August 2, 2023

The President
The White House
Washington, D.C. 20500

Re: OSC File No. DI-21-000354

Dear Mr. President:

I am forwarding to you a report transmitted to the Office of Special Counsel (OSC) by the Secretary of Veterans Affairs (VA) in response to the Special Counsel’s referral of disclosures of wrongdoing at the Veterans Integrated Service Network (VISN-4) Clinical Resource Hub (CRH) for TeleMental Health (TeleMental Health Hub or Hub), Pittsburgh, Pennsylvania. The whistleblower, [REDACTED], who consented to the release of her name, is a former Telehealth Clinical Technician at the Hub. I have reviewed the disclosure, agency report, and whistleblower comments, and, in accordance with 5 U.S.C. § 1213(e), have determined that the report contains the information required by statute and the findings appear reasonable.¹ The following is a summary of those findings.

The Allegations

[REDACTED] alleged that the TeleMental Health Hub had a backlog of approximately 1,000 Mental Health Services (MHS) consults and over 1,700 Return to Clinic Orders (RTCOs) for patients that needed to be scheduled or resolved in the VA’s Computerized Patient Record System (CPRS). The investigation did not substantiate the allegations, but recommended a number of corrective actions, which were implemented. [REDACTED] commented on the report.

The Agency Report

In 2012, the Hub was aligned under the VA Pittsburgh Healthcare System (Pittsburgh). In 2021, it was re-aligned under the VISN-4 CRH. The Hub provides MHS to patients in underserved areas, including the North Florida/South Georgia Veterans Health System and Tallahassee, Florida. CRHs, like the Hub, provide services to medical facilities and clinics, experiencing staffing gaps and shortages, called spoke-sites.

¹ OSC referred the allegations to Secretary of Veterans Affairs Denis McDonough for investigation pursuant to 5 U.S.C. § 1213(c) and (d). The Office of the Medical Inspector investigated the allegations and Secretary McDonough reviewed and signed the agency report.
In 2020, the North Florida/South Georgia Veterans Health System initiated using Hub services on behalf of the Tallahassee Health Clinic, which created a challenging surge in consults at the Hub. To accommodate the surge, the Hub assigned several providers to Tallahassee, which required approximately 4-6 weeks of preparation, including credentialing and privileging Hub providers. Investigators reviewed the total number of consults for the Hub and found no evidence of a 1,000-consult backlog. Investigators instead found approximately 307 consults that needed to be scheduled or resolved—147 of which came from Tallahassee—and Tallahassee staff recalled approximately 400 as the highest number of pending consults.

However, investigators also learned that confusion existed among Hub and spoke-site staff regarding scheduled appointments. Investigators discovered that Hub and spoke-site staff used a SharePoint calendar system as an adjunct to the Veterans Health Information Systems and Technology Architecture (VistA) scheduling system because the latter did not allow a spoke-site scheduler to see a Hub provider’s calendar. Hub staff used SharePoint calendars to provide spoke-site schedulers an accurate snapshot of providers’ calendars when arranging appointment times with patients. The actual appointments were then scheduled in the VistA system at the spoke site, which emailed the appointment information to the Hub for scheduling in the Hub’s VistA system, but this process created discrepancies and confusion.

Consequently, the TeleMental Health Hub revised the Hub Provider and Spoke Site Scheduling Standard Operating Procedure (SOP) to include clear instructions on how to schedule Hub appointments in VistA and how to use the SharePoint calendar as an adjunct to help ensure providers’ schedules are blocked appropriately among different spoke-sites. The SOP includes a monthly auditing and reporting process that Hub staff completes to validate that all appointments are scheduled in VistA. Hub and spoke-site staff received training on the SOP.

Further, the investigation did not substantiate that over 1,700 RTCOs were outstanding in CPRS. Investigators learned that the above number came from the VistA Scheduling Graphical User Interface (VS-GUI) system—a scheduling software module—and included patient requested appointments as well as RTCOs. Investigators also learned that the VHA Support Service Center (VSSC) RTCO-Open-Report Viewer is the official data site for accurate RTCO data—not VS-GUI. Pursuant to the VSSC RTCO-Open-Report-Viewer, the number of open Hub RTCOs was 370, comprised of 195 past due and 175 future RTCOs. Investigators determined that given that the Hub assisted 35 spoke-sites, this number was not atypical.

However, investigators discovered that Hub staff used a number of RTCO monitoring and tracking processes, but none were documented or standardized in SOPs. For example, before the Hub realignment, the Pittsburgh Group Practice Manager (GPM) tracked RTCOs and acknowledged Pittsburgh struggled to manage RTCOs across the facility. Therefore, the GPM held stand-down meetings with needed facility staff, including the Hub Administrative Officer (AO) to schedule RTCOs when they trended-up. The GPM noted that patients received timely MHSs but scheduled appointments were not always connected to the correct application or order, which caused roughly 20-30% of the RTCOs to appear incomplete or unresolved—he also
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noted no adverse events associated with RTCOs were reported. The Hub AO also tracked RTCOs by collaborating with the Hub Program Analyst to determine if RTCOs had been completed or required disposition. But investigators discovered these tracking processes were undocumented. Investigators also discovered that Hub leadership lacked familiarity with VHA processes and policies related to their roles.

As a result of the investigation, the Hub updated the *Hub Provider and Spoke Site Scheduling SOP* to describe the RTCO management process, and all Hub and spoke-site staff were trained on the SOP. Ongoing monitoring of RTCO scheduling processes showed a 99% compliance rate. The National CRH Operations Office completed four leadership training sessions with Hub leadership and staff, and leadership also attend monthly meetings with the National CRH Operations Office and other nationwide CRH staff to discuss business operations and quality management among other topics. Hub managers also review and discuss with staff the National CRH Operations Office SharePoint, operations guides, and discipline-specific quality management tools in monthly meetings. Hub leadership also consulted with the Office of Mental Health and Suicide Prevention for guidance and mentorship, then met with VISN-19 Hub leadership for additional mentorship—VISN-19 continues to provide ongoing guidance to the Hub.

**The Whistleblower’s Comments**

[Redacted] criticized Hub leadership’s lack of experience and how it on-boarded and managed new providers. [Redacted] disputed the report’s findings and disagreed with the conclusions regarding the unsubstantiated allegations. She also believed the investigators confused or limited the allegations.

I thank [Redacted] for bringing these important allegations to OSC’s attention. As required by 5 U.S.C. § 1213(e)(3), I have sent copies of this letter, the agency report, and whistleblower comments to the Chairmen and Ranking Members of the Senate and House Committees on Veterans’ Affairs. I have also filed redacted copies of these documents and the redacted referral letter in our public file, which is available online at www.osc.gov. This matter is now closed.

Respectfully,

[Signature]

Henry J. Kerner  
*Special Counsel*

Enclosures