacted] Supplies update

From the information you gave me I provided you the answer. NOW if we used another vendor provide that information and I will be glad to provide guidance.

From: [redacted]
Sent: Friday, March 26, 2021 8:52 AM
To: [redacted]
Cc: [redacted]
Subject: RE: [redacted] Supplies update

To [redacted]

From my review of prior correspondence, it seems that the syringes were from [redacted] Braun).

Is it possible for the two of you to communicate directly to assure that the order is placed.

We did order, receive, and use these syringes previously.

This is not a new item.

[redacted]

From: [redacted]
Sent: Friday, March 26, 2021 8:45 AM
To: [redacted]
Cc: [redacted]
Subject: RE: [redacted] Supplies update

[redacted],

If these items were previously purchased then Whole Health will not have a problem ordering them for you now. But as I stated below [redacted] has not been vendorized.

v/r,

[redacted]
Management Analyst/Program Analyst/COR

Surgical Service
CTVHCS, Temple
[redacted]

From: [redacted]
Sent: Thursday, March 25, 2021 4:04 PM
To: [redacted]
Cc: [redacted]
Subject: RE: [redacted] Supplies update

[redacted]

I just forwarded prior correspondence to you.

Please review it and communicate with [redacted]; I am really hoping that nothing additional is needed. We did purchase this previously, and I do not recall any additional efforts being made for the product in question (syringes).

Thank you,

[redacted]

From: [redacted]
Sent: Thursday, March 25, 2021 3:58 PM
To: [redacted]
Cc: [redacted]
Subject: RE: [redacted] Supplies update

This vendor must be vendorized in FMS to order from and AVANOS has not.

From: [redacted]
Sent: Thursday, March 25, 2021 3:42 PM
To: [redacted]
Cc: [redacted]

Subject: RE: [redacted] Supplies update

[redacted]

Thank you for checking.

[redacted]

Was a CPRC processed for the syringes while under Surgery?

The syringes were obviously purchased, as we used them…

Thank you,

[redacted]

From: [redacted]
Sent: Thursday, March 25, 2021 3:08 PM
To: [redacted]
Cc: [redacted]
Subject: RE: [redacted] Supplies update

I have checked on pass emails. Only the needles were purchased back in December 2020. See attached. I know there was talk about the trays but I believe we stayed with the trays that we use already.

Going forward I will process a CPRC for the syringes and update you [redacted]

Thank you,

[redacted]
Program Assistant
Whole Health Service
Central Texas Veteran Healthcare System
[redacted]

From: [redacted]

Sent: Thursday, March 25, 2021 2:57 PM
To: [redacted]
Cc: [redacted]
Subject: RE: [redacted] Supplies update

They have definitely been ordered previously.

Please check with both [redacted] directly.

Thank you,

[redacted]

From: [redacted]
Sent: Thursday, March 25, 2021 2:56 PM
To: [redacted]
Cc: [redacted]
Subject: RE [redacted] Supplies update

The Touhy needles have been ordered before but we have no record of the syringes being ordered before

From: [redacted]
Sent: Thursday, March 25, 2021 2:53 PM
To [redacted]
Cc: [redacted]
Subject: RE: [redacted] Supplies update

I understand.

What I am asking is:

Have both items gone through the CPRC process before ordering, already when ordered initially by surgery?

-If so, then this should not be needed.

-If it is required, then, why was it not previously required?

Thank you,

[redacted]

From: [redacted]
Sent: Thursday, March 25, 2021 2:50 PM
To: [redacted]
Cc: [redacted]
Subject: RE: [redacted] Supplies update

You will have to get it order by Whole Health now, as they should have funds to order supplies.

From: [redacted]
Sent: Thursday, March 25, 2021 2:43 PM
To: [redacted]
Cc: [redacted]
Subject: RE: [redacted] Supplies update

We have received both of these items through Surgery before.

Please advise.

[redacted]

From: [redacted]
Sent: Thursday, March 25, 2021 2:43 PM
To: [redacted]
Cc: [redacted]
Subject: RE: [redacted] Supplies update

[redacted]

I don't order for Whole Health and from the email traffic it sounds like a new item.

From: [redacted]
Sent: Thursday, March 25, 2021 2:09 PM
To: [redacted]
Cc: [redacted]

Subject: [redacted] Supplies update

[redacted]

Do we already have what is being requested by [redacted]?

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

To: [redacted]
Subject: FW: [redacted] Supplies update

These supplies are needed to be ordered again for this doctor. The quote looks to be a new item so it will need to go to CPRC possible

From: [redacted]
Sent: Wednesday, March 24, 2021 9:54 AM
To: [redacted]
Cc: [redacted]
Subject: FW: [redacted] Supplies update

Good Morning [redacted]
Whole Health is reaching out again for help with [redacted] Supply order (Needles). You were very helpful and prompt the first time. Can you get these ordered for [redacted]. He is also asking can he get these delivered monthly? If, so what do I need to do on my end? Your help is greatly appreciated.

Please see email below~

Thank you,

[redacted]
Program Assistant
Whole Health Service
Central Texas Veteran Healthcare System
[redacted]

From: [redacted]
Sent: Tuesday, March 23, 2021 9:33 AM
To: [redacted]
Cc: [redacted]
Subject: RE: [redacted] Supplies update

Hello [redacted]

We could use an additional delivery of the needles.

Were you able to ascertain if the needles were to be delivered monthly?

I need the items contained within the attachments ASAP (epidural needles and loss of resistance syringes).

Thank you!

[redacted]

From: [redacted]
Sent: Wednesday, December 30, 2020 12:07 PM
To: [redacted]
Subject: RE: [redacted] Supplies update

Hello.

I have received the needles.

Will these be delivered monthly?

Thank you,

[redacted]

From: [redacted]
Sent: Wednesday, December 30, 2020 11:21 AM
To: [redacted]
Subject: FW: [redacted] Supplies update

FYI~

From: [redacted]
Sent: Wednesday, December 23, 2020 4:21 PM
To: [redacted]
Subject: RE: [redacted] Supplies update

The 20 gauge Tuohy needles have arrived today.

[redacted]
Supervisor Inventory Management Specialist
Supply Chain Management
Central Texas Veterans Healthcare System
[redacted]

From: [redacted]
Sent: Monday, December 14, 2020 2:48 PM
To: [redacted]
Subject: [redacted] Supplies update

Hi [redacted]
Reaching out to get a update on [redacted] supplies

Thank you.

[redacted]
Program Assistant
Whole Health Service
Central Texas Veteran Healthcare System
[redacted]

From: [redacted]
To:
Subject: FW: [redacted] Supplies update
Date: Tuesday, June 15, 2021 3:12:00 PM
Attachments: image001.png

Hello [redacted]

As one of the issues you were investigating was the Realignment of the Pain Management section under Whole Health, please see the email exchange.

It has been **roughly 8 or more months** since the requests for the syringes was made. Apparently, **Whole Health can "now order" my syringes**.

Without the proper supplies, it becomes difficult to do procedures: they take longer to do safely. Whenever I feel I cannot progress safely during a procedure with what I have, I abort.

Sincerely,

[redacted]

From: [redacted]
Sent: Monday, June 14, 2021 3:54 PM
To: [redacted]
Cc: [redacted]
Subject: RE: [redacted] Supplies update

80 of each.

[redacted]

From: [redacted]
Sent: Monday, June 14, 2021 3:54 PM
To: [redacted]
Cc: [redacted]
Subject: RE: [redacted] Supplies update

How many needles and syringes do you want right now?

From: [redacted]
Sent: Monday, June 14, 2021 3:39 PM

To: [redacted]>
Cc [redacted]

Subject: RE [redacted] Supplies update

Hello [redacted]

Yes to both.

Please order these ASAP

If you can order the Tuohy needles in the 19 and 18 Gauge sizes as well, I would appreciate it.

If that is too complex for the system in terms of ordering, I will await the needles and syringes you have planned to order as per prior communications.

I thought these were already ordered?

[redacted]

From: [redacted]
Sent: Monday, June 14, 2021 3:07 PM
To: [redacted]
Cc: [redacted]

Subject: RE: [redacted] Supplies update

[redacted]
I can now order your syringes. Logistic is asking do you want these stocked in your area (Supply closet)? Also, you mentioned too, if your needles could be ordered monthly. Would you like the needles and syringes stocked in your area (supply closet)? Please advise.

Thank you,

[redacted]

From: [redacted]
Sent: Monday, June 14, 2021 9:49 AM
To: [redacted]
Cc: [redacted]

Subject: RE: [redacted] Supplies update

Hello [redacted]

I am writing to request an update on the Green LOR syringes I requested back in 10/2020 or 11/2020.

To date, I have not received these.

Please let me know.

Be well,

[redacted]

From: [redacted]
Sent: Friday, March 26, 2021 9:16 AM
To: [redacted]
Cc: [redacted]
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To: [redacted]
Cc: [redacted]
Subject: RE: [redacted] Supplies update

To [redacted]

From my review of prior correspondence, it seems that the syringes were from [redacted]

Is it possible for the two of you to communicate directly to assure that the order is placed.

We did order, receive, and use these syringes previously.

This is not a new item.

[redacted]

From: [redacted]
Sent: Friday, March 26, 2021 8:45 AM
To: [redacted]
Cc: [redacted]
Subject: RE: [redacted] Supplies update

[redacted]

If these items were previously purchased then Whole Health will not have a problem ordering them for you now. But as I stated below [redacted] has not been vendorized.

v/r,

[redacted]
Management Analyst/Program Analyst/COR
Surgical Service
CTVHCS, Temple
[redacted]

From: [redacted]
Sent: Thursday, March 25, 2021 4:04 PM
To: [redacted]
Cc: [redacted]
Subject: RE: [redacted] Supplies update

[redacted],

I just forwarded prior correspondence to you.

Please review it and communicate with [redacted]; I am really hoping that nothing additional is needed. We did purchase this previously, and I do not recall any additional efforts being made for the product in question (syringes).

Thank you,

[redacted]

From: [redacted]
Sent: Thursday, March 25, 2021 3:58 PM
To: [redacted]
Cc: [redacted]
Subject: RE: [redacted] Supplies update

This vendor must be vendorized in FMS to order from and AVANOS has not.

From: [redacted]
Sent: Thursday, March 25, 2021 3:42 PM
To: [redacted]
Cc: [redacted]
Subject: RE: [redacted] Supplies update

[redacted]

Thank you for checking.

[redacted]

Was a CPRC processed for the syringes while under Surgery?

The syringes were obviously purchased, as we used them…

Thank you,

[redacted]

From: [redacted]
Sent: Thursday, March 25, 2021 3:08 PM
To: [redacted]
Cc: [redacted]
Subject: RE: [redacted] Supplies update

I have checked on pass emails. Only the needles were purchased back in December 2020. See attached. I know there was talk about the trays but I believe we stayed with the trays that we use already.

Going forward I will process a CPRC for the syringes and update you [redacted]

Thank you,

[redacted]
Program Assistant
Whole Health Service
Central Texas Veteran Healthcare System
[redacted]

From: [redacted]
Sent: Thursday, March 25, 2021 2:57 PM
To: [redacted]
Cc: [redacted]
Subject: RE: [redacted] Supplies update

They have definitely been ordered previously.

Please check with both [redacted] directly.

Thank you,

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To: [redacted]
Cc: [redacted]
Subject: RE: [redacted] Supplies update

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Sent: Thursday, March 25, 2021 2:53 PM
To: [redacted]
Cc: [redacted]
Subject: RE: [redacted] Supplies update

I understand.

What I am asking is:

Have both items gone through the CPRC process before ordering, already when ordered initially by surgery?

-If so, then this should not be needed.

-If it is required, then, why was it not previously required?

Thank you,

[redacted]

From: [redacted]
Sent: Thursday, March 25, 2021 2:50 PM
To: [redacted]
Cc: [redacted]
Subject: RE: [redacted] Supplies update

You will have to get it order by Whole Health now, as they should have funds to order supplies.

From: [redacted]
Sent: Thursday, March 25, 2021 2:43 PM
To: [redacted]
Cc: [redacted]
Subject: RE [redacted] Supplies update

We have received both of these items through Surgery before.

Please advise.

[redacted]

From: [redacted]
Sent: Thursday, March 25, 2021 2:43 PM
To: [redacted]
Cc: [redacted]
[redacted]
Subject: RE: [redacted] Supplies update

[redacted]

I don't order for Whole Health and from the email traffic it sounds like a new item.

From: [redacted] >
Sent: Thursday, March 25, 2021 2:09 PM
To: [redacted]
Cc: [redacted]
[redacted]
Subject: RE: [redacted] Supplies update

[redacted]

Do we already have what is being requested by [redacted]

[redacted]

From: [redacted]
[redacted]

[redacted]

[redacted]

[redacted]

To: [redacted]
Subject: FW: [redacted] Supplies update

These supplies are needed to be ordered again for this doctor. The quote looks to be a new item so it will need to go to CPRC possible

From: [redacted]
Sent: Wednesday, March 24, 2021 9:54 AM
To: [redacted]
Cc: [redacted]
Subject: FW: [redacted] Supplies update

Good Morning [redacted],
Whole Health is reaching out again for help with [redacted] Supply order (Needles). You were very helpful and prompt the first time. Can you get these ordered for [redacted]. He is also asking can he get these delivered monthly? If, so what do I need to do on my end? Your help is greatly appreciated.

Please see email below~

Thank you,

[redacted]
Program Assistant
Whole Health Service
Central Texas Veteran Healthcare System
[redacted]

From: [redacted]
Sent: Tuesday, March 23, 2021 9:33 AM
To: [redacted]
Cc: [redacted]
Subject: RE: [redacted] Supplies update

Hello [redacted]

We could use an additional delivery of the needles.

Were you able to ascertain if the needles were to be delivered monthly?

I need the items contained within the attachments ASAP (epidural needles and loss of resistance syringes).

Thank you!

[redacted]

From: [redacted]
Sent: Wednesday, December 30, 2020 12:07 PM
To: [redacted]
Subject: RE: [redacted] Supplies update

Hello.

I have received the needles.

Will these be delivered monthly?

Thank you,

[redacted]

From: [redacted]
Sent: Wednesday, December 30, 2020 11:21 AM
To: [redacted]
Subject: FW: [redacted] Supplies update

FYI~

From: [redacted]
Sent: Wednesday, December 23, 2020 4:21 PM
To: [redacted]
Subject: RE: [redacted] Supplies update

The 20 gauge Touhy needles have arrived today.

[redacted]
Supervisor Inventory Management Specialist
Supply Chain Management
Central Texas Veterans Healthcare System
[redacted]

From: [redacted]
Sent: Monday, December 14, 2020 2:48 PM
To: [redacted]
Subject: [redacted] Supplies update

Hi [redacted]
Reaching out to get a update on [redacted] supplies

Thank you.

[redacted]
Program Assistant
Whole Health Service
Central Texas Veteran Healthcare System
[redacted]

From: [redacted]
To:
Subject: RE: [PRIVATE]
Date: Friday, March 26, 2021 2:58:00 PM

1. Loss of resistance syringe that I have literally already been using, but now apparently, more is required of me… we will run out before they are replenished.

2. Trays never were allowed; [redacted] approved it and then retracted the approval; then I asked him if there was anyone else I could speak to regarding the matter; he denied me this, and then he accused me of going over his head anyway (which I did not…). The trays I want have relevant syringes in them and much less redundant paper, so as to minimize contamination… if a tray gets contaminated, I have to throw the whole thing out… which I have had to do for patients… this can add to patient time on the table, while they wait for the procedure to start…

3. I should be getting my Tuohy needles, but there will be a delay.. I will run out before they are replenished.

4. I have no faith that asking for anything new is even an option, when I practically have to beg to get these bare minimal items…

[redacted]

From: [redacted]
Sent: Friday, March 26, 2021 2:54 PM
To: [redacted]
Subject: RE: [PRIVATE]

What specific supplies are you referring to?

From: [redacted]
Sent: Friday, March 26, 2021 12:11 PM
To: [redacted]
Subject: [PRIVATE]

Hello [redacted]

I want you to know that between the move to Whole Health and [redacted] response to my requests, I am in real danger of not having the specific supplies I need to continue to perform interventions for some veterans.

I do anticipate that I may have to cancel or not offer procedures I the very near future.

This is a direct result of (1) having been realigned under Whole Health from Surgery and (2) [redacted] approach to my request(s).

I have no one else to relay this to…

Thank you,

[redacted]

From: [redacted]
To:
Subject: RE: CPRC Portal
Date: Friday, June 24, 2022 9:43:23 AM

Very seldom.

From: [redacted]
Sent: Friday, June 24, 2022 9:41 AM
To: [redacted]
Subject: RE: CPRC Portal

Hello [redacted]

Out of curiosity, how often does the committee “deadlock” on items requested?

Thank you!

[redacted]

From: [redacted]
Sent: Friday, June 24, 2022 9:37 AM
To: [redacted]
Cc: [redacted]
Subject: RE: CPRC Portal

If needed it can be moved to July.

From: [redacted]
Sent: Friday, June 24, 2022 9:35 AM
To: [redacted]
Cc: [redacted]
Subject: RE: CPRC Portal

[redacted]
Can you present this for [redacted]? Or can this be pushed to the July CPRC?

[redacted]

From: [redacted]
Sent: Thursday, June 23, 2022 4:11 PM
To: [redacted]
Cc: [redacted]
Subject: RE: CPRC Portal

I am on leave that day.

[redacted]

From: [redacted]
Sent: Thursday, June 23, 2022 1:54 PM
To: [redacted]
Cc: [redacted]
Subject: RE: CPRC Portal

Hello [redacted]

I am in the middle of clinic..

I may be on leave that day?

[redacted]

From: [redacted]
Sent: Thursday, June 23, 2022 1:51 PM
To: [redacted]
Cc: [redacted]
Subject: RE: CPRC Portal

[redacted]
I apologize, this was for [redacted]

Ty~

From: [redacted]
Sent: Thursday, June 23, 2022 1:50 PM
To: [redacted]
Cc: [redacted]
Subject: RE: CPRC Portal

[redacted]
Please confirm you will present. I will not. Then I can move forward to adjust your clinic for June 27th @ 14:30.

Thank you,
[redacted]

From: [redacted]
Sent: Thursday, June 23, 2022 11:36 AM
To: [redacted]
Cc: [redacted]
Subject: RE: CPRC Portal

The Universal Block Tray- have not received enough votes to deny or proceed. I wanted to address the issue again if you would like. [redacted] can present it if you all want him too.

From: [redacted]
Sent: Thursday, June 23, 2022 11:34 AM
To: [redacted]
Cc: [redacted]
Subject: RE: CPRC Portal

Hello [redacted]

What product are you referring to?

I have copied [redacted] who you have been in communication with regarding a prior request, and [redacted], the Section Chief for Pain Management.

Thank you,

[redacted]

From: [redacted]
Sent: Thursday, June 23, 2022 11:31 AM
To: [redacted]
Cc: [redacted]
Subject: CPRC Portal

Good Afternoon,

This email is to notify you, that you have a product that will be added to the CPRC monthly meeting on 6/27/22 via [redacted] @ 14:30.

To avoid delays or confusion if I don't receive a reply your item will not be added to the agenda.
The agenda and a CPRC committee invite will be forwarded to on tomorrow.
You or a designated presentive must attend the meeting to present your product to the committee. No request will be addressed by the committee without a POC available.

During the presentation you will be asked an array of questions such as: (all listed on the original request)

An explanation of what the product is, and how the product will be utilized.
What is the current practice in place.
How will the product impact patient care?
Will the product replace any item currently being utilized?
What is the product usage and cost?
It is important that you provide an image of the product to help the board visualize its usage. The image can either be the actual product or a printed copy of the product.

After your presentation is completed you will be asked to leave the meeting.
You will be notified of the committee vote within five working days. If the request is approved you will also be informed of the upcoming actions to ensure the product is procured and stocked in your designated area.

The purpose of this email is to ensure that your product is reviewed without any delays. You may reach out to me as needed.

Please disregard if we have already discussed this matter, the information is provided as an FYI.

[redacted]
Logistics Management Specialist (LMS)
Facility Recall Coordinator
[redacted]

From: [redacted]
To:
Subject: RE: CPRC Request 171905
Date: Tuesday, December 8, 2020 9:01:00 AM

Well.

It is hard to coordinate with the other providers to decide whether the new trays can replace the old ones, if the other providers have never used this other tray…

[redacted]

From: [redacted]
Sent: Tuesday, December 8, 2020 9:01 AM
To: [redacted]
Subject: RE: CPRC Request 171905

No. That is not how this works.

From: [redacted]
Sent: Tuesday, December 8, 2020 9:00 AM
To: [redacted]
Subject: RE: CPRC Request 171905

Hello,

Re: We are being asked to limit items in inventory.

--- Can I communicate with the parties that made this request of you to discuss further?

[redacted]

From: [redacted]
Sent: Tuesday, December 8, 2020 8:59 AM
To: [redacted]
Subject: RE: CPRC Request 171905

We are being asked to limit items in inventory.

My approval was given under the assumption that this was a replacement.

Unless there is information on improved outcomes or limitations to what can be done with one tray vs. another, we cannot stock both.

Please coordinate with the other providers to decide whether the new trays can replace the old ones.

[redacted]

From: [redacted]
Sent: Tuesday, December 8, 2020 8:54 AM
To: [redacted]>
Subject: RE: CPRC Request 171905

Because different physicians utilize and rely on different materials to optimally perform procedures in their own respective hands.

[redacted]

From: [redacted]
Sent: Tuesday, December 8, 2020 8:53 AM
To: [redacted]
Subject: RE: CPRC Request 171905

Please explain why we need both

[redacted]

From: [redacted]
Sent: Tuesday, December 8, 2020 8:52 AM
To: [redacted]
Subject: RE: CPRC Request 171905

Correct.

[redacted]

From: [redacted]
Sent: Tuesday, December 8, 2020 8:52 AM
To: [redacted]
Subject: RE: CPRC Request 171905

So, you are not requesting to replace the old trays with the new ones?

[redacted]

From: [redacted]
Sent: Tuesday, December 8, 2020 8:44 AM
To: [redacted]
Subject: RE: CPRC Request 171905

Hello,

They are consumable items.

We are not planning to retire the old trays.

[redacted]

From: [redacted]
Sent: Tuesday, December 8, 2020 8:42 AM
To: [redacted]
Subject: FW: CPRC Request 171905

[redacted]

The trays you are requesting are consumable items, correct?

[redacted]

From: [redacted]
Sent: Tuesday, December 8, 2020 8:30 AM
To: [redacted]
Cc: [redacted]
Subject: RE: CPRC Request 171905

Does the service plan to retire the old tray please

From: [redacted]
Sent: Tuesday, December 8, 2020 8:26 AM
To: [redacted]
Cc: [redacted]
Subject: CPRC Request 171905

[redacted]

CPRC Request 171905, has been submitted by Whole Health as an emergency request.

The POC’s are on the CC Line

[redacted]

Thanks

Reference 77

From: [redacted]
To: [redacted]
Subject: Information request
Date: Tuesday, February 16, 2021 7:50:00 PM
Attachments: [redacted]
Letter_regarding_concerns_02162021.pdf
Correspondence_regarding_concerns_1_02162021.pdf
Correspondence_regarding_concerns_2_02162021.pdf

Hello [redacted]

Please see attached.

[redacted]

From: [redacted]
To: [redacted]
Subject: Information request
Date: Monday, October 4, 2021 4:20:00 PM
Attachments: [redacted]
Letter_regarding_concerns_02162021.pdf
Correspondence_regarding_concerns_1_02162021.pdf
Correspondence_regarding_concerns_2_02162021.pdf

Hello [redacted]

Disclosure/concern #7 in the attachment Letter of my concerns should read:

Based on my understanding of information from the VISN 17 Pain Stewardship Meeting (***not*** *the CTVHCS Pain Oversight Committee*).

[redacted]

From: [redacted]
To: [redacted]
Subject: OSC Investigation --- OUD and Patient Care under Whole Health
Date: Monday, November 22, 2021 8:12:00 AM
Attachments: Understanding the Epidemic__CDC_03172021.pdf
ExtramedicalUseandDiversionofBuprenorphine_JournalofSubstanceAbuseTreatment_10282021.pdf
Opioid Data_2011_2021.pdf
POISON_NPDS2019_excerpt.pdf
POISON_NPDS2019_fullreport.pdf
Buprenorphine in the United States__Motives for abuse_misuse_and_diversion.pdf

---

Hello [redacted]

As I have conveyed previously, one of the problems with VISN 17's (maybe other/all VISNs also) **not tracking** Buprenorphine as an opioid included in the measure for New Long Term Opioid Patients, while **tracking** Buprenorphine products for the SUD16 parameter, is that it can appear that there are decreasing total opioid prescriptions, decreasing co-prescribing of opioids and benzodiazepines, and increasing treatment of OUD, even when OUD is not diagnosed. (*If this tracking behavior has changed since I last reported the concern, I would not know, as I have been formally or functionally removed by* [redacted] *from: - the VISN 17 Pain Stewardship Committee Meetings (my patient care slots don't get blocked off), - the CTVHCS Pain Oversight Committee (*[redacted] *directly removed me), - the CTVHCS Pain Management Team (my patient care slots don't get blocked off)… I am kept in the dark.*)

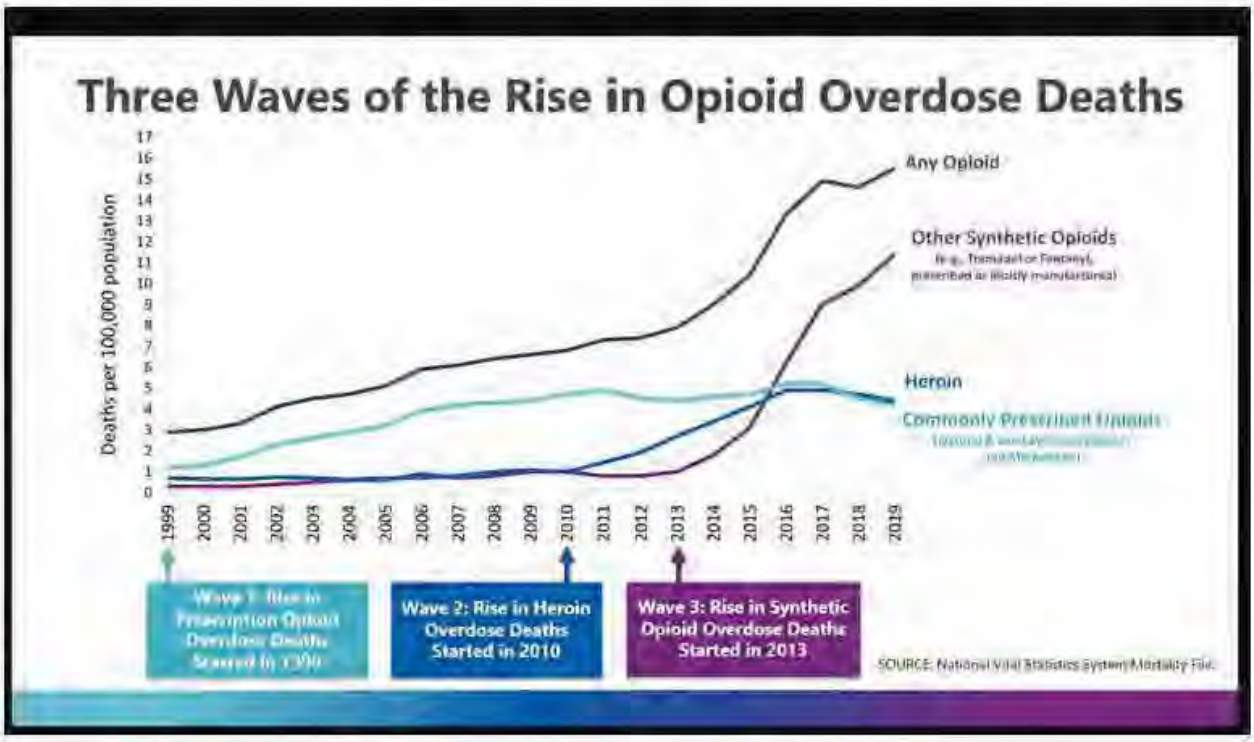
The decision to track and not track Buprenorphine in this fashion (much like [redacted] attempt to coerce us to prescribe it) is concerning because morbidity and mortality may even go up, instead of down; by the time dissemination of the drug is entrenched in prescriber habits and clinical approaches with sewn-in clinical/diagnostic ambiguity, it may be too late to reverse. Notably, if typical dosing regimens that are used in the treatment of OUD are instead used in the treatment of chronic pain due to confounding of approach (e.g. "CPOD"), this may well result in an excess of Buprenorphine over what the prescribed-to patient/veteran needs; this increases the risk of diversion and the downstream effects on the community at large. The harms of this possibility becoming reality **may take months to years before becoming apparent**.

Could the characteristics of Buprenorphine that make it a good option for the treatment of OUD make it more worrisome to the patient/veteran and the community when utilized in the treatment of chronic pain? Does the duration of action of the drug along with the potential prescribed dosages facilitate intrapersonal and interpersonal behavior via economies of sorts, with their attendant incidences of fatal synthetic and/or illicit drug consumption? This question seems far more relevant to the current wave of opioid related deaths than does the focus on trying to get intra-facility measures cited above looking better and better.

- The first 2 attachments are new attachments to you (and excerpts are represented below).
- The last 4 attachments are ones I have previously sent you (included ?again for context / your review).

//

Understanding the Epidemic | CDC's Response to the Opioid Overdose Epidemic | CDC



//

Beyond harm-producing versus harm-reducing: A qualitative meta-synthesis of people who use drugs' perspectives of and experiences with the extramedical use and diversion of buprenorphine - PubMed (nih.gov)

Excerpts:

3.4.The buprenorphine drug economy Studies described buprenorphine as a **priced commodity within an informal but extensive economy of drugs that included other opioids** as well as, to a lesser extent, alcohol, cocaine, benzodiazepines, and other commodities such as "clean" urine and forged prescriptions. Different kinds of relationships among PWUD strongly influenced the distribution pathways of buprenorphine within this economy. **Buprenorphine occu-pied a distinct niche partly because of its unique pharmacological properties**. A dynamic interplay existed between these commodities, and thus the availability and **use of extramedical buprenorphine was greatly influenced by fluctuations in supply, quality, and pricing of these other substances**, besides fluctuations of buprenorphine supply via medical treatment.

3.4.1.Sharing, trading, selling, and buying extramedical buprenorphine PWUD noted that buprenorphine was **distributed extramedically through a variety of ad hoc pathways immersed in a robust and stratified social network built around drug use**. Channels for buprenorphine dis-tribution included sharing, trading, selling, and buying (Allen & Har-ocopos, 2016). The kind of distribution depended on the closeness of the relationship between the individual who used drugs and the person providing the buprenorphine (Table 3).

3.4.2.The buprenorphine-demand niche **The pharmacological qualities of buprenorphine compared to other opioids and substances conferred it with a niche status within an economy of drug use and exchange** (Daniulaityte et al., 2012). Its extra- long-acting effects offered PWUD greater flexibility in adjusting quantity or frequency of dosing **depending on the availability of buprenorphine or a preferred opioid such as heroin or an opioid analgesic. These properties also provided an opportunity for selling excess supply** by taking multiple doses on a single day and thus **prolonging use of the drug of choice** (Furst, 2013; Johnson & Richert, 2015). As one participant explained: "...my money wouldn't last. So I know if I, pay day's on Friday, it's Tuesday. I buy a bup, okay that a get me through Tuesday, Wednesday, maybe Thursday something new might arrive" (Monico 2015, p.60). One study noted explicitly that the local discounted pricing of extramedical buprenorphine was a result of its primary use for with-drawal management

rather than for getting high (Allen & Harocopos, 2016). While other substances could also be used for withdrawal avoidance, their shorter acting effects resulted in a higher overall cost when used in this way (Monico et al., 2015; Monte et al., 2009).

3.4.3.Supply and price of buprenorphine and other drugs The supply of buprenorphine and the other substances in its economy was described as an ebb and flow (Furst, 2014). Patterns and pricing of buprenorphine use may be tied closely to supply. Six studies noted **over-prescribing as being an important contributor to extramedical use** (Allen & Harocopos, 2016; Daniulaityte et al., 2012; Johnson & Richert, 2015; Kavanaugh & McLean, 2020; Monte et al., 2009; Pedersen et al., 2017). This over-prescribing included prescribing doses that were **too high for the needs of individual patients: "I have a prescription for 64mg a day, I take 16 or 24mg and sell the rest"** (Monte 2009, p.229). Pedersen et al. (2017) and Monico et al. (2015), reporting from Norway and the United States, respectively, noted that the **low costs of publicly funded medical buprenorphine led to over-supply**. Excess sup-ply would then contribute to lower street costs thereby increasing extramedical buprenorphine utilization (Kavanaugh & McLean, 2020; Weckroth, 2007). This, in turn, created a market for buprenorphine in areas with low medical supply such as those outside of major metro-politan centers (Johnson & Richert, 2015; Monte et al., 2009).

//

At the time of the Realignment of the Pain Management section: I was a probationary employee; I still am; I moved my entire family here and my wife and I both put our livelihoods in the hands of CTVHCS; [redacted] was nearing completed 20 years of service at the VA; My understanding is that benefits change for the individual/family at the 20 year mark. [redacted] and I have both suffered immensely to raise these concerns. We have put ourselves and our families at risk, proudly, for the veterans. After all, the veterans had put themselves at risk for us. In the VA, it is rightly described as a responsibility to raise any such concerns.

I hope the OSC investigation validates the fulfillment of that responsibility and recognizes the validity of these concerns.

And I hope the OSC investigation recognizes that the reason we have been made to suffer for bringing up these very valid concerns --- **the thing that enabled harms and restrictions against our veterans and enabled our suffering and stifled our voices and our practices and our contributions --- was the Realignment of the traditional section of Pain Management under the Whole Health Service**, the latter of which was supposed to have been aligned with Primary Care and Mental Health as opposed to what has happened here in the CTVHCS' Realignment.

Sincerely,

[redacted]

From: [redacted]
To: [redacted]
Subject: OMI -- Buprenorphine, Confounding and the Realignment of Pain Management under Whole Health
Date: Friday, November 5, 2021 1:40:00 PM
Attachments: Understanding the Epidemic _ CDC_03172021.pdf
ExtramedicalUseandDiversionofBuprenorphine_JournalofSubstanceAbuseTreatment_10282021.pdf
Opioid Data_2011_2021.pdf
POISON_NPDS2019_excerpt.pdf
POISON_NPDS2019_fullreport.pdf
Buprenorphine in the United States _ Motives for abuse, misuse, and diversion.pdf

---

Hello OMI team,

As I have conveyed previously, one of the problems with VISN 17's (maybe other/all VISNs also) **not tracking** Buprenorphine as an opioid included in the measure for New Long Term Opioid Patients, while **tracking** Buprenorphine products for the SUD16 parameter, is that it can appear that there are decreasing total opioid prescriptions, decreasing co-prescribing of opioids and benzodiazepines, and increasing treatment of OUD, even when OUD is not diagnosed. (*If this tracking behavior has changed since I last reported the concern, I would not know, as I have been formally or functionally removed by* [redacted] *from: - the VISN 17 Pain Stewardship Committee Meetings (my patient care slots don't get blocked off), - the CTVHCS Pain Oversight Committee* [redacted] *directly removed me), - the CTVHCS Pain Management Team (my patient care slots don't get blocked off)... I am kept in the dark.*)

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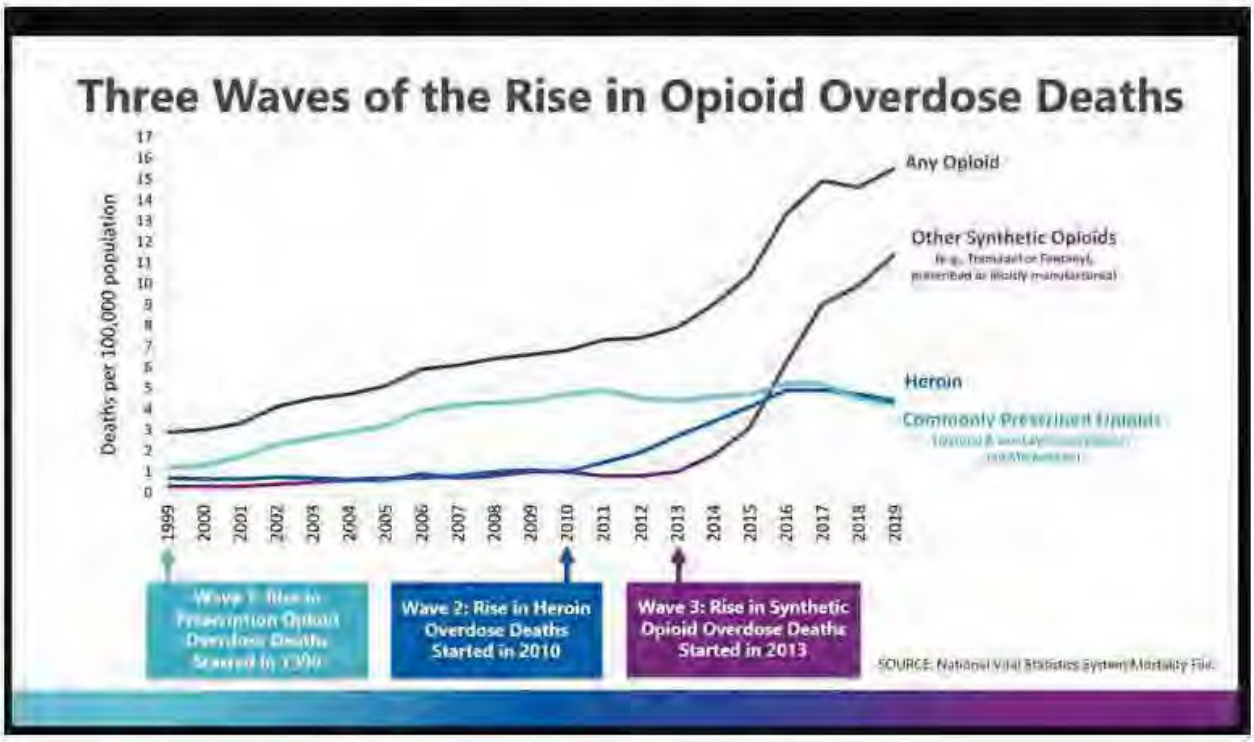

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And I hope the OMI team recognizes that the reason we have been made to suffer for bringing up these very valid concerns --- **the thing that enabled harms and restrictions against our veterans and enabled our suffering and stifled our voices and our practices and our contributions --- was the Realignment of the traditional section of Pain Management under the Whole Health Service**, the latter of which was supposed to have been aligned with Primary Care and Mental Health as opposed to what has happened here in the CTVHCS' Realignment.

Sincerely,

[redacted]

Reference 78

From: [redacted]
To: [redacted]
Cc: [redacted]
Subject: Follow-up (Addendum #2) --- Meeting#2 with the Pain Management section and the Union
Date: Wednesday, February 10, 2021 10:04:00 AM
Attachments: Opioid Data_2011_2021.pdf
POISON_NPDS2019_excerpt.pdf
POISON_NPDS2019_fullreport.pdf

Hello [redacted],

I was hoping to send this yesterday, but I could not find it…

Please consider these attachments in the context of the information I had sent yesterday.

Of note, regarding the **excerpt** of the 2019 Annual Report of the American Association of Poison Control Centers' National Poison Data System (NPDS): 37th Annual Report (the full report is also attached):

- Please view the numbers for Opioids: including buprenorphine, hydrocodone, oxycodone, tramadol.

- My question: If one was to cover up the left hand margin of the table with the names of the opioids, would it have been easy to guess that

  (1) Buprenorphine would have even been on the list at all?

  (2) Which of the numbers/data corresponded to Buprenorphine?

  If the answer to either question is no, it should give us something to think about when considering to broaden the usage of buprenorphine from OUD/Opioid dependence.

Thank you for your review and consideration in these matters.

Sincerely,

[redacted]

Clinical Toxicology

ISSN: 1556-3650 (Print) 1556-9519 (Online) Journal homepage: https://www.tandfonline.com/loi/ictx20

2019 Annual Report of the American Association of Poison Control Centers' National Poison Data System (NPDS): 37th Annual Report

David D. Gummin, James B. Mowry, Michael C. Beuhler, Daniel A. Spyker, Daniel E. Brooks, Katherine W. Dibert, Laura J. Rivers, Nathaniel P. T. Pham & Mark L. Ryan

To cite this article: David D. Gummin, James B. Mowry, Michael C. Beuhler, Daniel A. Spyker, Daniel E. Brooks, Katherine W. Dibert, Laura J. Rivers, Nathaniel P. T. Pham & Mark L. Ryan (2020) 2019 Annual Report of the American Association of Poison Control Centers' National Poison Data System (NPDS): 37th Annual Report, Clinical Toxicology, 58:12, 1360-1541, DOI: 10.1080/15563650.2020.1834219

To link to this article: https://doi.org/10.1080/15563650.2020.1834219

Table 22A. Demographic profile of SINGLE SUBSTANCE Nonpharmaceutical exposure cases by generic category – Continued.

			Age							Reason					Outcome				
	No. of Case Mentions	No. of Single Exposures	<=5	6-12	13-19	>=20	Unknown Child	Unknown Adult	Unknown Age	Unint	nt	Other	Adv Rxn	Treated in Health Care Facility	None	Minor	Moderate	Major	Death
Aquarium Products, Miscellaneous	1,224	1,163	834	81	32	180	2	32	2	1,132	19	8	4	77	252	44	12	0	0
Bromine Shock Treatments	48	45	9	4	1	26	0	5	0	43	0	0	1	12	3	14	3	0	0
Chlorine Shock Treatments	3,138	3,025	580	385	232	1,514	11	272	31	2,881	45	16	74	816	218	1,052	340	8	0
Other Types of Swimming Pool or Aquarium Product	2,101	2,008	493	222	118	973	2	172	28	1,913	35	3	51	468	220	665	186	7	0
Swimming Pool and Aquarium Test Kits	161	147	32	29	43	32	0	10	1	140	5	0	1	18	13	27	4	0	0
Category Total:	7,080	6,758	2,075	744	439	2,894	18	523	65	6,472	106	28	135	1,454	771	1,876	566	18	0
Tobacco/Nicotine/eCigarette Products																			
eCigarettes: Nicotine Containing																			
eCigarettes: Nicotine Device Flavor Unknown	1,792	1,417	790	46	204	298	4	59	16	1,040	220	17	131	509	358	266	116	16	5
eCigarettes: Nicotine Device With Added Flavors	518	481	325	25	28	84	0	16	3	413	35	1	31	134	178	77	18	3	0
eCigarettes: Nicotine Device Without Added Flavors	692	445	227	8	79	108	0	21	2	303	67	11	61	180	105	77	59	9	2
eCigarettes: Nicotine Liquid Flavor Unknown	1,271	1,151	755	26	111	221	4	28	6	986	100	13	43	431	346	263	37	8	1
eCigarettes: Nicotine Liquid With Added Flavors	1,000	918	565	31	126	159	0	28	9	738	110	6	54	273	296	189	43	8	1
eCigarettes: Nicotine Liquid Without Added Flavors	121	116	73	2	12	23	0	6	0	103	6	0	6	25	39	21	4	0	0
Miscellaneous Tobacco Products																			
Chewing Tobacco	1,880	1,842	1,623	37	46	121	0	12	3	1,769	46	8	14	339	539	423	39	2	0
Cigarettes	5,426	5,260	4,800	35	54	285	11	65	10	5,054	87	22	60	562	1,542	753	40	0	0
Cigars	269	252	155	1	16	55	1	20	4	179	34	1	33	37	59	53	12	0	0
Dissolvable Tobacco	11	11	7	0	1	3	0	0	0	10	1	0	0	1	5	2	0	0	0
Filter Tips Only (i.e. Butts)	109	102	93	2	0	4	0	3	0	99	3	0	0	13	42	6	2	0	0
Heat Not Burn Tobacco	3	3	2	0	0	1	0	0	0	2	1	0	0	0	2	0	0	0	0
Other Types of Tobacco Product	227	211	138	4	10	41	0	16	2	190	14	0	7	47	58	37	4	0	0
Snuff	245	240	219	3	3	14	0	1	0	232	3	0	1	41	80	53	4	0	0
Unknown Types of Tobacco Product	1,855	1,745	1,081	43	136	377	1	96	11	1,467	173	8	86	447	455	327	74	3	1
Category Total:	15,419	14,194	10,853	263	826	1,794	21	371	66	12,585	900	87	527	3,039	4,104	2,547	452	49	10
Waterproofers/Sealants																			
Miscellaneous Waterproofers/Sealants																			
Waterproofers/sealants: aerosols	164	163	69	11	13	55	0	14	1	152	2	2	6	41	16	31	8	2	0
Waterproofers/sealants: liquids	117	114	36	2	4	47	0	24	1	108	5	0	1	19	18	16	3	0	0
Waterproofers/sealants: solids	7	7	4	2	0	1	0	0	0	7	0	0	0	0	0	0	0	0	0
Waterproofers/sealants: unknown form	27	26	10	0	2	11	0	3	0	25	0	0	1	8	1	3	3	0	0
Category Total:	315	310	119	15	19	114	0	41	2	292	7	2	8	68	35	50	14	2	0
Weapons of Mass Destruction																			
Miscellaneous Weapons of Mass Destruction																			
Anthrax	9	8	0	1	1	6	0	0	0	4	0	4	0	4	2	0	0	0	0
Nerve Gases	2	1	0	0	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0
Other Biological Weapons	1	1	0	0	0	1	0	0	0	1	0	0	0	0	0	0	0	0	0
Other Chemical Weapons	12	10	0	0	0	8	0	2	0	7	0	2	0	7	3	1	1	0	0
Other Suspicious Powders	226	203	45	12	11	106	1	26	2	136	24	25	2	102	45	52	15	5	0
Other Suspicious Substances (Non-Powder)	2,190	1,992	401	102	133	977	13	295	71	1,065	203	357	75	890	221	282	216	108	9
Suspicious Powders in Envelope or Package	36	34	2	5	2	20	1	4	0	26	2	3	0	19	10	10	1	1	0
Category Total:	2,476	2,249	448	120	147	1,118	15	327	74	1,239	229	392	77	1,022	281	345	233	114	9
Nonpharmaceuticals Total:	1,081,392	969,604	493,406	65,950	45,792	290,124	3,348	61,217	9,767	890,856	40,599	13,683	17,908	167,043	158,034	154,703	33,445	3,116	319

Table 22B. Demographic profi e of S NGLE SUBSTANCE pharmaceutica s exposure cases by generic category.

	No. of Case Mentions	No. of Single Exposures	Age							Reason				Treated in Health Care Facility	Outcome				
			<=5	6-12	13-19	>=20	Unknown Child	Unknown Adult	Unknown Age	Unint	nt	Other	Adv Rxn		None	Minor	Moderate	Major	Death
Analgesics																			
Acetaminophen Alone																			
Acetaminophen A one, Adu t	47,314	30,676	6,574	1,294	7,559	14,257	21	800	171	14,037	15,707	11	477	19,389	8,424	5,238	2,840	985	101
Acetaminophen A one, Pediatric	20,792	18,751	16,608	1,394	240	409	26	64	10	18,146	456	4	98	2,509	3,959	370	113	34	0
Acetaminophen A one, Unknown if Adu t or Pediatric	6,765	3,868	955	203	888	1,710	5	74	33	1,701	2,011	1	43	2,546	976	732	412	147	26
Acetaminophen Combinations																			
Acetaminophen in Combination with Other Drugs, Adu t Formu ations	5,638	3,186	661	139	1,256	1,041	2	64	23	1,141	1,924	2	70	2,170	774	808	502	57	1
Acetaminophen in Combination with Other Drugs, Pediatric Formu ations	365	308	263	41	3	1	0	0	0	298	5	0	3	23	73	9	1	1	0
Acetaminophen with Codeine	2,869	1,338	167	40	182	877	0	58	14	562	638	3	109	789	344	261	146	32	5
Acetaminophen with Diphenhydramine	6,400	3,779	565	94	733	2,278	2	87	20	1,117	2,576	2	36	2,765	811	861	825	177	9
Acetaminophen with Hydrocodone	11,323	4,890	696	122	537	3,309	1	189	36	2,316	2,240	23	215	2,868	1,217	1,008	542	217	14
Acetaminophen with Other Narcotics or Narcotic Ana ogs	195	96	8	1	12	69	0	4	2	38	47	1	8	63	26	18	14	9	0
Acetaminophen with Oxycodone	6,056	2,673	315	44	260	1,896	1	122	35	1,050	1,411	13	140	1,778	590	456	420	262	7
Acetaminophen with Propoxyphene	48	15	3	1	2	8	0	1	0	6	8	0	0	13	4	2	4	1	0
Acetylsalicylic Acid Alone																			
Acety sa icy ic Acid A one, Adu t Formu ations	8,224	4,304	1,531	208	823	1,633	1	85	23	2,175	1,959	5	75	2,528	1,080	628	754	106	11
Acety sa icy ic Acid A one, Pediatric Formu ations	2,086	959	466	71	136	265	2	12	7	606	304	1	17	433	238	81	113	23	0
Acety sa icy ic Acid A one, Unknown if Adu t or Pediatric Formu ations	6,007	2,748	716	135	557	1,259	5	47	29	1,148	1,415	3	52	1,792	612	511	521	112	8
Acetylsalicylic Acid Combinations																			
Acety sa icy ic Acid In Combination with Other Drugs, Adu t Formu ations	803	521	148	23	30	301	0	17	2	276	205	3	24	288	106	75	107	18	0
Acety sa icy ic Acid In Combination with Other Drugs, Pediatric Formu ations	2	1	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0
Acety sa icy ic Acid with Carisoprodo	3	1	0	0	0	1	0	0	0	1	0	0	0	1	0	0	0	0	0
Acety sa icy ic Acid with Codeine	24	19	2	0	2	15	0	0	0	6	11	0	2	13	2	5	7	1	0
Acety sa icy ic Acid with Other Narcotics or Narcotic Ana ogs	4	3	1	0	0	1	0	1	0	3	0	0	0	0	0	0	0	0	0
Acety sa icy ic Acid with Oxycodone	5	2	0	0	1	1	0	0	0	1	1	0	0	1	0	0	0	1	0

(continued)

Table 22B. Demographic profi e of S NGLE SUBSTANCE pharmaceutica s exposure cases by generic category – Continued.

			Age							Reason				Treated in Health Care Facility	Outcome				
	No. of Case Mentions	No. of Single Exposures	<=5	6-12	13-19	>=20	Unknown Child	Unknown Adult	Unknown Age	Unint	nt	Other	Adv Rxn		None	Minor	Moderate	Major	Death
Miscellaneous Analgesics																			
Non-Aspirin Sa icy ates (Exc uding Topica s and/or Gastrointestina Drugs)	357	282	145	10	34	72	1	15	5	238	32	1	10	71	57	38	13	2	0
Other Ana gesics	713	503	194	22	61	203	0	18	5	329	150	0	20	189	90	111	50	6	0
Phenazopyridine	1,432	1,233	929	30	40	208	0	22	4	1,121	52	0	55	269	413	99	29	5	0
Sa icy amide	5	4	4	0	0	0	0	0	0	4	0	0	0	1	1	0	0	0	0
Unknown Ana gesics	164	74	16	3	29	22	0	3	1	26	42	0	4	54	22	17	7	1	0
Nonsteroidal Antiinflammatory Drugs																			
Co chicine	384	255	51	7	5	186	1	5	0	175	48	0	30	141	55	47	40	7	3
Cyc ooxygenase-2 nhibitors	864	421	129	19	13	230	0	26	4	364	34	0	18	65	107	29	3	0	0
buprofen	83,082	62,762	38,959	3,621	8,631	10,182	45	1,036	288	48,745	13,168	33	560	14,982	14,666	4,385	1,124	97	1
buprofen with Diphenhydramine	2,411	1,490	321	31	273	797	0	58	10	737	714	0	29	783	288	289	238	22	0
buprofen with Hydrocodone	37	11	4	0	0	5	0	2	0	6	3	0	1	6	5	1	0	0	0
ndomethacin	356	190	47	6	17	107	0	11	2	126	44	0	18	63	34	31	10	0	1
Ketoprofen	35	12	7	0	1	4	0	0	0	8	1	0	3	3	4	2	1	0	0
Naproxen	12,509	7,103	2,099	267	1,667	2,734	3	280	53	4,102	2,762	2	191	2,902	1,964	941	261	14	1
Other Types of Nonsteroida	7,630	4,167	1,361	159	254	2,085	4	264	40	3,480	497	6	162	847	940	299	64	12	0
Antiinf ammatory Drug																			
Unknown Types of Nonsteroida	16	5	2	0	0	2	0	0	1	4	0	0	1	1	2	0	1	0	0
Antiinf ammatory Drug																			
Other Acetaminophen and Acetylsalicylic Acid Combinations																			
Acetaminophen and Acety sa icy ic Acid with Other ngredients	6,832	4,301	1,409	183	1,129	1,460	3	95	22	2,130	2,013	1	116	2,339	996	977	503	28	2
Acetaminophen and Acety sa icy ic Acid without Other ngredients	239	146	49	5	21	67	0	3	1	83	52	0	8	82	34	25	16	5	0
Pharmaceutical and llegal Opioid Preparations																			
A fentani	2	1	0	0	0	1	0	0	0	0	1	0	0	1	0	0	0	1	0
Buprenorphine	4,642	2,800	1,172	61	61	1,316	9	164	17	1,647	785	113	195	2,072	421	686	635	131	1
Butorphano	53	25	2	1	0	19	0	3	0	14	10	0	1	16	3	7	3	1	0
Codeine	1,203	802	233	100	64	368	0	31	6	632	126	2	33	218	197	110	23	2	1
Difenoxin	3	1	0	0	0	1	0	0	0	1	0	0	0	1	0	1	0	0	0
Dihydrocodeine	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Fentany (Prescription)	2,657	1,354	60	10	79	1,121	0	61	23	287	934	50	42	1,089	198	171	231	390	60
Heroin	8,317	4,859	25	5	93	4,561	0	132	43	209	4,441	135	25	4,381	466	447	842	2,193	121
Hydrocodone A one or in Combination (Exc uding Combination Products with Acetaminophen, Acety sa icy ic Acid or buprofen)	1,217	501	77	18	41	316	0	38	11	303	152	5	29	212	112	89	41	8	0
Hydromorphone	850	390	26	11	18	306	0	23	6	209	135	5	33	225	79	62	48	30	1
Levorphano	4	1	0	0	0	1	0	0	0	0	1	0	0	1	0	0	0	0	0
Meperidine	57	23	3	3	1	14	0	1	1	12	5	0	5	18	6	4	8	2	0
Methadone	2,117	979	123	16	30	746	1	49	14	406	382	64	73	799	116	161	250	191	5
Morphine	2,074	972	130	15	36	731	0	53	7	543	343	16	46	609	207	154	159	83	4
Na buphine	7	4	0	0	0	4	0	0	0	1	0	0	3	2	0	1	0	0	0
Non-Prescription Fentany	54	25	1	1	7	16	0	0	0	1	22	2	0	24	1	4	8	11	1

(continued)

Table 22B. Demographic profi e of S NGLE SUBSTANCE pharmaceutica s exposure cases by generic category – Continued.

	No. of Case Mentions	No. of Single Exposures	Age							Reason				Treated in Health Care Facility	Outcome				
			<=5	6-12	13-19	>=20	Unknown Child	Unknown Adult	Unknown Age	Unint	nt	Other	Adv Rxn		None	Minor	Moderate	Major	Death
Other or Unknown Narcotics	2,837	1,559	70	6	63	1,339	1	63	17	171	1,066	203	29	1,306	86	107	268	725	70
Oxycodone A one or In Combination (Exc uding Combination Products with Acetaminophen or Acety sa icy ic Acid)	6,529	2,989	399	117	255	2,015	2	162	39	1,355	1,383	38	135	1,907	584	521	480	366	12
Oxymorphone	91	44	5	1	2	34	0	1	1	14	26	0	2	36	8	2	12	10	0
Pentazocine	20	12	1	0	1	9	0	1	0	6	5	0	0	7	4	1	2	0	0
Propoxyphene	10	2	0	0	0	2	0	0	0	0	0	0	0	2	0	0	1	1	0
Synthetic Opioids, Ana ogs and Precursors (Exc uding Pharmaceutica Preparations)	117	68	1	0	6	52	0	7	2	19	45	2	1	63	7	10	21	17	3
Tapentado	184	94	6	1	3	80	0	4	0	49	36	4	3	55	18	21	16	5	0
Tramado	8,287	3,706	579	85	327	2,547	3	121	44	1,590	1,822	29	194	2,511	879	882	590	144	5
Serotonin 5-HT 1B,1D Receptor Agonists																			
Serotonin 5-HT 1B,1D Receptor Agonists: Other or Unknown	299	138	51	16	17	48	0	6	0	108	18	0	12	47	49	11	8	1	0
Serotonin 5-HT 1B,1D Receptor Agonists: Sumatriptan	980	454	119	37	51	228	0	15	4	327	70	0	55	184	126	59	34	1	1
Category Total:	**284,582**	**182,900**	**78,489**	**8,677**	**26,551**	**63,570**	**139**	**4,398**	**1,076**	**114,211**	**62,338**	**783**	**3,511**	**78,553**	**42,481**	**21,865**	**13,361**	**6,695**	**475**
Anesthetics																			
nhalation Anesthetics																			
Nitrous Oxide	195	149	24	6	14	98	0	6	1	61	73	1	14	87	17	35	32	8	1
Other Types of nha ation Anesthetic	74	58	1	0	2	48	0	5	2	45	4	3	3	35	9	15	5	2	2
Unknown Types of nha ation Anesthetic	1	1	0	0	0	1	0	0	0	0	0	0	1	1	0	0	1	0	0
Local and/or Topical Anesthetics																			
Dibucaine	16	15	11	0	0	3	0	1	0	15	0	0	0	1	3	1	0	0	0
Lidocaine	2,188	1,934	621	88	90	946	4	164	21	1,533	107	2	277	444	377	244	96	24	3
Other or Unknown Loca and/or Topica Anesthetic	2,993	2,774	1,378	140	148	937	7	152	12	2,340	124	23	269	472	696	305	113	30	0
Miscellaneous Anesthetics																			
Ketamine and Ana ogs	310	137	7	6	16	102	1	3	2	38	65	6	23	109	14	28	41	19	1
Other Types of Anesthetic	30	24	11	3	0	8	0	2	0	21	0	0	3	1	5	1	1	0	0
Unknown Types of Anesthetic	8	7	2	0	0	3	0	2	0	6	1	0	0	1	2	0	0	0	0
Category Total:	**5,815**	**5,099**	**2,055**	**243**	**270**	**2,146**	**12**	**335**	**38**	**4,059**	**374**	**35**	**590**	**1,151**	**1,123**	**629**	**289**	**83**	**7**
Anticholinergic Drugs																			
Miscellaneous Anticholinergic Drugs																			
Anticho inergic Drugs (Exc uding Cough and Co d Preparations, and P ants)	5,316	2,886	218	46	120	2,183	3	287	29	2,390	310	7	159	601	435	239	194	30	0
Category Total:	**5,316**	**2,886**	**218**	**46**	**120**	**2,183**	**3**	**287**	**29**	**2,390**	**310**	**7**	**159**	**601**	**435**	**239**	**194**	**30**	**0**
Anticoagulants																			
Miscellaneous Anticoagulants																			
G ycoprotein a/ b nhibitors	18	12	0	0	0	9	0	3	0	9	1	0	2	4	0	0	1	0	1
Heparins	213	185	31	6	3	123	0	21	1	160	13	0	10	60	43	16	7	0	1
Other Antip ate ets	3,096	1,060	196	18	10	745	0	82	9	979	54	1	22	179	260	26	5	3	0
Other Types of Anticoagu ant	5,583	2,847	478	28	22	2,099	4	204	12	2,564	183	1	88	528	663	71	55	12	2
Unknown Types of Anticoagu ant	20	14	8	0	0	4	0	0	2	13	0	1	0	3	8	0	0	0	0
Warfarin (Exc uding Rodenticides)	2,227	1,066	156	15	15	822	0	53	5	895	133	4	24	321	196	65	77	16	0

(*continued*)

Table 22B. Demographic profi e of S NGLE SUBSTANCE pharmaceutica s exposure cases by generic category – Continued.

			Age							Reason				Treated in Health Care Facility	Outcome				
	No. of Case Mentions	No. of Single Exposures	<=5	6-12	13-19	>=20	Unknown Child	Unknown Adult	Unknown Age	Unint	nt	Other	Adv Rxn		None	Minor	Moderate	Major	Death
Category Total:	11,157	5,184	869	67	50	3,802	4	363	29	4,620	384	7	146	1,095	1,170	178	145	31	4
Anticonvulsants																			
Anticonvulsants: Carbamazepine and Analogs																			
Carbamazepine	3,139	1,556	111	29	106	1,261	0	36	13	526	800	0	160	1,199	325	319	425	88	3
Oxcarbazepine	4,593	2,073	394	267	507	847	1	44	13	1,108	895	3	50	1,159	431	486	307	51	0
Anticonvulsants: Gamma Aminobutyric Acid and Analogs																			
Gabapentin	22,974	7,803	1,284	152	556	5,465	6	273	67	3,328	4,068	42	222	4,651	2,017	1,585	922	190	7
Other Types of Gamma Aminobutyric Acid Anticonvu sant	2,843	1,076	199	18	53	764	0	33	9	536	469	8	42	632	238	225	178	39	0
Anticonvulsants: Hydantoins																			
Fosphenytoin	12	10	2	0	2	6	0	0	0	5	0	0	5	10	1	4	2	1	0
Phenytoin	1,920	1,262	42	4	21	1,168	0	22	5	409	243	2	522	1,088	161	356	407	41	2
Miscellaneous Anticonvulsants																			
Fe bamate	71	27	8	8	3	8	0	0	0	25	2	0	0	9	9	4	4	0	0
Lamotrigine	10,774	4,223	510	193	795	2,513	3	189	20	2,569	1,483	2	141	2,043	744	895	581	121	2
Levetiracetam	5,584	2,803	942	270	258	1,243	3	72	15	2,191	536	5	47	862	769	343	111	21	0
Other Types of Anticonvu sant (Exc uding Barbiturates)	1,415	546	100	53	51	321	0	18	3	451	82	1	9	207	102	95	54	12	1
Primidone	350	120	12	3	6	96	0	2	1	80	30	0	9	59	22	26	22	4	0
Succinimides	198	133	64	42	15	10	0	1	1	120	12	0	1	23	38	19	6	0	0
Topiramate	4,553	1,659	413	145	349	689	1	46	16	910	668	3	67	925	467	351	178	12	0
Unknown Types of Anticonvu sant (Exc uding Barbiturates)	11	4	1	0	0	2	0	0	1	4	0	0	0	0	0	0	0	0	0
Va proic Acid	7,748	3,033	278	143	375	2,130	2	88	17	1,197	1,221	3	473	2,084	674	602	594	119	2
Zonisamide	742	374	83	35	51	189	1	14	1	310	55	0	6	80	105	37	12	0	0
Category Total:	66,927	26,702	4,443	1,362	3,148	16,712	17	838	182	13,769	10,564	69	1,754	15,031	6,103	5,347	3,803	699	17
Antidepressants																			
Lithium Salts																			
Lithium	7,085	3,869	98	51	420	3,146	2	111	41	912	1,342	4	1,384	3,270	574	910	1,348	197	4
Miscellaneous Antidepressants																			
Antidepressants: Type Unknown to Consumer	71	19	3	1	3	6	0	3	3	5	14	0	0	15	0	3	2	0	0
Bupropion	16,254	7,920	666	201	1,358	5,281	3	356	55	4,347	3,344	7	153	5,138	1,450	1,254	1,861	509	15
Other Types of Antidepressant	270	92	11	4	15	56	0	4	2	35	50	3	3	60	28	18	8	5	0
Trazodone	22,772	8,533	566	261	1,663	5,791	3	184	65	1,931	6,402	10	104	6,810	1,739	2,584	2,049	169	2
Monoamine Oxidase nhibitors (MAO)																			
Other Types of Monoamine Oxidase nhibitor (MAO)	63	22	5	0	0	15	0	2	0	19	0	0	3	7	10	2	2	0	0
Phene zine	45	16	0	0	0	15	0	1	0	6	6	1	3	11	3	1	5	0	0
Se egi line	43	15	6	0	0	8	0	1	0	14	0	0	1	5	6	0	1	0	0
Trany cypromine	51	25	0	0	0	21	0	4	0	11	7	0	5	19	3	2	11	1	0
Selective Serotonin Reuptake nhibitors (SSR)																			
Cita opram	7,508	3,082	662	148	782	1,383	1	89	17	1,506	1,494	8	58	1,719	834	558	460	58	0
Escita opram	10,663	4,798	778	304	1,753	1,783	1	143	36	2,039	2,597	7	124	2,865	1,336	990	648	36	1
F uoxetine	14,933	6,710	848	534	3,069	2,050	3	159	47	2,457	4,060	10	138	4,335	2,168	1,429	630	65	0
F uvoxamine	513	169	24	9	40	89	0	7	0	101	60	0	7	72	39	26	20	5	0

(continued)

Reference 79

From: [redacted]
To:
Subject: FW: Stepped Care Model for Pain / Other sources
Date: Friday, April 15, 2022 1:01:00 PM
Attachments: Opioid Taper Decision Tool.pdf
VADoDOTCPG022717.pdf
GAO-18-380 Progress Made Towards Improving Opioid Safety, but Further Efforts to Assess Progress and Reduce Risk Are Needed.pdf
CCCM_for_MHBM_102019.pdf
CCCM_rct_032019.pdf
STEPPED CARE MODEL FOR PM.pdf
painmgmt.pptx
Final_Report_Draft_11-15-2017.pdf
PLAW-114publ198.pdf

From: [redacted]
Sent: Friday, March 4, 2022 12:03 PM
To: [redacted]
Subject: Stepped Care Model for Pain / Other sources

I think many of the "concerns" regarding pain management at the facility (including increased numbers of patients going to the community) can be rectified by the facility simply following the Stepped Care Model for Pain and supporting the Primary Care Service's role in performing those functions which fall to them.

On the topic of tapering of any/all medications, while it can be done by the same prescriber who chooses to initiate the medication, best I can tell, otherwise, deprescribing of any medication would appropriately be a Primary Care duty. If patients needing to have their lisinopril or aspirin (or other such medication) discontinued were referred to Cardiology for the Cardiologists to deprescribe it, this would very quickly cause the Cardiology clinic to grind to a halt. The same would be true for an Interventional Pain Clinic if patients were referred to a clinic to do the actual deprescribing, reducing availability of a very important supply-side intervention in the treatment of chronic pain --- one that can both help minimize new opioid starts and help minimize the reliance on opioids even if they have already been initiated; furthermore, if the task of deprescribing were assigned to an interventional pain clinic, it may create a perverse incentive structure where the veteran feels compelled to undergo interventional pain procedures in order to influence the deprescribing rate/trajectory/plan of the interventionalist-would-be-also-deprescriber.

[redacted]

Not only does this facility require DEA licenses for its clinic providers, but aspects of the required education/training on opioids is mandated by law. This all falls within the purview of Primary Care providers practicing within their scope.

(1)

From CARA 2016:

b) PAIN MANAGEMENT EDUCATION AND TRAINING.—
(1) IN GENERAL.—In carrying out the **Opioid Safety Initiative** of the Department, the Secretary shall require **all employees of the Department responsible for prescribing opioids to receive education and training described in paragraph (2)**.
(2) EDUCATION AND TRAINING.—Education and training described in this paragraph is education and training on pain management and safe opioid prescribing practices for purposes of safely and effectively managing patients with chronic pain, including education and training on the following:
(A) The implementation of and full compliance with the VA/DOD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain, including any update to such guideline.
(B) The use of evidence-based pain management thera[1]pies and complementary and integrative health services, including cognitive-behavioral therapy, non-opioid alter[1]natives, and non-drug methods and procedures to managing pain and related health conditions including, to the extent practicable, medical devices approved or cleared by the Food and Drug Administration for the treatment of patients with chronic pain and related health conditions.
(C) Screening and identification of patients with sub[1]stance use disorder, including drug-seeking behavior, before prescribing opioids, assessment of risk potential for patients developing an addiction, and referral of patients to appro[1]priate addiction treatment professionals if addiction is identified or strongly suspected.
(D) Communication with patients on the potential harm associated with the use of opioids and other controlled substances, including the need to safely store and dispose of supplies relating to the use of opioids and other con[1]trolled substances.
(E) Such other education and training as the Secretary considers appropriate to ensure that veterans receive safe and high-quality pain management care from the Department.

(2)

From the Opioid taper tool:

“The Opioid Taper Decision Tool is designed to assist Primary Care providers in determining if an opioid taper is necessary for a specific patient, in performing the taper, and in providing follow-up and support during the taper.”

(3)

US Government Accountability Office --- May 2018 VA HEALTH CARE Progress Made Towards Improving Opioid Safety, but Further Efforts to Assess Progress and Reduce Risk Are Needed Accessible Version Report to Congressional Committees

- VISNs must develop local tapering protocols and plans to resource the implementation of those tapering proto
- 41VHA policy requires each medical facility to maintain a 0.25-0.50 full-time equivalent pain champion serving in primary care. See VHA Memorandum, *System-wide Implementation of Academic Detailing and Pain Program Champions* (Washington, D.C.: March 27, 201
- The Undersecretary for Health should require VHA medical facilities to take steps to ensure provider adherence to opioid risk mitigation strategies, including querying PDMPs, obtaining written informed consent, and conducting urine drug screening. For example, these steps could include creating alerts in the electronic medical record system to remind primary care teams when these actions should be completed or strengthening facility monitoring of providers. (Recommendation 5
- VA also stated that it will take actions to ensure that academic detailing programs are fully implemented and primary care pain champions are in place across the system.

OSI goal(9) Develop new models of mental health and primary care collaboration to manage the prescribing of opioids and benzodiazepines in patients with chronic pain	**VHA-required action** Identify strong practices that can be operationalized across VHA by quarter 3, fiscal year 2015; a request for proposal to be released to the field to establish model interdisciplinary teams and strategies fo

(4)

From the President's Opioid Commission of 2017

Final report (draft) – November 1, 2017

- "The expectation of eliminating a patient's pain as an indication of successful treatment, and

seeing pain as the fifth vital sign … was cited as a core cause of the culture of overprescribing in this country that led to the current health crisis. This must end immediately."

- CMS remove pain survey questions entirely on patient satisfaction surveys, so that providers are never incentivized for offering opioids to raise their survey score; prevent hospital administrators from using patient ratings from CMS surveys improperly
- CMS to review policies that may discourage the use of non-opioid treatments for pain. All primary care providers employed by federal health systems should screen for SUDs and, directly or through referral, provide treatment within 24-to-48 hours.
- Each physician employee should be able to prescribe buprenorphine (if that is the most appropriate treatment for the patient) in primary care settings.

(5)

Stepped Care Model for Pain Management

PACT in Primary Care (Step 1)
Routine Screening for presence and severity of pain; Assessment and Management of Common Pain Conditions; Support from MH-PC Integration; OEF/OIF; Post-deployment teams, Expanded Care management; "Pharmacy Pain Care Clinics"; Pain Schools, CAM integration.