RESPONSE TO THE OFFICE OF INSPECTOR GENERAL REPORTS
DATED JULY 28, 2015 AND SEPTEMBER 8, 2015
OSC FILE NO. DI-14-2762

REVIEW SUMMARY

Overall, my concerns are related to the inconsistencies, lack of thorough investigation, omission of pertinent information and bias towards the whistleblower. These deficits makes it clear that the intent of this investigation was to discredit my claims and not fully investigate my allegations.

The two letters from Robert Nabors, dated July 28, 2015 and September 8, 2015 are not consistent in regard to my allegations. To clarify, my allegations are as follows:

1. Mental Health Service line staff was improperly directed to record and track patient appointments on a separate Excel spreadsheet instead of the Veteran's Administration (VA) electronic tracking system; This is a violation of agency policy.
2. Scheduling staff in certain units were improperly directed to "zero out" patient wait times in violation of agency policy.
3. Management's failure to adhere to scheduling protocols and the use of improper scheduling practices have created a false appearance of acceptable wait times, while making significant delays in Veteran's access to care.

These allegations are in violation of VHA Outpatient Scheduling Processes and Procedures, VHA Directive 2010-027, June 9, 2010 as outlined below;

1. Per Agency's report: Allegation #1 was not substantiated despite Directive 2010-027 (19) (b) "No other wait list formats (paper, electronic spreadsheets) are to be used for tracking request for outpatient appointments." Per Witness 1. "The database is used to comprehensively track Veteran's care.....database consist of three separate databases, one for referrals, one for CORE and one for treatment. Concurrently, Veterans are immediately scheduled for appointments in VISTA as available."
2. Per Agency's report: Allegation #2 substantiated that MSA staff was directed to change data within the VISTA system. "Gaming strategies" were used to decrease the appearance of excessive patient wait times.
3. Per Agency's report: Allegation #3 was not substantiated despite the evidence to substantiate Allegation #2 was that the Chief of PAS (management) instructed MSAs to change scheduling data. It is important to note that this practice of "gaming" the system was taking place nationally throughout the VHA. Management, including Hines Director's office had full knowledge of these improper practices. In Joan Ricard's memo on May 8, 2014, she admits wait time issues at Hines and stated "we are monitoring metrics to assure timely care." She also outlined and gave examples on how scheduling can be manipulated and continues with the "pressure to improve reported results." This memo came the day after I met with Ms. Ricard to share with her "secret" or "separate wait list" that employees reported to me. It was my intention to assist with addressing these concerns. My request was to protect the employees that brought these reports but Ms. Ricard instructed me to tell employees to bring their

concerns to the Compliance Officer directly. I explained to her the fears of retaliation and she continue to insist that employees contact the Compliance Officer.

Furthermore, VHA DIRECTIVE 2010-027 also states in section 4. ACTION b. VISN Director, or designee, is responsible for the oversight of enrollment, scheduling, processing, consult management, and wait lists for eligible Veterans. Cc. Facility Director is responsible for (d) Ensuring standardized systems are in place to balance supply and demand for outpatient services including continuous forecasting and contingency planning. (e) Ensuring each clinic follows these additional business rules for standardizing work. 3. RESPONSIBILITIES: (1) Facility leadership must be vigilant in the identification and avoidance of inappropriate scheduling activities.

Both OIG reports contain information that is misleading and not accurate. It is important to point out that I was not provided a complete investigation file or transcripts of witness testimonies. My response below is solely focusing on the limited information provided in agency's summary reports.

Discrepancies, inconsistencies and inappropriate comments

My additional comments will focus on four specifics areas of concern:

1. The term "secret";
2. Patient care issues;
3. References to who my allegations were reported; and
4. Motives to manipulate wait times.

The term "Secret"

- The term "Secret" lists are used by staff and leadership in the context of waiting list that were not approved by central office, created internally, not openly available to stakeholders or veterans. The Agency's report does not provide a definition or criteria used to determine what is secret and was is not. Focusing on the term "secret" distracted from the purpose of the investigation by focusing on discrediting the whistleblower.

Violations of VHA Directive 2010-027 June 9, 2010 (19) (b) "No other wait list formats (paper, electronic spreadsheets) are to be used for tracking request for outpatient appointments."

VHA currently has two systems used for scheduling and charting, VISTA and CPRS. VISTA is the primary system for scheduling with appointments also being seen on CPRS. Providers are able to track and monitor veterans' appointments. The only justification for using a separate means for tracking treatments/appointments would be to keep information separate from VISTA which allows for manipulation. Employees are pressured to meet timeliness goals and therefore are motivated to create systems outside of CPRS and VISTA to meet those goals. In other words, the meeting of goals on paper is more important than the real experience of the veteran. Per Witness 1, the "database" consists of three separate databases, one for referrals, one for CORE and one for treatment. All of these can be

maintained in VISTA. Rather, these lists "databases" were used to track treatment. As Witness 1 stated, when an opening was available for individual therapy they had the MSA schedule the appointment. Referrals are consults and are tracked in CPRS. VHA DIRECTIVE 2010-027 VHA OUTPATIENT SCEDULING PROCESS AND PROCEDURES, outlines specific directions on the use of consults, Attachment E Consult Management. A separate list "database" is not necessary for tracking referrals.

- The "databases" used in Trauma Services were not known openly to stakeholders or veterans and therefore are considered "secret." For example, when a veteran requests a copy of his chart these "databases" are not included or referenced in his charting. If these "databases" are truly used to track treatment then the veteran should also be aware of the tracking of his/or treatment. To our veterans, these "list/databases" are definitely a secret.
- Privacy and security of these databases. The report does not discuss how these databases are maintained or the security procedures used to ensure privacy.
- "Patient Record System (CPRS) consult software (i.e., the consult tab in CPRS) to generate all request for specialty care consultations" "The only approved electronic wait list is the VISTA EWL (Electronic Wait List) No other wait list can be used for clinical services."
  (VHA DIRECTIVE 2010-027 VHA OUTPATIENT SCEDULING PROCESS AND PROCEDURES, June 9, 2010, Attachment A 3. And 4.)

Patient Care

The Agency's report does not reference how these lists and the manipulation of scheduling or wait times effected patient care. Numerous staff were interviewed but veterans were omitted. The report discusses the review of complaints but the policy if very clear on the surveying of veterans. There is no reference to these surveys in the report. VHA Directive 2010-027, "In addition, patients (both new and established) are surveyed to determine if they received an appointment when they wanted one." "It is VHA's commitment to provide clinically appropriate quality care for eligible veterans when they want and need it. This requires the ability to create appointments that meet the patient's needs with no undue waits or delays."

As a provider in Mental Health, I experienced the frustration of referring veterans into the Trauma Services Program. When veterans requested individual therapy it was a requirement that they attend the CORE sessions and then placed in groups in order to wait for an opening for a therapist for individual therapy. Many staff, including myself referred to these groups as "holding pens for veterans that we couldn't get into treatment."

The importance of accurate data and providing quality care to our veterans are synonymous. Public Law 104-262 is very clear on how reports to the Secretary are valuable in determining the needs of our veterans. This is also echoed in the Review of Veterans Access to Mental Health Care OIG April 23, 2012 12-00900-168; "Meaningful analysis and decision making requires reliable data, on not only the timeliness of access but also on trends in demand for mental health services, treatments, and providers; the availability and mix of mental health staffing; provider productivity; and treatment capacity. These demand and supply variables in turn feedback upon a system's ability to provide treatment that is patient centered and timely." This report continues to point out "VHA does not have a reliable and accurate method of determining whether they are providing patients timely access to mental health care services."

Orientation groups, similar to the CORE sessions is a mechanism used to give the appearance that the veterans are receiving treatment in a timely manner, this data is not reliable or accurate data. The use of data that is not a clear indicator of the supply and demand or the experience of the veteran interferes with Congress's ability to make appropriate recommendations.

Discrepancy of Witness 1 statement; she states beginning to utilize the database in approximately 2008 "log before the 2011, 14-day mandate. Per the Review of Veterans Access to Mental Health Care report, page 49 A. 1. "The first metric, "First-Time Patient's Access to a full Mental Health Evaluation", was developed in 2007" (not 2011). It assesses the time that takes for a veteran to receive a full mental health evaluation and treatment initiation if they have never previously had such a mental health service at VA. VHA mandated this be completed in 14 days after an initial 24 hour period in which a triage evaluation was completed."

References to how I made my disclosure

Comments "allegations made publicly" are derogatory and demonstrates bias towards the whistleblower and are misleading. The reports fails to report that I followed the Chain of Command, made a report to the OSC and cooperated with then OIG. My CBS interview was also mentioned in Witness #2 statements.

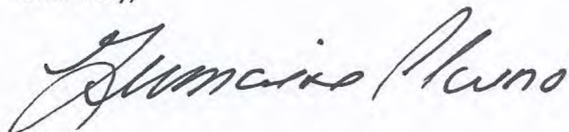
Motives to manipulate wait times:

Critical elements are used in VA's Performance Reviews. One of the critical elements is "Access to Care." Performance reviews provide a rating that are reflective of the amount of a bonus. The amount of the bonus is not as important as the deception it took for the "Access to Care" data to reflect outstanding performance in this critical area. The report does not reference reviewing any of the performance appraisals for Hines leadership but the element "access to care" is in front line providers appraisals and are also an element in the performance of managers and Hines leadership.

Conclusion:

This investigation by the OIG is an appalling. The levels I pursued to get the attention of Hines leadership to address these very serious allegation was frustrating but I never imagined that the oversight agency of VHA would continue the pattern of deceitfulness. This report is another form of disgrace and dishonors the men and women that made the sacrifices to protect and defend the United States of America.

Sincerely,



Germaine Clarno, LSCW, CADC