



DEPARTMENT OF VETERANS AFFAIRS
Veterans Health Administration
Washington DC 20420

JUL 22 2014

In Reply Refer To:

The Honorable Carolyn N. Lerner
Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW, Suite 300
Washington, DC 20036

RE: OSC File No. DI-13-4505

Dear Ms. Lerner:

I very much appreciate the great discussion we had yesterday with your staff. There were several very useful insights that I think our entire team gained. I also appreciate the opportunity to provide additional details on the referenced case.

I want to start this story by stating that these patients were not on a psychiatric unit. Both patients were in a nursing home, or "Community Living Center" (CLC), under the care of a geriatrics team that included physicians, physician assistants, nurse practitioners, social workers, psychologists, pharmacists, physical therapists, recreational therapists, and nursing staff.

Case #1:

This Veteran was admitted to the CLC in 2003 with longstanding stable PTSD and chronic pain. Because he had a history of previous suicide attempts and depression, he was evaluated by psychology and psychiatry at that time. Over the next several months there were multiple evaluations by psychology, including a 3,853-word, extraordinarily detailed mental health evaluation. There was also a full evaluation by a psychiatrist at the time of admission. Periodic psychosocial assessments were documented, primarily to evaluate his decision-making capacity, and his psychiatric condition was consistently felt to be stable.

On admission, it was very clear that the Veteran was interested in moving from a non-VA nursing home to a VA long-term care facility. He rejected medication and visits by clinical consultants (and at times friends and family) on numerous well-documented occasions, but psychiatrists repeatedly assessed that he was competent to make simple decisions, including rejection of treatment. Although his clinical situation was very stable for a long time, it was a change in status that prompted his attending physician and the CLC psychologist to again consult a psychiatrist. The psychiatrist recommended adjustments to his antidepressant medications, but the patient rejected the recommendations. His course remained stable, and he participated intermittently in

individual psychotherapy, which had always been available to him. The patient's care team wrote more than 3000 notes in his chart during his stay in the CLC.

Case #2:

This Veteran required nursing home care because of physical limitations related to long-standing, severe Parkinson's disease that had been treated with both surgery and medications, as well as dementia. He also had a history of PTSD and psychosis prior to being admitted to the CLC. As in the case of patient #1, he received regular, continuous care by a geriatric care team who also consulted with neurologists and psychologists intermittently. Psychiatry was consulted once during his CLC stay to evaluate his medications. This patient's care team entered more than 2000 notes in his chart during the course of his CLC stay.

Although he had mental health issues, his PTSD had not been active for several years as documented by an extensive psychiatry evaluation a few months before admission. Furthermore, he had been on a stable medication regimen for his mental health problems for some time. A brief mental health evaluation was completed within days of admission to the CLC. Although it is true that a repeat psychiatric evaluation was not performed until 2012, the geriatric CLC team followed him regularly and obtained periodic consultation with neurologists to help manage his Parkinson's disease. The psychiatric evaluation that was done in 2012 was very limited because of the patient's advanced Parkinson's disease, dementia, and inability to communicate.

The patient's clinical course was characterized by progressive limitation in movement and worsening dementia. He passed away in 2013 while receiving comfort care following a 20-year course of progressive Parkinson's disease. I understand the patient's wife was very grateful and felt the patient received extraordinary care.

The Boston VA Medical Center (VAMC) viewed the OMI recommendation as an opportunity to augment the mental health care of CLC patients with regularly scheduled psychiatry visits rather than relying upon a psychologist's request for consultation. The medical center has fully implemented a new program whereby CLC patients on antipsychotic medications or those with significant psychiatric conditions now receive psychiatric consultation at least once a year. In fact, when the program began the Boston VAMC conducted a review of all patients receiving psychoactive medications, including simple sleep enhancing drugs. In addition, a clinical pharmacist now compiles a medication profile on all new patients admitted to the CLC and makes recommendations to the clinical staff about tapering, discontinuing, or adjusting medications during ongoing, monthly reviews. CLC patients are regularly tested for side effects of psychotropic medications, such as movement disorders. Since OMI's site visit, nursing personnel have undergone additional training in behavioral measures to reduce the need for psychotropic medications.

It is also noteworthy that the Boston VAMC has had for some time multiple mechanisms for staff to report concerns about patient care, safety, and business integrity or other ethical concerns. In addition to reporting through the chain of command, staff can report concerns anonymously through software tools that reside on every employee's desktop. I am told that they have averaged over 2000 internal reports every year. There is also an anonymous Director's hotline. I firmly believe the leadership has fostered a just culture of improvement and provided staff with multiple mechanisms to raise concerns. Additionally, I mentioned today that the father of one of our psychiatrists was a patient on that unit. She had regular contact with her dad and the staff. She told me that she never had any doubt that her father was getting the very best care available.

I hope this information is useful to you. It was not my intention to change the course of events when we discussed this yesterday. Rather, I had hoped to better understand ways in which we could better inform your adjudication of these disclosures. That conversation was extraordinarily helpful. We clearly need to do a better job of providing you with the evidence you need to draw your own conclusions about allegations like these. I think that will come with better dialogue and reporting. You have my most earnest commitment to make that happen. If I can provide any further information, please do not hesitate to contact me.

Sincerely,

A handwritten signature in black ink, appearing to read 'J. Tuchs Schmidt', with a stylized flourish at the end.

James Tuchs Schmidt, MD, MM
Acting Principal Deputy Under Secretary