Response to U.S. Office of Special Counsel (OSC), received from the U.S. Department of Veterans Affairs, in response to your allegations that employees at the Veterans Integrated Service Networks, Clinical Resource Hub for TeleMental Health, Pittsburgh, Pennsylvania, may have engaged in conduct that constitutes a violation of law, rule, or regulation, gross mismanagement, and a substantial and specific danger to public health.

The origins of my complaints were the mismanagement of onboarding and utilization of providers. The active or overdue consults and return to clinic (RTC) list demonstrated the need for staff to be onboarded. However, the investigators got confused and concentrated on scheduling processes and did not identify the link between the onboarding and delay in scheduling of patients since onboarding was significantly delayed due to mismanagement and disregard of the onboarding process.

Please see my comments below to allegations, recommendations, and summary statements.

**Allegation 1**-The investigators supported that Consults and Return to Clinic (RTC) orders were outstanding. Their confusion with VVSE vs. GUI as a mean to pull reports is confused with scheduling process. The use of Share Point and Vista have nothing to do with reports that documented that the HUB was not processing or documenting the required scheduling attempts outline in: VHA Directive 1230(4), Outpatient Scheduling Processes and Procedures, July 15, 2016.d in

**Recommendation** from investigators addressed a scheduling module that the HUB utilizes as a work around when TMP is unavailable and not the outstanding Consults or RTC list that are still pending. Ie: the HUB is processing large numbers of overdue Consults most notable from Wilmington and the associated CBOC: Cape May and Georgetown. New IFC are being submitted so dates fall within the range however the original Consults are all outside the mandated times.
**Allegation 2**-The investigators did not ask or observe the process in which RTC were pulled but identified the process as “not substantiate” when the witness provided a list for each provider at the HUB that included patients’ specific information. Investigators did note that “lack of documented processes regrading HUB operations” was found and disposition of RTC process” is not documented either. Furthermore, the finding that “leadership is relatively new to their position, the longest being in the role for 8 months” is not an excuse or lack /delay of patient care that the patients experience on the pending Consult and RTC list. The mismanagement and underutilization of admin staff and their concerns being validated by the HUB Chief, Program Manager/Operations Manager and AO is at the root of this problem.

**Recommendation** from investigators suggested that the HUB “develop a process to include RTC and education to staff” which has not occurred since National Scheduling Processes are in place but not monitored or adhered to by Management. No preceptors or collaboration has occurred.

In respects to the **Summary Statement** or finding of investigation that the HUB “may have engaged in conduct that constitutes a violation of law, rule or regulation; gross mismanagement and danger to public Heath” is documented even though they did not investigate the list provided. The egregious mismanagement and disregard for National Scheduling Policy is still on going. The original allegation of providers not being utilized or sitting and not seeing patients to include the Chief, averaged 4 months and the list of RTC and Consult provided need for timely on boarding.

The most recent example of mismanagement and waste is the creation of a 2.0 Subside Prevention Program (SPP) at the HUB that hired its first Social Worker in Oct. 2021 but did not start seeing patients until 3/2022. The gross delay and accuracy of clinic creation and basic access prevented the timely onboarding and impacted patient safety as well as waste since a paid employee sat unused for over 5 months. The 2.0 SPP has since hired 3 full time Social Workers and an MSA to support a program that has seen 29 patients to date however 39 consults were scheduled but 10 were cancelled. The VISN 4 2.0 metrics numbers presented by Psychology Program Manager for 3/2022 document numbers. (chart below)

The implantation of TMP as mandated by the VISN was successfully rolled out in Oct 2021 to include an SOP but since the detail of HUB RN/Scheduling Supervisor ended, Nov. 2021, the present leadership has not updated but irresponsibly circulated a signed SOP by only CRH Chief and not Director to patient’s sites that only confirms mismanagement and miscommunication that is routinely demonstrated by the operations manager (OM) that still does not perform the required duties of the position. The most recent mistake by the OM is delegating clinic creations by incorrect clinic name to GS7/GS6 that were rejected and prevented the creation of new clinic for establish PHD that is expanding care to PAL/HOSC. On 4/20 Psychology Program Manager delegated the clinic creation of Clinic to OM and the exact format NEEDED however the OM clinic names submitted or delegated to GS 7/6’s by newly hired scheduling supervisor were incorrect and rejected due to National Clinic name convention. As of 5/17/22 this clinic is still pending the corrections and therefor an example of the mismanagement, ill-trained and non-clinical OM that has only delayed onboarding since joining the HUB Aug. 2020 and beyond the “8 months” grace period sited in Conclusion for allegation 2. The OM is responsible for all clinic builds for all 29 providers at 51 sites as well as new hires.

My summary of the ongoing and not corrected action, gross mismanagement, inability to onboard new providers/prescribers and waste at the HUB are continuing, still impacting our patients, admirative staff,
providers, prescribers, as well as taxpayers. The fact the Telehealth Behavior Health being moved under the VISN 4 umbrella, and all new management was hired from outside the service line and that not 1 position was promoted from within, has contributed to the confusion and stifled it growth and adherence to mandated guidelines.

In conclusion the chart above shows how underutilized the social workers in the newly formed Suicide Prevention Program 2.0 (SPP 2.0) after a lengthy on boarding process. The delay and gross mismanagement onboarding the new Social Works ranged from 2-6 months, which is consistent with the original complaint and demonstrates that none of the issues have been corrected by the VISN 04 Tele Mental Health Clinical Resource Hubs: Director, Chief, Psychology Program Manager, Health Systems Specialist to Director, Telehealth Technology Manager (former Program Specialist), Director Operations Manager, Nurse Manger, Administrative Officer and MSA Supervisor. The gross mismanagement of resources and funds by inadequate, inattentive, discriminatory, retaliatory, and abusive leadership has negatively affected our veterans, patients, staff morale and wasted vast amounts of taxpayer’s money on staff salaries who were not providing much needed services.

Thank you!