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October 30, 2015

Ms. Johanna Oliver
Attorney Disclosure Unit
U.S. Office of Special Counsel
1730 M Street, NW, Ste. 218
Washington, DC 20036

Re: OSC File No. DI-14-3657

Response of Shea Wilkes to the VA OIG Investigative Report,
*Results of Investigation by the Office of Inspector General of
Allegations of Misconduct Regarding Scheduling Practices in
Mental Health Clinic, Shreveport, LA VA Medical Center*

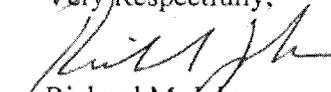
Ms. Oliver:

In accordance with 5 U.S.C. § 1213(e)(1), please find attached the response of Mr. Shea Wilkes to the above captioned investigative report issued by the VA Office of Inspector General in regard to complaints he made concerning improper scheduling tactics being used by the Overton Brooks Veteran's Administration Hospital in Shreveport, Louisiana.

Additionally, please find attached the *Consent to Public Release of Written Comments on Agency Report*.

Mr. Wilkes has asked that I express his gratitude to you and the other members of the Office of Special Counsel who have worked so diligently to protect our nation's Veterans and to correct the unacceptable conditions endemic to the current VA bureaucracy.

Very Respectfully,


Richard M. John

OSC File No. DI-14-3657

**5 U.S.C. § 1213(e)(1) Comments of Christopher Shea Wilkes
to the Report of the Office of the Secretary of Veterans Affairs Regarding
the VA OIG Investigative Report,**

*Results of Investigation by the Office of Inspector General of
Allegations of Misconduct Regarding Scheduling Practices in
Mental Health Clinic, Shreveport, LA VA Medical Center*

EXHIBITS

- Exhibit 1 Referral Letter from the Office of Special Counsel to the Secretary of the Department of Veterans Affairs
- Exhibit 2 Department of Veterans Affairs Response to the Referral from Office of Special Counsel
- Exhibit 3 Results of Investigation by the VA Office of Inspector General of Allegations of Misconduct Regarding Scheduling Practices in the Mental Health Clinic, Shreveport, LA VA Medical Center
- Exhibit 4 Internal Emails Regarding the Scheduling Issues at OBVAMC
- Exhibit 5 Letter from United States Senator David Vitter to VA Office of Inspector General
- Exhibit 6 Response to Freedom of Information Request for VA OIG Investigation of Christopher Shea Wilkes
- Exhibit 7 Screen Shot of the Computer File Folder Containing the Updated Combined Patient List
- Exhibit 8 Emails to the Office of Special Counsel
- Exhibit 9 Chart Summarizing the Failure to Meet OSC Standards for Completeness

SUMMARY OF RESPONSE OF CHRISTOPHER SHEA WILKES

In early 2013 Christopher Shea Wilkes initiated complaints concerning the manipulation of wait times for patients of the Overton Brooks Veterans Administration Medical Center, faulty hiring practices and abuse of comp time practices. After receiving no response to his complaints from the hospital administration or the VA OIG, Mr. Wilkes took his complaints to the press, to Senator David Vitter and to the Office of Special Counsel.

Mr. Wilkes complained that the hospital was manipulating the reported wait times of new and existing patients. Specifically, Mr. Wilkes complained as follows:

- The Overton Brooks Veterans Administration Medical Center uses several methods to manipulate the reported new patient wait times, including but not limited to the use of lists other than the EWL. In addition to maintaining lists other than the EWL the OBVAMC schedulers have been instructed in the use of “gaming strategies” to manipulate reported wait times. These practices include holding appointments without scheduling until capacity opens or entering into the system that the patient requested the out of date appointment. This can be confirmed through interviewing current and prior scheduling staff;
- The Overton Brooks Veterans Administration Medical Center uses several methods to manipulate the reported established patient wait times, including the use of wait list for existing patients. According to VHA procedure there should be no wait list for existing patients, they should not even be on the EWL because they are existing patients. Additionally, existing mental health patients are often provided appointments to group therapy in large groups and such an appointment is counted as being scheduled for an appointment to a prescribing mental health care provider. This can be confirmed through the existence of an actual list for existing patients containing over 600 patients waiting for appointments;
- The Overton Brooks Veterans Administration Medical Center disguises the lack of necessary providers or productivity of such providers through the use of the wait list. If the Overton Brooks Veterans Administration Medical Center is unable to provide access to care for existing patients it should use fee contract providers and evaluate the reason for the lack of capacity. Instead, the OBVAMC uses a wait list to hide the backlog of appointments;

- These practices are believed to be utilized for the purpose of protecting performance metrics, bonuses related to performance metrics, and the measurements of productivity.

The Mental Health Unit of the Overton Brooks Veterans Administration Medical Center was suffering from a lack of prescribing mental health care providers and that veterans were not being provided the medical care they needed. Mr. Wilkes was aware that many schedulers at the OBVAMC were not properly using the Electronic Wait List (EWL) and were not properly scheduling appointments for existing patients. According to the Veterans Administration, the EWL is the only wait list maintained by the VHA. A new patient should either be provided an appointment to a primary care provider or team within 90 days of requesting an appointment or should be placed on the EWL. An existing patient (other than one who has not been seen within the last 24 months) should never be on the EWL. The existing patient should always be provided a follow-up appointment. **There should be no other waiting list maintained by the VA.**

In the Spring of 2014 a scheduler at the hospital provided Mr. Wilkes a copy of an Excel spreadsheet which contained the names of 2,700 veterans. He was informed that this list was a list of veterans waiting for appointments. He was informed that it was a compilation of multiple lists (some on paper) that had been collected from schedulers that contained the names of veterans who needed to be scheduled, some of whom had not been seen in 12 to 15 months. When Mr. Wilkes provided this list to the VA OIG he and the scheduler who provided the list to him were placed under investigation for suspicion of Privacy Act Violations, HIPPPAA violations and Data breach.

As time passed more and more employees came forward and provided Mr. Wilkes with email documentation substantiating his concerns of wait time manipulation and scheduling problems. He provided these documents to the Office of Special Counsel and to the VA OIG.

After reviewing the documentation and information provided by Mr. Wilkes, the Office of Special Counsel determined that actions at the hospital “may constitute a violation of law, rule or regulation and a substantial danger to public health and safety.” Interestingly, the VA OIG, after being provided with the same documents, did not even find them of sufficient relevance to note their existence in the Investigative Report. Instead the report relied solely upon spreadsheets and witness interviews, even though the emails provided direct contradiction to the testimony of some of the witnesses.

Mr. Wilkes provides the following comments on the report issued by the Office of the Secretary of Veterans Affairs. As further discussed below, Mr. Wilkes believes that the report by the Office of the Secretary of Veterans Affairs and the Investigative Report of the VA OIG are a manifestation of the chronic, endemic problems plaguing the VA. When provided direct evidence of wait time manipulation, inadequate training of schedulers, intimidation by superiors and willful misdirection of facts to the press and others, the reaction of the VA administrators and the VA OIG was to whitewash the problems and to attack the messenger. Mr. Wilkes’ complaint is not important just because it lifts the shroud on the shady inner workings of the Overton Brooks Veterans Administration Medical Center, but because it is a common example of the problems existing throughout the VA system. It demonstrates the need for accountability in the VA system and the need for an investigative body that is independent from VA oversight.

The report issued by the Office of the Secretary of Veterans Affairs fails to address the issues referred to it by the Office of Special Counsel. The Office of the Secretary of Veterans Affairs investigative findings and conclusions are not reasonable nor are they complete. Additionally, even though the report notes several alarming practices at the OBVAMC the report concludes that there was no wrong doing and offers no corrective action. The practice of wait time manipulations and many other bad acts of administrators continue to the present day.

SUMMARY OF
DEPARTMENT OF VETERANS AFFAIRS
5 U.S.C. § 1213(d) AGENCY REVIEW

On June 30, 2014 Shea Wilkes filed Compliant DI-14-3657 with the Office of Special Counsel. After reviewing the information and documents provided by Mr. Wilkes, the Office of Special Counsel found a substantial likelihood that the information regarding Overton Brooks Veterans Administration Medical Center disclosed a violation of law, rule or regulation and a substantial specific danger to public health and safety. The Office of Special Counsel forwarded a request to the Secretary of Veterans Affairs on December 22, 2014 to investigate allegations:

1. that the hospital “failed to follow proper scheduling protocols”;
2. that scheduling personnel “are not properly trained on agency scheduling policies and that management does not require such policies be followed”;
3. that schedulers “were not using the electronic waiting lists at all, but rather maintained handwritten paper waitlist contrary to VA policy”; and
4. that in the spring of 2014 that management had determined that the “numerous paper wait lists had become unmanageable and had all the paper waitlist combined into one master list in the form of an Excel spreadsheet.” **See Exhibit 1.**

On August 26, 2015 the Office of the Secretary of Veterans Affairs responded to the referral from the Office of Special Counsel, pursuant to 5 U.S.C. 1213, to conduct an investigation with respect to the above stated allegations of Mr. Wilkes. **See Exhibit 2.**

The Office of the Secretary of Veterans Affairs Report stated that it addressed the following allegations submitted to it by the Office of Special Counsel:

1. Employees failed to follow proper scheduling protocols;

2. Scheduling personnel were not using the Electronic Wait List (EWL) as required;
3. Management failed to adhere to and enforce agency scheduling policies, which endangered public health and safety.

The Office of the Secretary of Veterans Affairs Report stated the following findings:

1. The Office of the Secretary of Veterans Affairs relied upon the Investigative Report of the VA OIG. The Office of the Secretary of Veterans Affairs Report stated that the VA OIG's Report investigated allegations that employees at the Shreveport Medical Center were instructed not to use the EWL and to keep a "secret" list instead;
2. The Office of the Secretary of Veterans Affairs Report stated that the VA OIG Report concluded that its investigation did not substantiate the allegations that employees at the Shreveport Medical Center were instructed not to use the EWL and to keep a "secret" list instead;
3. The Office of the Secretary of Veterans Affairs Report stated that an Excel spreadsheet was used in the Mental Health Clinic which identified veterans who needed to be assigned to a Mental Health provider;
4. The Office of the Secretary of Veterans Affairs Report stated that the spreadsheet was not used in place of scheduling patients who wanted to be seen nor was it used as a substitute for the EWL;
5. The Office of the Secretary of Veterans Affairs Report stated that there had been inappropriate training several years ago that carried through to present activities;
6. The Office of the Secretary of Veterans Affairs Report stated that there was evidence of a culture which may have promoted manipulation of wait times, but that culture was not apparent in the recent past or currently;
7. The Office of the Secretary of Veterans Affairs Report stated that it found "No evidence of patient harm or criminal activity".

SUMMARY OF VA OIG INVESTIGATIVE REPORT

Attached to the report from the Office of the Secretary of Veterans Affairs was a document titled *Report for the Office of Special Counsel Pursuant to the Provisions of Title 5 U.S.C. §1213, Results of Investigation by the VA Office of Inspector General of Allegations of Misconduct Regarding Scheduling Practices in the Mental Health Clinic, Shreveport, LA VA Medical Center.*¹ **See Exhibit 3.**

The Investigative Report states that the focus of the investigation by the VA OIG was:

1. To determine whether “Operations Manager Ruthie McDaniel instructed employees in the Mental Health care line to not use the Veterans Health Information Systems and Technology Architecture (VistaA), Electronic Waiting List (EWL), and to keep a secret list instead”; and
2. Whether a “secret wait list” was kept “on the Mental Health Clinic’s shared network drive.”

The Investigative Report concluded:

1. The spreadsheet containing the names of 2,700 veterans who needed to be assigned a Mental Health provider was not used in place of scheduling patients who wanted to be seen nor as a substitute for the EWL;
2. There was no evidence that “Ruthie McDaniel instructed employees in the Mental Health Clinic to avoid using the EWL or to keep a secret list.”

The following are relevant evidence and investigator conclusions cited in the Investigative Report:

¹ It should be noted that the Investigative Report does not identify when the investigation was conducted or when the witnesses were interviewed. The investigation by the OIG was initiated to determine whether Shea Wilkes, the whistleblower, had “disseminated the information on the Excel spreadsheets to anyone” and was not concerned with why the Excel spreadsheets existed or how they were being used. It was an investigation of Mr. Wilkes, not of his whistleblowing disclosure. Mr. Wilkes contends that it was a threatened personnel action in violation of 5 USC 2302(b)(8). It insults the Whistleblower Protection Act and the OSC to present an illegal retaliatory investigation as a response to the Special Counsel’s order under 5 USC 1213(b) to investigate the agency’s misconduct. Specifically the investigation was focused upon whether Shea Wilkes had committed a Privacy Act Violation, HIPAA violation or Data Breach in his effort to obtain information to substantiate his complaints of wrong doing by the VA.

1. The spreadsheet contained tabs "Appts Needed", "Deceased", "Followed by Another VA", and "Seen Recent but No Follow-up";
2. The tab titled "Appts Needed" contained notes indicating the last time the patient had been seen, with many not having been seen since 2013;
3. The tab titled "Deceased" had notes associated with patients. "There was no information indicating cause of death";
4. The list was created to "keep patients" from falling through the cracks;
5. In January 2014, Stephanie Alexander used the Data Support System (DSS) to compile a list of all patients seen by Mental Health Services at Shreveport VAMC from December 2012 to January 2014;²
6. It was a waiting list for providers, not a list of patients waiting for a specific appointment;
7. The list was used "to make sure that no veterans were lost";
8. "They could not use the Electronic Wait List (EWL) because the patient did not have a doctor assigned to them";
9. "Stephanie Alexander was tasked to collect the names of all patients that had been 'cast adrift' due to loss of physicians"; and
10. "There was no mention of any handwritten lists created by anybody at any time."

² The DSS list was not obtained from DSS until sometime after it was requested on February 27, 2014 by Ruthie McDaniel. Email from Ruthie McDaniel dated February 27, 2015 confirms the date that she requested a list from DSS. See **Exhibit 4, page 69**. Emails from Stephanie Alexander dated February 26, 2014 discuss the use of multiple lists, including excel spreadsheets and paper lists. It does not mention the DSS list. See **Exhibit 4, page 70**.

RESPONSE OF SHEA WILKES

Initiation of the Complaint

Christopher Shea Wilkes is an employee of the Overton Brooks VA Medical Center in Shreveport, Louisiana and he is a veteran of Operation Enduring Freedom and Operation Iraqi Freedom. He has a Master's Degree in Social Work and is employed by the VA as a licensed clinical social worker. He has dedicated his life to caring for his soldiers and fellow veterans.

In early 2013 he addressed the Acting Chief of Staff of OBVAMC with issues concerning faulty hiring practices and the manipulation of numbers related to performance measures and scheduling.

No action was taken by the VA Leadership.

In June 2013 he reported issues concerning faulty hiring practices and the manipulation of numbers related to performance measures and scheduling to the Office of the Inspector General for the VA (OIG). **See Exhibit 4, page 82.**

He has never received a response to this complaint.

During this time Mr. Wilkes heard fellow employees complaining about veteran scheduling problems and the lack of providers. He heard veterans being told that they would be called at a later date when an appointment was available. He knew that the Mental Health Unit was suffering from a shortage of prescribing mental health providers and that veterans were not being provided referrals to physicians outside of the VA system. He knew that the veterans who received treatment from the OBVAMC were not receiving the care that they needed and he knew that the substandard care was not being reflected in the statistics reported by the hospital.

After watching the Phoenix VAMC story develop, Mr. Wilkes decided that he could no longer wait on action from OIG. He had exhausted all internal options and decided to take his story to the media. In May 2014, he worked with a reporter from the *Shreveport Times* to expose the practices used to manipulate wait times and performance measures at the Overton Brooks Veterans Administration Medical Center. During this process he was able to secure a copy of a document that he referred to as a wait list. This document was a password protected document that was being drafted by a scheduler, Stephanie Alexander at the instruction of hospital leadership. The document was titled "Updated Combined Patient List".³ **See Exhibit 7.** He immediately informed OIG of the existence of the list.

He also contacted the office of Senator David Vitter in an effort to get the VA OIG or OBVAMC to investigate the existence of the manipulation of patient wait times. He provided the Senator's office with a synopsis of the problems he had witnessed. This synopsis noted several methods used by the hospital to manipulate wait times and to hide the backlog of appointments. The existence a list outside of the EWL was only one example of this manipulation.⁴

On June 17, 2014, Senator Vitter sent a letter to the Acting Inspector General, Richard J. Griffin. In this letter Senator Vitter informed Mr. Griffin of the information that he received from Mr. Wilkes and requested that the VA OIG "launch a full review about these claims immediately." **See Exhibit 5.**

³ The VA OIG removed the hardrive from Mr. Wilkes computer that contained a copy of the list. No mention is made in the Investigative report of any effort to ascertain when the list was created or to compare it to the DSS list requested by Ruthie McDaniel on February 27, 2014.

⁴ The complaints made by Shea Wilkes never mentioned Ruthie McDaniel. Ms. McDaniel's name was later mentioned to the VA OIG as an example of what was occurring. It is unknown why the VA OIG decided to focus its investigation solely upon the actions of Ruthie McDaniel rather than the entire scheduling manipulation process. **See Exhibit 6.**

On June 18, 2014, Mr. Wilkes received a call from a VA OIG Special Agent in the criminal division. The Special Agent explained that he and another agent were on their way to Shreveport from New Orleans and that they wanted to meet with Mr. Wilkes and obtain the spreadsheet list. He believed that the VA OIG was calling in response to the request from Senator Vitter. It appeared that after months of trying to get the VA OIG's attention that the existence of the wait-list was going to be investigated.

However, the Special Agents were not there to investigate the existence of the wait list. They were there to conduct a criminal investigation into Mr. Wilkes actions in obtaining a list that was not supposed to even exist. The investigation by the VA OIG was initiated to determine whether Shea Wilkes, the whistleblower, had "disseminated the information on the spreadsheet list to anyone" and was not concerned with why the spreadsheet list existed or how they were being used by the schedulers. Specifically, the investigation was focused upon whether Shea Wilkes had committed a Privacy Act Violation, HIPAA violation or Data Breach in his effort to obtain information to substantiate his complaints of wrong doing by the VA. **See Exhibit 6, page 4.**

Once Mr. Wilkes realized that the VA OIG investigators were conducting a criminal investigation into his actions, on advice of counsel, he refused to discuss how the spreadsheet list was obtained, but agreed to explain to them how the patient wait times were being manipulated and provided them with documents to substantiate his claims. The VA OIG agents were not interested in discussing the issues concerning the manipulation of wait times and how the spreadsheet list came into existence.

On June 30, 2014, Mr. Wilkes contacted the Office of Special Counsel and provided them with the same documents that he had provided to the VA OIG.

The Investigation by the Office of the Secretary of Veterans Affairs and the VA OIG was Focused Upon the Actions of the Whistle Blowers and not the Allegations of scheduling manipulation by the OBVAMC

When a referral is made from the Office of Special Counsel to the Office of the Secretary of Veteran Affairs the findings must be reasonable and complete. The findings are reasonable if they are credible, consistent and complete based upon facts in the disclosure, the agency report and the comments offered by the whistleblower under 5 U.S.C. § 1213(e)(1). As a matter of policy the VA OIG investigators are expected to interview the whistleblower at the beginning of the investigation. The referral letter was sent on December 22, 2014.

Mr. Wilkes was never interviewed by the VA OIG after the referral from the Office of Special Counsel. The only interviews conducted by the VA OIG was by Special Agents from the Criminal Investigations Division of the VA OIG. **See Exhibit 4, page 45 to 47.** These interviews occurred on June 18 and 19, 2014 concerned with how Mr. Wilkes obtained the spreadsheet and whether he had committed a Privacy Act Violation, HIPPA Violation or Data Breach Violation. The interview was not concerned with why the spreadsheet existed or how it was being used to manipulate wait times. **See Exhibit 6.**

The Investigative Report issued by the VA OIG demonstrates that the investigation by the VA OIG was tailored to reach a result unrelated to the actual allegations of wrong doing by Mr. Wilkes. **See Exhibit 3.**

The VA OIG Investigative Report is specifically limited to whether “Ruthie McDaniel instructed employees” to take certain action and to whether the spreadsheet was a “secret list.” By narrowing the investigation to two specific and less consequential

aspects of the problem, the VA OIG was able to conclude that “the investigation did not substantiate the allegations raised by the Complainant.” The focus of the VA OIG’s investigation did not address the issues submitted to the Secretary of Veterans Affairs by the Office of Special Counsel and it did not address the complaints made directly to the VA OIG by Shea Wilkes. The focus of the VA OIG Investigative Report was a purposeful manipulation of the Complaints made to them and were specifically tailored to not address the issues of scheduling manipulation and the use of unauthorized lists.

The issues raised by the Office of Special Counsel and by the complaints of Mr. Wilkes concerned the broader issues of how scheduling was being manipulated and how Veterans were not being provided treatment in a timely manner. The complaints made by Mr. Wilkes did not even address the actions of Ruthie McDaniel.

The Response to the Referral of the Office of Special Counsel by the Office of the Secretary of Veterans Affairs does not comply with Statutory Requirements

The response to the referral of the Office of Special Counsel by the Office of the Secretary of Veterans Affairs fails to comply with the requirements of 5 U.S.C. § 1213(e). The statute requires that the response be reasonable and complete. Using the OSC’s *Guidance for Submission of Agency Reports to Office of Special Counsel (OSC) Pursuant to 5 USC 1213(c)* as a baseline, the investigation by the VA OIG was not complete and did not adequately address the issues submitted to the Office of the Secretary of Veterans Affairs by the Office of Special Counsel.

The Office of Special Counsel requested that the agency investigators interview Mr. Wilkes concerning the issues raised. As stated above, the VA OIG investigators with the Criminal Division interviewed Mr. Wilkes on June 18 and 19, 2014. The interviews were concerning the actions of Mr. Wilkes and did not concern the manipulation of wait

times. The VA OIG never interviewed Mr. Wilkes after the referral by the Office of Special Counsel on December 22, 2014. Mr. Wilkes, on several occasions, offered to discuss the manipulation of wait times and other inappropriate practices at the OBVAMC with the VA OIG. This offer was never accepted.

Mr. Wilkes remains ready to provide VA OIG investigators with the names of individuals who could provide information regarding the manipulation of wait times. Since Mr. Wilkes provided this list to the Office of Special Counsel on July 22, 2014. **See Exhibit 8, page 1.** On August 4, 2014 Mr. Wilkes provided the Office of Special Counsel the identity of a witness who noted in a patients file that her patient was placed on a wait list and of continued manipulation of wait times by the OBVAMC. **See Exhibit 8, page 2 to 3.** September 12, 2014 Mr. Wilkes provided the Office of Special Counsel with a memo outlining how schedulers were continuing to manipulate the system. **Exhibit 8, page 4 to 5.** Had the VA OIG investigators contacted Mr. Wilkes he could have provided them with this and other pertinent information.

The Report issued by the Office of the Secretary of Veteran Affairs was also incomplete in that it did not address the issues presented to it by the Office of Special Counsel. Instead it relied upon an investigative report filed by the VA OIG which focused on other issues such as the specific actions of Ruthie McDaniel and whether there was a "secret list". The VA OIG Investigative Report itself states, "This investigation was based upon information reported to the VA OIG Hotline Division by an employee at the VA Medical Center (VAMC) in Shreveport, Louisiana." There is no mention in the Investigative Report that the investigation was in response to the referral from the Office of Special Counsel or that it addressed the issues contained in the referral.

The Report issued by the Office of the Secretary of Veteran Affairs was also incomplete in that it did not identify the personnel who performed the investigation, it did not disclose whether any of the witnesses were offered confidentiality, it did not state whether any witnesses were granted anonymity, it did not state whether notice was provided for the on-site investigation and it did not reveal the areas of inquiry for each witness. The report did not cite which law or rule of law was relevant to the whistle blowers complaint nor did it clarify why it deemed some of the findings to be more persuasive than others. A chart summarizing the failure to meet OSC standards for completeness is enclosed as Exhibit 9.

The Documents Provided to the VA OIG Directly Contradict the Witness Testimony and Conclusions of the VA OIG Investigative Report

The documents provided to the Office of Special Counsel and the VA OIG support the complaints of Mr. Wilkes and directly call into questions the witness testimony and conclusions of the VA OIG Investigative Report:

1. OBVAMC initially denied the existence of the Excel spreadsheet to the media. *Email from James C. Patterson to VHASHR MH Service dated June 18, 2014, "There is no secret wait list." See Exhibit 4, page 56 .*
2. The existence of the Excel spreadsheet and the lists which were used to comprise it was an open secret within the halls of the OBVAMC. The VA OIG report incorrectly suggests that "paper wait lists" did not exist. *Email from Stephanie Alexander to Numerous Employees dated February 26, 2014 "As we all know, there are a 'few' (>2400) patients that need to be scheduled. They are currently on multiple lists **and some on paper.** It is imperative that we start this scheduling process so that these patients can be seen in a timely fashion." See Exhibit 4, page 70. Email from Stephanie Alexander to Numerous Employees including Ruthie McDaniel and James Patterson dated February 26, 2014 "As you are aware, there are multiple lists, excel sheets, appears **that contain names of patients that need to be scheduled** – just a few approximately 2400 existing patients- some have not been seen in as long as 12-15 months ... This assignment of patients is going to involve: combing the lists, identifying "asap" patients, identifying high risk patients, identifying oef/oif patients ... the MSA will be working the excel sheets updating and making appointments ..." See Exhibit 4, page 74.*

3. *Email from Stephanie Alexander to Numerous Employees dated February 26, 2014* “There have [sic] are **many patients that have been assessed as needing an “asap” appointment** ... For the rest: The majority have either been seen via the MHACS or not seen in 6, 12 or more months ... take the patients who are marked as “asap” or High Risk and schedule them first in with new providers ... This is a starting process – if it is not efficient, we will re-group and try again, but if we don’t get started, we will only delay having these patients seen.” **See Exhibit 4, page 70.**
4. After denying the existence of the list to the media, the hospital eventually confirmed the list existed. *Email from John Magee to Toby Matthew dated June 20, 2014, 3:03 pm* “Staff were informed that **there was a list of Veterans waiting to be scheduled for appointments** with prescribing providers ... We were told that the list was over 2,700 veterans.” **See Exhibit 4, page 7 to 12.** *KTBS News dated June 20, 2014 9:35 p.m.* “Rep. John Fleming (R-La.) said that **he has confirmed the existence of a waiting list separate from the official scheduling system** ... Mr. Matthews confirmed that a list was kept, separate from the scheduling system that the facility is supposed to use, mental health patients seeking appointments. He explained that it was a pass-word protected list that was available to a number of staffers.” <http://www.ktbs.com/story/25834191/more-details-of-overton-brooks-va-wait-list-revealed>
5. The various lists were in existence and in use prior to April 2013. *Email from Paul Antoniou to James Patterson, Ruthie McDaniel, et al dated February 27, 2014* “Team, I have been intimately involved with this process which started in April 13 and want to move forward with it ...” **See Exhibit 4, page 70.**
6. The improper lists were being used to schedule patients as late as June 2014. *Email from John Magee to Toby Matthew dated June 20, 2014, 3:03 pm* “We were told that the scheduling of Veterans appointments from this list had been ordered to be stopped. We were told that the order came from MHS leadership/administration and that the scheduling had indeed been stopped, per orders.” **See Exhibit 4, page 8.**
7. The hospital administration and the VA OIG improperly characterized the list as a DSS list, a BHIT list and a waiting list kept separate from the official list. **The VA OIG Investigative Report even states that the list was obtained from DSS by Stephanie Alexander in January 2014.** The request to DSS for a list was not even made until February 27, 2014. *Email from Ruthie McDaniel to Paul E. Antoniou, James Patterson, et al. dated February 27, 2014 3:16 p.m.* “ Just FYI – I have communicated with DSS to see if there is a query that can be ran to assist with the dates, identification of HR Veterans, etc. ... I will share on Monday. Comp time not approved.” **See Exhibit 4, page 69.**
8. Hospital Directors routinely emailed employees with thinly veiled threats against those bucking the system stating that the whistleblowers are liars and not team players. *Email James Patterson to VHASHR MH SERVICE dated June 24, 2014* “it

is unfortunate that others are twisting this to be the lies presented in the media. The misrepresentations, misinterpretations, and other propaganda in the media are just that, never forget ... I am just as sick of this propaganda as you are ..." See Exhibit 4, page 16. Email James Patterson to VHASHR MH Service dated June 18, 2014 "The VAMC is not obligated to reply to these types of stores [sic] in the media, and to do so would be inappropriate, given that the OIG is investigating. We can and will let the OIG determine what is true." See Exhibit 4, page 56. Email James Patterson to VHASHR MH SERVICE dated June 18, 2014 "To begin with I want to remind you of the definition of propaganda: Propaganda ideas or statements that are often false or exaggerated and that are spread in order to help a cause, a political leader, a government, etc. Keep this definition in mind when reviewing media about our service, because it most definitely applies." See Exhibit 4, page 50. Email James Patterson to VHASHR MH SERVICE dated June 19, 2014 "VINCIT OMNIA VERITAS I've added this to my email signatures as I think that this is a message that should serve both as a reminder of this time that we are all going through, as well as something that is just good. It means TRUTH CONQUERS ALL. And while I can't say anything about my meeting I may have had with anyone, I can say this {image of large smiley face}. See Exhibit 4, page 49.

9. Attempts to hide scheduling problems through manipulation resulted in a significant delay of care to 2,700 veterans waiting to receive care from the mental health unit of OBVAMC. Email from John Magee to Toby Matthew dated June 20, 2014, 3:03 pm "The staff member indicated that three Veterans on the waiting list for an appointment had been hospitalized on the in patient psychiatric unit here while still waiting for an outpatient appointment in MHS ... It was also shared that an MSA/PSA in MHS had found that there were "37 deaths" of Veterans who were on the list awaiting appointments ... However, the information at the 5/7/14 meeting suggested very serious concerns in a process of halting the scheduling of appointments for Veterans, which was indeed affecting Veterans. When the order came to stop scheduling, Veterans were indeed waiting." See Exhibit 4, page 7 to 12.
10. The Report by the Office of the Secretary of Veterans Affairs concludes that there was no problem with schedulers using the EWL. Email from John Magee dated June 26, 2014 recounting an Administration Meeting. The email notes that at a June 17, 2014 meeting the medical director asked who was using the EWL. One person responded, "We just got trained, we haven't used it yet." Others agreed that they had "just" been trained, but had not used it yet. See Exhibit 4, page 5.
11. The shortage of prescribing providers for mental health created a significant lack care for veterans. Email from James Patterson dated October 15, 2013 describes the lack of providers as "things are getting grim". See exhibit 4, page 87. During this

same time period the OBVAMC reported that 98.8% of all established mental health patients received appointments within 14 days.⁵

An Eye-Witness came forward to the Media to Confirm the Existence of Paper Wait-Lists

On July 2, 2014 the KTBS news Station in Shreveport, Louisiana ran a story regarding the existence of paper wait-list. A veteran and patient of the OBVAMC, Michael Stewart, came forward and shared his experiences of trying to have appointments scheduled with mental health services at OBVAMC. Mr. Stewart told the reporter,

“The secretary that I was standing in front of, she said well we need to see if I can schedule you an appointment, and let's see if you're on this list. She pulls out this list that's all stapled together. It's 5-7 pages of veterans names and social security numbers, I mean it was 5-7 pages of it, and I was not on that list. So she leans back and talks to her neighbor,” says Stewart. “She asked the other person if I was on her set of lists, and she brought it over, and it was another list, that was pages, it was 5-7 pages, it was a packet, and of course they found my name on the list, and they said okay, we'll put you down for an appointment, and they marked my name down, they put a check beside it, and that's all that happened.” <http://www.ktbs.com/story/25927957/overton-brooks-mental-health-patient-says-va-is-lying-about-access-to-care>

Issues caused by the Improper Practices:

- Metrics are skewed which result in an improper analysis of the actual healthcare being provided to Veterans, thus the fact that delayed care is being provided is hidden;
- The skewed metrics have a direct effect upon the bonuses received by employees;
- The skewed metrics have a direct effect upon performance evaluations of staff and the hospital as a whole;
- The skewed metrics allow for manipulation of budget practices.

⁵ <http://www.ktbs.com/story/27940739/emails-obtained-by-ktbs-show-shreveport-va-wait-times-in-2013-didnt-match-grim-reality>

Suggested Actions to Investigate the issues at the OBVAMC

- Press the VA OIG to send new investigators to the facility to interview the scheduling staff, employees and providers to discuss the systems used for scheduling;
- Perform a search of electronic documents identified by such employees;
- Establish a hotline solely for employees of the OBVAMC to expose improper practices in regarding to scheduling, the use of wait lists and other measures to manipulate performance metrics, bonuses and productivity;
- Provide these employees with anonymity and protection for their jobs and confirm whistleblower status.

CONCLUSION

The current controversies emanating from the U.S. Department of Veterans Affairs Medical Centers across the nation are merely symptoms of a disease that permeates the entire system. The scheduling manipulation at the OBVAMC and intimidation by criminal investigation faced by Shea Wilkes and other whistleblowers is a reflection of systematic problems. The VAMC's undeniably suffer from unaccountable leadership, which in many cases has become more concerned with perpetuating itself rather than caring for its patients. This disease is so ingrained into the system that prophylactic remedies will not provide a cure.

The VA has fostered a culture of cronyism and fraudulent practices that allows administrators to game the system for their personal gain. Strategies to manipulate wait lists are used to hide the failure to provide timely care and to shield administrators from bad performance reviews. *The New York Times* reported on May 28, 2014 that a report from the Acting Inspector General confirmed "manipulation to hide long and possibly growing waiting times were 'systematic throughout' the sprawling Veterans Affairs health care system." The approval of comp time is used to punish or reward employees

depending upon whether they are willing to “play the game”. Fraudulent hiring practices are used to place “the right” people into key positions.

The very agency that is to police the system, the VA Office of Inspector General, has been shown time and time again to be more concerned with stifling dissent by investigating whistleblowers themselves or finding that the wrongdoing resulted in no harm to patients. On June 25, 2014 *Fox News* reported that the Office of Special Counsel was investigating 37 cases of whistleblower reprisals by the VA. It also reported that the Office of Special Counsel informed President Obama “that the embattled VA had not properly investigated more than two dozen cases in which employees alleged manipulated wait-times and improper care.”

These problems are ingrained in the very fabric of the system itself and have existed for years. On June 9, 2014 the *New York Times* issued a previous report showing that the problems of manipulating wait times had existed for over fifteen years. The VA makes gaming the system profitable, providing larger bonuses and better performance evaluations for those who “play the game.” Despite the enormous failures on the part of the VA system, *CNN* confirmed in a June 20, 2014 report that 78% of VA senior managers received bonuses and 100% received ratings of “fully successful or better.” The VA leadership has proven that it is unable to correct its course without outside influence.

Currently, the most public manifestations of the disease are the “secret wait list”. This term is a bit of a misnomer because **the lists are not “secret” to the administrators in the hospitals. The lists are “secret” because, under the VA system they are not supposed to exist.**

The VA uses a comprehensive process for tracking the medical care our veterans receive. Essential to this process is the use of an electronic wait list. This list, the EWL, is the only VA appointment list that is supposed to exist. According to a May 2014 memorandum issued by the Department of Veterans Affairs, the primary purpose of the list is to “provide a transparent list of patients who cannot be scheduled for an appointment within 90 days or are waiting for an appointment. This computerized list is managed, tracked and reported at multiple levels in VA.” The VA policy is clear, “No other wait list formats (paper, electronic spreadsheets) are to be used for tracking requests for outpatient appointments.” If the facility does not have the capacity to schedule a follow-up appointment facility managers must evaluate the reason and take appropriate steps to resolve it.

The revelations from the Overton Brooks Veterans Affairs Medical Center demonstrate that many of the symptoms of the disease exhibited across the country are manifesting themselves there. Denial of scheduling problems, the use of lists other than the EWL, intimidation of whistleblowers by investigation and threats of reprisals, use of comp time denials to punish those who push against the system and comp time allowances to reward those who play along all result in covering up the problems plaguing the VA and directly result in diminished care to Veterans.

When faced with questions concerning problems with scheduling the OBVAMC's reaction was to deny all allegations against it. Once faced with incontrovertible truth of the allegations against it, the system turned on the very people trying to expose its illness. Today the OBVAMC administration asserts that the list was merely gathered to insure that the patients were receiving the best care and to make sure that past patients were

assigned to a BHIT. It asserts that this was merely a DSS list. This assertion has been incontrovertibly proven to be a purposeful attempt to hide the truth. The disease infecting the VA system has been diagnosed. The disease is aggressive and in need of immediate care. Curing the VA of its systemic disease should be done now. Like our veterans, it is too important to put on a wait list.

Respectfully submitted,



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SMITH & JOHN
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(318) 219-1001
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ATTORNEY FOR
Christopher Shea Wilkes

Approved and Verified by:



Christopher Shea Wilkes

10/30/2015

Date



U.S. OFFICE OF SPECIAL COUNSEL
1730 M Street, N.W., Suite 300
Washington, D.C. 20036-4505

The Special Counsel

December 22, 2014

The Honorable Robert A. McDonald
Secretary
Department of Veterans Affairs
810 Vermont Avenue, N.W.
Washington, D.C. 20420

Re: OSC File No. DI-14-3657

Dear Secretary McDonald:

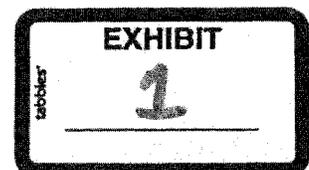
Pursuant to my responsibilities as Special Counsel, I am sending to you a whistleblower disclosure that employees at the Department of Veterans Affairs (VA), Overton Brooks VA Medical Center (Overton Brooks), Mental Health Services in Shreveport, Louisiana, may have engaged in actions that constitute a violation of law, rule, or regulation, and a substantial and specific danger to public health and safety.

Mr. Christopher Shea Wilkes, an Operation Enduring Freedom/Operation Iraqi Freedom social worker who consented to the release of his name, disclosed that employees of the Mental Health Services at Overton Brooks failed to follow proper scheduling protocols. The allegations to be investigated are as follows:

- Scheduling personnel were not using electronic waiting lists as required; and
- Management's failure to adhere to and enforce agency scheduling policies endangered public health and safety.

OSC has recently referred similar allegations of improper scheduling at other VA facilities. These matters include OSC File Nos. DI-14-2975, DI-14-2839, DI-13-4425, DI-14-3017, DI-14-2763, DI-14-2953, DI-14-3424, DI-14-2948, DI-14-2947, DI-14-3657, and DI-14-4835. The number of these referrals indicates that this is a systemic and pervasive problem at the VA that presents a serious threat to the health of veterans.

Mr. Wilkes was the recovery coordinator in Mental Health Services at Overton Brooks from December 2011 through February 2014 and served as the acting assistant chief of Mental Health Services from December 2011 through January 2012. Mr. Wilkes disclosed that scheduling personnel at Overton Brooks are not properly trained on agency scheduling policies and that management does not require that such policies be followed. Specifically, Mr. Wilkes alleged that, between 2012 and June 2014, schedulers were not



The Special Counsel

The Honorable Robert McDonald
December 22, 2014
Page 2 of 4

using electronic waiting lists as required by VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures* (June 9, 2010).

According to VHA Directive 2010-027 (the directive), para. 4.c.(19)(b), new patients whose appointments cannot be scheduled in target timeframes must be put on electronic waiting lists (EWL). Recall/Reminder software is to be used to record the appointment needs of established patients requiring follow-up appointments that cannot be immediately scheduled within target timeframes. VHA Directive 2010-027, para. 4.c.(3)(f)2.a. When appointments become available, scheduling personnel are to offer openings either to patients on the EWL or to those who have appointments scheduled more than 30 days past their desired date. VHA Directive 2010-027, para. 4.c.(18). The directive further provides that, “[n]o other wait list formats (paper, electronic spreadsheets) are to be used for tracking requests for outpatient appointments.”

Mr. Wilkes alleged that contrary to this directive, scheduling personnel were not trained to use EWL or the Recall/Reminder software and observed that each scheduler maintained his or her own handwritten paper wait list. Mr. Wilkes indicated that in the spring of 2014, management determined the numerous paper wait lists had become unmanageable and instructed Stephanie Alexander, a nurse in Mental Health Services, to combine all of the paper waitlists into one master list, in the form of an Excel spreadsheet. Once the master list was compiled, it was determined that there were over 2,700 veterans on the wait list for Mental Health Services, dating back to 2012. According to Mr. Wilkes, because schedulers did not use the EWL and Recall/Reminder software, the electronic systems did not reflect that there were any patients waiting for appointments in Mental Health Services despite the significant delay in access to care, which endangered public health and safety.

Mr. Wilkes alleged that schedulers were taught and encouraged to manipulate the scheduling of appointments in Mental Health Services because there were not enough prescribing providers to see patients within target timeframes. However, facility management wanted the electronic reports to reflect they were meeting measures for performance bonuses. His contentions are consistent with the OSC referrals noted previously in which whistleblowers observed that improper scheduling practices were associated with performance bonuses.

Mr. Wilkes reported the improper scheduling practices at Overton Brooks to the VA Office of Inspector General (OIG) and provided a copy of the master wait list discussed above to OIG investigators during his interview in June 2014. On October 7, 2014, OIG confirmed that a criminal investigation into scheduling improprieties at Overton Brooks is ongoing. We are referring these allegations to provide additional information that may aid in that investigation.

* * * * *

The Special Counsel

The Honorable Robert McDonald

December 22, 2014

Page 3 of 4

The Office of Special Counsel (OSC) is authorized by law to receive disclosures of information from federal employees alleging violations 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 and safety. 5 U.S.C. § 1213(a) and (b). OSC does not have the authority to investigate a whistleblower's disclosure; rather, if I determine that there is a substantial likelihood that one of the aforementioned conditions exists, I am required to advise the appropriate agency head of my determination, and the agency head is required to conduct an investigation of the allegations and submit a written report within 60 days after the date on which the information is transmitted. 5 U.S.C. § 1213(c).

Upon receipt, I will review the agency report to determine whether it contains all of the information required by statute and that the findings of the head of the agency appear to be reasonable. 5 U.S.C. § 1213(e)(2). I will determine that the agency's investigative findings and conclusions appear reasonable if they are credible, consistent, and complete based upon the facts in the disclosure, the agency report, and the comments offered by the whistleblower under 5 U.S.C. § 1213(e)(1).

In this case, I have determined that there is a substantial likelihood that the information Mr. Wilkes provided to OSC discloses a violation of law, rule, or regulation, and a substantial and specific danger to public health. I am referring this information to you for an investigation of these allegations and a report of your findings within 60 days after the date on which the information is transmitted. OSC will not routinely grant an extension of time to an agency in conducting a whistleblower disclosure investigation. However, OSC will consider an extension request where an agency concretely evidences that it is conducting a good faith investigation that will require more time to successfully complete. By law, this report should be reviewed and signed by you personally. Nevertheless, should you delegate your authority to review and sign the report to the Inspector General, or other agency official, the delegation must be specifically stated and must include the authority to take the actions necessary under 5 U.S.C. § 1213(d)(5). The requirements of the report are set forth at 5 U.S.C. § 1213(c) and (d). A summary of section 1213(d) is enclosed. Please note that where specific violations of law, rule, or regulation are identified, these references are not intended to be exclusive. As you conduct your review of these disclosures and prepare your report, OSC requests that you include information reflecting any dollar savings, or projected savings, and any management initiatives related to these cost savings, that may result from your review.

As a matter of policy, OSC also requires that agency investigators interview the whistleblower at the beginning of the investigation. As the originator of the complaint, Mr. Wilkes can provide additional information and an explanation of his allegations, thereby streamlining the agency investigation.

The Special Counsel

The Honorable Robert McDonald
December 22, 2014
Page 4 of 4

At the outset, or during the course of your investigation, your investigative team may have questions regarding the statutorily mandated report you will deliver to OSC under 5 U.S.C. § 1213. OSC attorneys are available in person or by telephone to discuss OSC's statutory process, expectations for credible, consistent, and complete reports, and for general assistance. Please contact Catherine A. McMullen, Chief, Disclosure Unit, at (202) 254-3604 to initiate this process.

Further, in some cases, whistleblowers who have made disclosures to OSC that are referred for investigation pursuant to 5 U.S.C. § 1213 also allege retaliation for whistleblowing once the agency is on notice of their claims. I urge you to take all appropriate measures to ensure that those reporting wrongdoing are protected from such retaliation and from other prohibited personnel practices, including informing those charged with investigating Mr. Wilkes' allegations that retaliation is unlawful and will not be tolerated.

As required by 5 U.S.C. § 1213(e)(3), I will send copies of the report, along with any comments on the report from the whistleblower and any comments or recommendations from me, to the President and the appropriate oversight committees in the Senate and House of Representatives. Unless the report is classified or prohibited from release by law or by Executive Order requiring that information be kept secret in the interest of national defense or the conduct of foreign affairs, OSC will place a copy of the report in a public file in accordance with 5 U.S.C. § 1219(a). To prevent public disclosure of PII, OSC requests that you ensure that the report does not contain any sensitive PII, such as Social Security numbers, home addresses and phone numbers, personal e-mail addresses, dates and places of birth, personal financial information, and patient names. OSC does not consider names and titles to be sensitive PII requiring redaction. Agencies are requested not to redact such information in reports provided to OSC for the public file.

Please refer to our file number in any correspondence on these matters. If you need further information, please contact Ms. McMullen. I am also available for any questions you may have.

Sincerely,



Carolyn N. Lerner

Enclosure

cc: The Honorable Richard J. Griffin, Acting Inspector General

Enclosure

Requirements of 5 U.S.C. § 1213(d)

Any report required under subsection (c) shall be reviewed and signed by the head of the agency¹ and shall include:

- (1) a summary of the information with respect to which the investigation was initiated;
- (2) a description of the conduct of the investigation;
- (3) a summary of any evidence obtained from the investigation;
- (4) a listing of any violation or apparent violation of law, rule, or regulation; and
- (5) a description of any action taken or planned as a result of the investigation, such as:
 - (A) changes in agency rules, regulations or practices;
 - (B) the restoration of any aggrieved employee;
 - (C) disciplinary action against any employee; and
 - (D) referral to the Attorney General of any evidence of criminal violation.

In addition, we are interested in learning of any dollar savings, or projected savings, and any management initiatives that may result from this review.

To prevent public disclosure of personally identifiable information (PII), OSC requests that you ensure that the report does not contain any sensitive PII, such as Social Security numbers, home addresses and phone numbers, personal e-mail addresses, dates and places of birth, and personal financial information. With the exception of patient names, OSC does not consider names and titles to be sensitive PII requiring redaction. Agencies are requested not to redact such information in reports provided to OSC for inclusion in the public file.

¹ Should you decide to delegate authority to another official to review and sign the report, your delegation must be specifically stated.



U.S. OFFICE OF SPECIAL COUNSEL
1730 M Street, N.W., Suite 218
Washington, D.C. 20036-4505
202-254-3600

December 22, 2014

Mr. Christopher Wilkes
C/o Mr. Richard John
3646 Youree Drive
Shreveport, LA 71105

Re: OSC File No. DI-14-3657

Dear Mr. Wilkes:

The Office of Special Counsel (OSC) has completed its review of the information you referred to the Disclosure Unit. You alleged employees at the Department of Veterans Affairs (VA), Overton Brooks VA Medical Center (Overton Brooks), Mental Health Services in Shreveport, Louisiana, have engaged in actions that may constitute a violation of law, rule, or regulation, and a substantial and specific danger to public health and safety.

The Office of Special Counsel (OSC) is authorized by law to receive disclosures of information from federal employees alleging violations 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 and safety. 5 U.S.C. § 1213(a) and (b). OSC does not have the authority to investigate a whistleblower's disclosure; rather, if the Special Counsel determines that there is a substantial likelihood that one of the aforementioned conditions exists, she is required to advise the appropriate agency head of her determination, and the agency head is required to conduct an investigation of the allegations and submit a written report. 5 U.S.C. § 1213(c) and (g).

Upon receipt, the Special Counsel reviews the agency report to determine whether it contains all of the information required by statute and that the findings of the head of the agency appear to be reasonable. 5 U.S.C. § 1213(e)(2). The Special Counsel will determine that the agency's investigative findings and conclusions appear reasonable if they are credible, consistent, and complete based upon the facts in the disclosure, the agency report, and the comments offered by the whistleblower under 5 U.S.C. § 1213(e)(1).

You alleged that employees of the Mental Health Services at Overton Brooks failed to follow proper scheduling protocols. You disclosed that scheduling personnel are not properly trained on agency scheduling policies and that management does not require that such policies be followed. Specifically, you indicated that, between 2012 and June 2014, schedulers were not using electronic waiting lists at all, but rather each maintained his or her own handwritten paper wait list contrary to VA policy. Further, you alleged that in the spring of 2014, management determined the numerous paper wait lists had become unmanageable and had all of the paper waitlists combined into one master list, in the form of

Mr. Christopher Wilkes
Page 2

an Excel spreadsheet. At that time, it was determined that there were over 2,700 veterans on the wait list for Mental Health Services, dating back to 2012.

We have concluded that there is a substantial likelihood that the information that you provided to OSC discloses a violation of law, rule, or regulation and a substantial and specific danger to public health and safety. Thus, we have transmitted these allegations to the Secretary of Veterans Affairs for a report within 60 days pursuant to 5 U.S.C. § 1213(c).

With your consent, we identified you as the source of the information, so that a representative of the Attorney General's office may speak with you directly. We have requested that the agency interview you at the beginning of the agency investigation when, as in this case, you consent to the disclosure of your name. As the originator of the complaint, you can provide additional information and an explanation of your allegations, thereby streamlining the agency investigation.

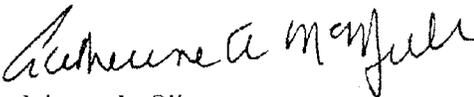
You should be aware, however, that these matters may take longer than 60 days and agencies may request an extension of the reporting date. After we have reviewed the report, unless it is classified or otherwise not releasable by law, we will send you a copy and give you an opportunity to comment. The report and your comments will be transmitted to the President and the appropriate congressional oversight committees, and will be maintained by OSC in a public file, which is now online at www.osc.gov.

We emphasize that until the agency's final report is forwarded to the President and Congress, this remains an open matter under investigation. Thus, we request that all information and correspondence related to this matter be kept confidential until you receive notification that the matter has been closed.

You also alleged that Ruth McDaniel is improperly awarding and denying compensatory time off for employees she supervises. This is an allegation of a prohibited personnel practice, which is reviewed by OSC's Complaints Examining Unit (CEU). Your complaint of prohibited personnel practices is under review by Ms. Ashley Sands, CEU. See OSC File No. MA-14-4081. Should you have any questions regarding your prohibited personnel practice complaint, please contact Ms. Sands at (202) 254-3655. Because the Disclosure Unit does not review allegations of prohibited personnel practices, we will take no further action on this allegation.

Please contact me at (202) 254-3682 if you have any questions regarding this matter.

Sincerely,



Johanna L. Oliver
Attorney, Disclosure Unit



DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON DC 20420

August 26, 2015

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-14-3657

Dear Ms. Lerner:

I am responding to your letter of December 22, 2014, regarding allegations made by a whistleblower at the Department of Veterans Affairs (VA), Overton Brooks VA Medical Center (Medical Center), Mental Health Services in Shreveport, Louisiana. The whistleblower alleged that:

Employees failed to follow proper scheduling protocols. Scheduling personnel were not using the Electronic Wait List (EWL) as required. Management failed to adhere to and enforce agency scheduling policies which endangered public health and safety.

The Secretary has delegated to me the authority to sign the enclosed report and take any actions deemed necessary under 5 United States Code §1213(d)(5).

On August 20, 2015, the VA Office of Inspector General's (OIG) Office of Healthcare Inspections provided the Office of Accountability Review a Report for the Office of Special Counsel Pursuant to the Provisions of Title 5 U.S.C. §1213 titled "Results of Investigation by the Office of Inspector General of Allegations of Misconduct Regarding Scheduling Practices in the Mental Health Clinic, Shreveport, LA VA Medical Center." This report was prepared subsequent to an investigation conducted in response to allegations that employees at the Shreveport Medical Center were instructed not to use the EWL and to keep a "secret" list instead. The OIG report states that their investigation did not substantiate the allegations. Evidence revealed that there was a spreadsheet used in the Mental Health Clinic which identified veterans who needed to be assigned to a Mental Health provider; however, it was not used in place of scheduling patients who wanted to be seen nor was it used as a substitute for the EWL. Evidence indicated that there had been inappropriate training several years ago that carried through to present activities. There was also evidence of a culture which may have promoted manipulation of wait times, but that culture was not apparent in the recent past or at the current time. There was no evidence of patient harm or criminal activity.

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SPECIAL COUNSEL
WASHINGTON D.C.

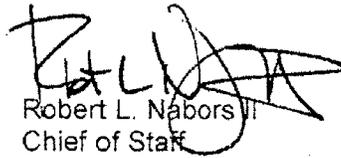


Page 2.

I have reviewed the OIG's report and find that it fully addresses the allegations we were asked to investigate in your letter of December 22, 2014. Therefore, I am submitting their report in response to that referral.

Thank you for the opportunity to respond.

Sincerely,



Robert L. Nabors II
Chief of Staff

Enclosure

**REPORT FOR THE OFFICE OF SPECIAL COUNSEL PURSUANT TO THE
PROVISIONS OF TITLE 5 U.S.C. § 1213**

**RESULTS OF INVESTIGATION BY THE VA OFFICE OF INSPECTOR GENERAL OF
ALLEGATIONS OF MISCONDUCT REGARDING SCHEDULING PRACTICES IN
THE MENTAL HEALTH CLINIC, SHREVEPORT, LA VA MEDICAL CENTER**

1. Summary of information with respect to which the investigations was initiated

This investigation was initiated based upon information reported to the VA OIG Hotline Division by an employee at the VA Medical Center (VAMC) in Shreveport, Louisiana, that Operations Manager Ruthie MCDANIEL instructed employees in the Mental Health care line to not use the Veterans Health Information Systems and Technology Architecture (Vista), Electronic Waiting List (EWL), and to keep a "secret" list instead. The Complainant also referred to a secret wait list kept on the Mental Health Clinic's shared network drive.

Overall, the investigation did not corroborate the Complainant's allegation. Investigative evidence revealed that there was a spreadsheet used in the Mental Health Clinic, Shreveport VAMC, identifying approximately 2,700 veterans who needed to be assigned a Mental Health provider. However, it was not a list used in place of scheduling patients who wanted to be seen, nor was it used as a substitute for the EWL. There was no evidence that Ruthie MCDANIEL instructed employees in the Mental Health Clinic to avoid using the EWL or to keep a secret list.

2. A description of the conduct of the investigation

The investigation included interviews with the following individuals:

- Kelly Herpin, Administrative Officer, Mental Health Service, Shreveport VAMC
- Stephanie Alexander, Registered Nurse, Shreveport VAMC, and creator of the list in question.
- Dr. James C. Patterson, Service Chief, Mental Health Service, Shreveport VAMC
- Paul Antoinco, Assistant Chief, Mental Health Service, Shreveport, VAMC
- Lynn Harris, Medical Support Assistant (MSA), Mental Health Service, Shreveport
- Ricky Lattimore, Medical Support Assistant (MSA), Primary Care Unit, Shreveport VAMCVAMC
- Paulette Halberg, Supervisor of the MSA staff, Shreveport VAMC
- David Williams II, Interim Assistant Chief, Business Office, Shreveport VAMC
- Christopher Shea Wilkes
- Genethia Martin, Program Analyst, Shreveport VAMC
- Jaquitua Hardy-Russell, Program Specialist, Shreveport VAMC
- Dr. John Magee, Lead Psychologist, Behavioral Health Integration Team (BHIT), Mental Health Service, Shreveport VAMC
- Toby Mathew, Interim Director, Shreveport VAMC
- Ruthie McDaniel, Operations Manager, Mental Health Service, Shreveport VAMC

- A smaller list titled "Appts Needed" appeared to be a list extrapolated from the list titled "Original List." For some of the patients, there were notes indicating the last time the patient had been seen. Many of the notes indicated that the patient had not been seen since 2013.
- A one page list titled "Deceased" appeared to be a list extrapolated from the list titled "Original List." There were notes associated with some of the patients. There was no information indicating cause of death.
- A one page list titled "Followed by Another VA" appeared to be a list extrapolated from the list titled "Original List." There were notes associated with some of the patients, such as "Followed in Oklahoma." It appeared that this was a list of patients that were being treated by another VAMC.
- A two-page list titled "Seen Recent but No follow-up" appeared to be a list extrapolated from the list titled "Original List." There were notes associated with some of the patients, the majority of which referenced a recall reminder that had been entered.

None of the witnesses interviewed, who had knowledge of the subject matters in the complaint, corroborated the Complainant's allegations that the employees in the Mental Health care line were instructed not to use VistA, EWL, and to keep a "secret" list instead.

With regard to the spreadsheet, no one denied the existence of the spreadsheet but did deny allegations regarding the purpose of the list and that it was a "secret" list. The following are relevant excerpts from their statements.

Witness A:

- About 4 or 5 months ago, a list of all patients who were seen in the Mental Health Department in the last 3 years was pulled. It was not a secret list. There was not another tracking system in place to serve the same purpose.
- The list was not for patients who had requested appointments. It was a list created to keep patients from "falling through the cracks."
- Paul Antoino and Stephanie Alexander compiled the list in question.

Witness B:

- In October 2013, Mental Health Services was short many providers and the witness feared some existing patients that were assigned to providers that departed the VA might "get lost through the cracks." So in January 2014, Stephanie Alexander used the Data Support System (DSS) to compile a list (on a spreadsheet) of all patients seen by Mental Health Services at Shreveport VAMC from approximately December 2012 until January 2014 (approximately 2,700 patients).

- The spreadsheet was used as an organizational tool to ensure these patients' appointments were set and they were assigned a mental health coordinator (a provider needed to see a patient three times before the provider was considered the patient's mental health coordinator). It was a waiting list for providers, not a list for patients waiting for a specific appointment.
- The list was not a secret; it was on the shared network drive for anyone in Mental Health Services to use.
- Some of the information the Complainant provided to the media about Mental Health Services and the list was true, but in the wrong context.

During the interview, Witness B provided a set of hardcopy e-mails which indicated a difference of opinion among staff on how to move forward with scheduling patients to a newly assigned doctor. There was no evidence to show that there were patients waiting for appointments that they had requested.

When interviewed a second time, the witness stated:

- The original list in question was not used to hide patients that were waiting for an appointment. The original list in question did not have a malevolent purpose. It was used to make sure no veterans were lost.
- The deceased list was a list of veterans from the original list that had died. No veteran died as a result of waiting for an appointment.
- The witness did not know the purpose of the appointments needed list.
- Veterans who called in or walked in needing to be seen were seen.
- The complainant did not have to ask the witness the purpose of the original list in question because, at the time the list was being created, he was still in Mental Health and his role was Recovery Coordinator. The witness opined that the Complainant should have known what the purpose of the original list in question was.
- The information about the purpose of the list that the Complainant provided the media was wrong.

Witness C

- When the witness first arrived in the Mental Health Clinic in 2012, there was already a shortage of providers. But as the problem got worse and the provider shortage increased, leadership decided to do a DSS data pull.
- The EWL was not used because there was not a problem getting patients scheduled timely for their follow up appointments. The problem was trying to assign them to a doctor when they did not know who that doctor was going to be.
- The DSS list in question was created to get an overall look at the patient population which would show how the Mental Health Clinic was affected by the loss of the

physicians. It was also used to integrate the patients that were lacking a provider into the new physician population.

Witness D

- The list in question was a DSS data pull and had 2707 names on it. It was a list created to prevent VA patients who did not have doctors assigned to them from falling “off the radar.”
- The witness did not believe that the Complainant knew the purpose of the list in question and that the Complainant mischaracterized the list to the media.
- The witness implemented the Mental Health Assessment Consult Service (MHACS) which assured that any walk-in mental health patients would be taken care of that same day.

When interviewed a second time, the witness stated:

- The “appointments-needed” list consisted of veterans needed to be reassigned to a new doctor and new treatment team. The list came from the original list in question and was created based on the information from the DSS data pull. They could not use the Electronic Wait List (EWL) because the patient did not have a doctor assigned to them. The veterans on the appointments needed list did not have a reason to be seen other than to be assigned to another doctor. And the veteran did not need to be seen in order to be reassigned.
- At the time of this interview, the project associated with the original list in question was completed. The original list and associated lists were no longer being used.

Witness E

- In about April of 2013, things were chaotic in the Mental Health Clinic because there was a staffing shortage, i.e. only 1 nurse practitioner serving hundreds of patients.
- Any patients that walked into the clinic were seen.
- Stephanie Alexander was tasked to collect the names of all the patients that had been “cast adrift” due to the loss of physicians.
- The list was developed to assign patients who were “adrift” to new doctors. The list was not for patients requesting to be seen. It was drawn from a data base of patients who needed to be reassigned to a doctor because their doctor had “dropped off.” The list was not used to circumvent numbers.
- The witness did not believe that what was said about the list in previous articles matched with what he knew the intent of the list to be. The witness believed that the Complainant would have known the intent of the list.

Witness F

- On May 7, 2014, during a BHIT meeting, Stephanie Alexander brought up the list of about 2700 (patients) because she was upset that mental health leadership had ordered staff to stop scheduling people from the list. According to the notes the witness took during the meeting, Alexander had said the list consisted of patients that needed to be scheduled for appointments. The witness heard later that the list was for review but that was not what the staff was told.
- The witness never saw the list in question. But it was his understanding that everybody on the list needed to be scheduled and they were using the list to establish who should be scheduled first, second, third, and so on.
- The witness received a complaint from a veteran about difficulties being scheduled. He also received a complaint from a staff member about how long it would be before a patient whose condition was deteriorating could get an appointment.
- The witness was unable to characterize the list in question as a method of hiding patients needing to be scheduled.
- The witness acknowledged that the Mental Health Clinic did go through a period where there was a shortage of doctors but he could not characterize how bad the shortage was.
- The witness did not believe that Stephanie Alexander would try to hide patients needing care.

Witness G

- Upon his arrival to the Shreveport VAMC, there were e-mails and news reports about an alleged wait list in the Behavioral Health Integrated Team (BHIT) program of the Mental Health Department. During his investigation, the witness learned that none of the names on the list were new patients waiting for an appointment. They were established patients in the Mental Health Clinic that were under active treatment who needed to be placed into the appropriate program. The witness did not find the list in question being used to circumvent timely scheduling of patients.

Witness H

- The witness heard that the Mental Health Service was accused of having a secret wait list. But there was no secret wait list and no list representing patients needing appointments.
- The Mental Health Service went through a period when there was a shortage of physicians, so a list was created for patients whose physicians had departed, to make sure that the patient was transitioned to the correct mental health team (and appropriate physician).

The Complainant provided the following significant details when interviewed by the VA OIG Special Agents:

- The list in question was a spreadsheet with multiple tabs containing the names and Social Security numbers of approximately 2,700 veterans that were patients of the Mental Health Services at Shreveport VAMC.
- The Complainant believed that, because of the shortage of providers in Mental Health Services, the spreadsheet was used to manipulate getting veterans in for appointments; although he was unsure exactly how the list was being used to do this.
- The Complainant had an electronic copy of the list on his work computer and 2 hardcopies of the list in his office.
- The Complainant provided information to the media about the manipulation of wait times at the Shreveport VAMC but did not provide the actual list.
- During a meeting (he did not recall the date); the Complainant heard Ruthie McDaniel, Operations Manager of Mental Health Services, Shreveport VAMC, instruct Kelly Herpin, Administrative Officer of Mental Health Services, Overton Brooks VAMC, to not use the electronic wait list.
- The Complainant provided both hard copies of the spreadsheet to the OIG case agent. The computer hard drive was also obtained. The Complainant denied possession of any additional copies (hard copy or electronic) of the spreadsheet and that no copy was provided to anyone else. Complainant advised that copies of the spreadsheet were never taken off the grounds of VAMC Shreveport.

The VA OIG Special Agents reviewed the lists that the Complainant provided during the interview on June 18, 2014. Two sets of lists that appeared to be replicas of each other. Each set of spreadsheets contained the following:

- A list titled "Original List," which contained approximately 2700 names and associated Social Security numbers. It was safe to assume that these were names of veterans/patients that were treated in the Mental Health Service, Shreveport VAMC. They also contained what appeared to be the last name of the doctor treating the patients. Some appeared to have been assigned a new physician. Overall, the lists appeared to be consistent with what the VA OIG Special Agent were told in the interviews from those who had a working knowledge about the list. In summary, the list in question was a DSS pull of patients who needed to be assigned a new physician. There was no evidence to suggest that these lists were used as a substitute for the EWL or to hide patients who wanted to be seen. [Note: The Decision support system (DSS) is an executive information system that directly impacts patient management, providing data on the patterns of care and patient outcomes, linked to the resource consumption and costs associated with the health care processes.]

- To the witness's knowledge, the list in question was not used as a substitute for the VistA EWL. The list in question was never used as a means of tracking patients calling in needing an appointment.
- The witness never instructed anybody to manipulate wait times in VistA in order to stay within the 14-day standard. The witness never pressured staff to stay within the 14-day standard in order to get a bonus.
- The witness was aware of the articles that had come out locally about the list in question and was disappointed by them because there was no secret list and the information in the articles was not true.

On April 2, 2014, the OIG Special Agents conducted telephonic follow-up interviews with Kelly Herpin, Dr. James Patterson, Paul Antoino, Lynn Harris, Dr. John Magee and Ruthie McDaniel. All parties interviewed denied creating any handwritten lists and denied any knowledge of anybody else creating handwritten lists while working on the list in question. There was no mention of any handwritten lists created by anybody at any time.

3. A summary of the evidence obtained during the investigation

The evidence is discussed in paragraph 2 above and consists primarily of the spreadsheets in questions and witness interviews.

4. A listing of any violation or apparent violation of any law, rule, or regulation

The investigation did not substantiate the allegations raised by the Complainant.

5. A description of any action taken or planned as a result of the investigation

The VA OIG did not recommend any further action regarding these allegations because the allegations were not substantiated.

**REPORT FOR THE OFFICE OF SPECIAL COUNSEL PURSUANT TO THE
PROVISIONS OF TITLE 5 U.S.C. § 1213**

**RESULTS OF INVESTIGATION BY THE VA OFFICE OF INSPECTOR GENERAL OF
ALLEGATIONS OF MISCONDUCT REGARDING SCHEDULING PRACTICES IN
THE MENTAL HEALTH CLINIC, SHREVEPORT, LA VA MEDICAL CENTER**

1. Summary of information with respect to which the investigations was initiated

This investigation was initiated based upon information reported to the VA OIG Hotline Division by an employee at the VA Medical Center (VAMC) in Shreveport, Louisiana, that Operations Manager Ruthie MCDANIEL instructed employees in the Mental Health care line to not use the Veterans Health Information Systems and Technology Architecture (Vista), Electronic Waiting List (EWL), and to keep a "secret" list instead. The Complainant also referred to a secret wait list kept on the Mental Health Clinic's shared network drive.

Overall, the investigation did not corroborate the Complainant's allegation. Investigative evidence revealed that there was a spreadsheet used in the Mental Health Clinic, Shreveport VAMC, identifying approximately 2,700 veterans who needed to be assigned a Mental Health provider. However, it was not a list used in place of scheduling patients who wanted to be seen, nor was it used as a substitute for the EWL. There was no evidence that Ruthie MCDANIEL instructed employees in the Mental Health Clinic to avoid using the EWL or to keep a secret list.

2. A description of the conduct of the investigation

The investigation included interviews with the following individuals:

- Kelly Herpin, Administrative Officer, Mental Health Service, Shreveport VAMC
- Stephanie Alexander, Registered Nurse, Shreveport VAMC, and creator of the list in question.
- Dr. James C. Patterson, Service Chief, Mental Health Service, Shreveport VAMC
- Paul Antoino, Assistant Chief, Mental Health Service, Shreveport, VAMC
- Lynn Harris, Medical Support Assistant (MSA), Mental Health Service, Shreveport
- Ricky Lattimore, Medical Support Assistant (MSA), Primary Care Unit, Shreveport VAMCVAMC
- Paulette Halberg, Supervisor of the MSA staff, Shreveport VAMC
- David Williams II, Interim Assistant Chief, Business Office, Shreveport VAMC
- Christopher Shea Wilkes
- Genethia Martin, Program Analyst, Shreveport VAMC
- Jaquitua Hardy-Russell, Program Specialist, Shreveport VAMC
- Dr. John Magee, Lead Psychologist, Behavioral Health Integration Team (BHIT), Mental Health Service, Shreveport VAMC
- Toby Mathew, Interim Director, Shreveport VAMC
- Ruthie McDaniel, Operations Manager, Mental Health Service, Shreveport VAMC



- A smaller list titled "Appts Needed" appeared to be a list extrapolated from the list titled "Original List." For some of the patients, there were notes indicating the last time the patient had been seen. Many of the notes indicated that the patient had not been seen since 2013.
- A one page list titled "Deceased" appeared to be a list extrapolated from the list titled "Original List." There were notes associated with some of the patients. There was no information indicating cause of death.
- A one page list titled "Followed by Another VA" appeared to be a list extrapolated from the list titled "Original List." There were notes associated with some of the patients, such as "Followed in Oklahoma." It appeared that this was a list of patients that were being treated by another VAMC.
- A two-page list titled "Seen Recent but No follow-up" appeared to be a list extrapolated from the list titled "Original List." There were notes associated with some of the patients, the majority of which referenced a recall reminder that had been entered.

None of the witnesses interviewed, who had knowledge of the subject matters in the complaint, corroborated the Complainant's allegations that the employees in the Mental Health care line were instructed not to use VistA, EWL, and to keep a "secret" list instead.

With regard to the spreadsheet, no one denied the existence of the spreadsheet but did deny allegations regarding the purpose of the list and that it was a "secret" list. The following are relevant excerpts from their statements.

Witness A:

- About 4 or 5 months ago, a list of all patients who were seen in the Mental Health Department in the last 3 years was pulled. It was not a secret list. There was not another tracking system in place to serve the same purpose.
- The list was not for patients who had requested appointments. It was a list created to keep patients from "falling through the cracks."
- Paul Antoino and Stephanie Alexander compiled the list in question.

Witness B:

- In October 2013, Mental Health Services was short many providers and the witness feared some existing patients that were assigned to providers that departed the VA might "get lost through the cracks." So in January 2014, Stephanie Alexander used the Data Support System (DSS) to compile a list (on a spreadsheet) of all patients seen by Mental Health Services at Shreveport VAMC from approximately December 2012 until January 2014 (approximately 2,700 patients).

- The spreadsheet was used as an organizational tool to ensure these patients' appointments were set and they were assigned a mental health coordinator (a provider needed to see a patient three times before the provider was considered the patient's mental health coordinator). It was a waiting list for providers, not a list for patients waiting for a specific appointment.
- The list was not a secret; it was on the shared network drive for anyone in Mental Health Services to use.
- Some of the information the Complainant provided to the media about Mental Health Services and the list was true, but in the wrong context.

During the interview, Witness B provided a set of hardcopy e-mails which indicated a difference of opinion among staff on how to move forward with scheduling patients to a newly assigned doctor. There was no evidence to show that there were patients waiting for appointments that they had requested.

When interviewed a second time, the witness stated:

- The original list in question was not used to hide patients that were waiting for an appointment. The original list in question did not have a malevolent purpose. It was used to make sure no veterans were lost.
- The deceased list was a list of veterans from the original list that had died. No veteran died as a result of waiting for an appointment.
- The witness did not know the purpose of the appointments needed list.
- Veterans who called in or walked in needing to be seen were seen.
- The complainant did not have to ask the witness the purpose of the original list in question because, at the time the list was being created, he was still in Mental Health and his role was Recovery Coordinator. The witness opined that the Complainant should have known what the purpose of the original list in question was.
- The information about the purpose of the list that the Complainant provided the media was wrong.

Witness C

- When the witness first arrived in the Mental Health Clinic in 2012, there was already a shortage of providers. But as the problem got worse and the provider shortage increased, leadership decided to do a DSS data pull.
- The EWL was not used because there was not a problem getting patients scheduled timely for their follow up appointments. The problem was trying to assign them to a doctor when they did not know who that doctor was going to be.
- The DSS list in question was created to get an overall look at the patient population which would show how the Mental Health Clinic was affected by the loss of the

physicians. It was also used to integrate the patients that were lacking a provider into the new physician population.

Witness D

- The list in question was a DSS data pull and had 2707 names on it. It was a list created to prevent VA patients who did not have doctors assigned to them from falling “off the radar.”
- The witness did not believe that the Complainant knew the purpose of the list in question and that the Complainant mischaracterized the list to the media.
- The witness implemented the Mental Health Assessment Consult Service (MHACS) which assured that any walk-in mental health patients would be taken care of that same day.

When interviewed a second time, the witness stated:

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- At the time of this interview, the project associated with the original list in question was completed. The original list and associated lists were no longer being used.

Witness E

- In about April of 2013, things were chaotic in the Mental Health Clinic because there was a staffing shortage, i.e. only 1 nurse practitioner serving hundreds of patients.
- Any patients that walked into the clinic were seen.
- Stephanie Alexander was tasked to collect the names of all the patients that had been “cast adrift” due to the loss of physicians.
- The list was developed to assign patients who were “adrift” to new doctors. The list was not for patients requesting to be seen. It was drawn from a data base of patients who needed to be reassigned to a doctor because their doctor had “dropped off.” The list was not used to circumvent numbers.
- The witness did not believe that what was said about the list in previous articles matched with what he knew the intent of the list to be. The witness believed that the Complainant would have known the intent of the list.

Witness F

- On May 7, 2014, during a BHIT meeting, Stephanie Alexander brought up the list of about 2700 (patients) because she was upset that mental health leadership had ordered staff to stop scheduling people from the list. According to the notes the witness took during the meeting, Alexander had said the list consisted of patients that needed to be scheduled for appointments. The witness heard later that the list was for review but that was not what the staff was told.
- The witness never saw the list in question. But it was his understanding that everybody on the list needed to be scheduled and they were using the list to establish who should be scheduled first, second, third, and so on.
- The witness received a complaint from a veteran about difficulties being scheduled. He also received a complaint from a staff member about how long it would be before a patient whose condition was deteriorating could get an appointment.
- The witness was unable to characterize the list in question as a method of hiding patients needing to be scheduled.
- The witness acknowledged that the Mental Health Clinic did go through a period where there was a shortage of doctors but he could not characterize how bad the shortage was.
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Witness G

- Upon his arrival to the Shreveport VAMC, there were e-mails and news reports about an alleged wait list in the Behavioral Health Integrated Team (BHIT) program of the Mental Health Department. During his investigation, the witness learned that none of the names on the list were new patients waiting for an appointment. They were established patients in the Mental Health Clinic that were under active treatment who needed to be placed into the appropriate program. The witness did not find the list in question being used to circumvent timely scheduling of patients.

Witness H

- The witness heard that the Mental Health Service was accused of having a secret wait list. But there was no secret wait list and no list representing patients needing appointments.
- The Mental Health Service went through a period when there was a shortage of physicians, so a list was created for patients whose physicians had departed, to make sure that the patient was transitioned to the correct mental health team (and appropriate physician).

The Complainant provided the following significant details when interviewed by the VA OIG Special Agents:

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The investigation did not substantiate the allegations raised by the Complainant.

5. A description of any action taken or planned as a result of the investigation

The VA OIG did not recommend any further action regarding these allegations because the allegations were not substantiated.

From: Magee, John
Sent: Thursday, June 26, 2014 10:59 AM
To: Wilkes, Christopher S.
Subject: Meeting Notes

MHS ("All Hands") Meeting. 6/17/14. Noon (NOTES FROM MEETING)

GUESTS: Mr. Toby Mathew (Interim Medical Center Director)

Dr. McGaully (Chief of Staff)

Julie Brandt (sp?) Associate Director of Patient Care Services

INTERIM MEDICAL CENTER DIRECTOR, MR. MATHEW:

"Shreveport does really well when we look at scheduling patients"

"our numbers look really well"

"we have a very good system, but there's room for improvement"

mail.google.com/mail/u/0/?ui=2&ik=87888e1ac5&view=pt&search=inbox&th=146d8f56aaf7e697&siml=146d8f56aaf7e697

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000001

"we know what's going on locally"

"Our goal should always be taking care of the Veteran in front of you"

"the media's trying to learn, the public's trying to learn how we schedule"

"LET'S BE HONEST ABOUT OUR PRACTICES"

"we do a great job here"

DR. MCGAULY/Chief of Staff

"that is the truth"

"that's why I opened this forum, so you can get your comments to us"

"the list...IT HAS NOTHING TO DO WITH SCHEDULING. It's the BHIT system"

DR. PATTERSON/Chief of MHS

"with my team, there's no cause for concern. We're doing a great job"

INTERIM DIRECTOR MR. MATHEW:

"MHACS...is a Best Practice"

DR. FORT, PSYCHIATRIST PCT PTSD Program:

"even though the MHACS is a best practice and I'm proud of that, we need help..."

"Need access to follow up"

CAROLE MARKHAM RN in PCT PTSD Program)

(Comments about no shows and cx appts w/in MHS)

000002

DR. MCGAULY:

"We have a damaged population. These people are damaged. They're hurt"

(A QUESTION FROM MALE EMPLOYEE IN ATTENDANCE)

Employee noted that Mr. Wilkes interview questioned accuracy of "only 5 people on the waiting list"

Employee wanted to know if that information was accurate

DR. MCGAULY:

"EWL" (Electronic Wait List) "VA Electronic Wait List of Vets that want appointments..."

"At the time, there were five"

** "IF THEY CAN'T GET INTO THE CLINIC WITHIN 90 DAYS, THEY GO ONTO EWL"

"It's a Safety System"

(SAME MALE EMPLOYEE IN ATTENDANCE)

Asks again about accuracy of information in media and interviews of Mr. Wilkes

"Are we denying it?"

DR. MCGAULY

***"We're not denying or agreeing with any of it"

(SAME MALE EMPLOYEE)

"There's unfair hiring practices in Mental Health"

"everyone in this room knows that"

000003

DR. MCGAULY

Media "they told half truths. You had a list with 2700 patients on it"

** "IT HAD NOTHING TO DO WITH SCHEDULING" *

(CAROLE MARKHAM, RN in PCT)

(Asks about Electronic Waiting List)

DR. MCGAULY

"You rarely see it" (that is, the Electronic Wait List)

"BECAUSE VERY RARELY DO YOU HAVE PEOPLE THAT YOU HAVE OVER 90 DAYS"

INTERIM MEDICAL DIRECTOR:

"you know what's in our system"

"if you know of a list, a secret list, tell us what it is"

(SAME MALE EMPLOYEE FROM BEFORE)

"There's people in this room that know better.

I hope they'll look into it"

[REDACTED], PSYCHIATRIST PCT PTSD
DR. MCGAULY above

(NOTE: VS

** "WE DID HAVE A LIST THAT WAS FOR SCHEDULING.
2700 patients on it"

"You had a list with

THE REASON WE HAD IT WAS BECAUSE WE DIDN'T HAVE THE PROVIDERS
TO DO WITH SCHEDULING"

"IT HAD NOTHING

TO SEE THEM.

THE SECRET WAS NOT SECRET"

000004

INTERIM MEDICAL DIRECTOR:

(Asks all staff: "who's using the EWL?" (Electronic Waiting List))

ANGELA MURPHY, PSA, BHIT1 Team

"we just got trained"

"we haven't used it yet"

(a couple of others indicate they just got trained. No one indicates they have used the EWL)

INTERIM MEDICAL DIRECTOR

** "We know we haven't used the EWL"

(FEMALE EMPLOYEE IN ATTENDANCE)

"I'm a Veteran"

Says she was supposed to be scheduled for an appointment a long time ago

"Nothing was ever scheduled"

INTERIM DIRECTOR

(says there are different factors that will have to be looked at "to change that")

(MALE EMPLOYEE ATTENDING)

Asked question about whether all appointments that are "90 to 120 days" out

From an appointment...do they go on Electronic Wait List"

(Question does not appear to have been answered)

000005

INTERIM MEDICAL DIRECTOR:

(tells story about a waiter recognizing his VA ID badge at hotel)

Waiter: "you guys are in a lot of trouble right now."

"There's a lot of attention to us right now.

"I'm proud to serve"

"THERE'S NOT ANYTHING WE'RE DOING THAT'S SECRET."

"THERE'S NOT ANYTHING WE'RE DOING THAT'S NOT VETERAN-CENTRIC"

"We're here for Veterans"

END OF MEETING.....

000006

From: Mathew, Toby T.
Sent: Wednesday, June 25, 2014 9:30 AM
To: Magee, John; Wilkes, Christopher S.
Cc: McGaully, Patrick (SHR)
Subject: RE: Clarity and further information

When you both are free, please stop by at Noon, today to meet with me and Dr. McGaully, Chief of Staff. Please obtain approval from your supervisors for a 15 minute introduction and reply. Thanks.

From: Magee, John
Sent: Friday, June 20, 2014 3:03 PM
To: Mathew, Toby T.
Cc: Wilkes, Christopher S.
Subject: RE: Clarity and further information

Dear Mr. Mathew:

I think we all appreciated the time that you provided to us all on Tuesday 6/17/14. One of your last statements was "There's not anything we're doing that's secret. There's not anything we're doing that's not Veteran-centric."

I believe your heart is in the right place. And for the most part, and for the vast majority of employees at this VA, you are right. But I also hope you'll be willing to investigate and deal with issues that are not Veteran-centric, and that are secret. Unfortunately, there is a lot you don't know.

I have seen a number of e-mails recently related to "the 2700" and scheduling, which are the only topics I'll deal with in this e-mail, because I haven't seen this information shared to date.

000007

The information that I've seen about the "2,700 List," I have not seen the information which I share below.

MENTAL HEALTH SERVICE WAITING LIST.

Regarding the issues of a "waiting list" in MHS:

1. There was a BHIT Meeting in the new wing in 2014 on Wednesday May 7, 2014 at 8 a.m. with 14 MHS staff present from different disciplines (including psychiatry, social work, psychology, psychology assistants, nursing). Both the BHITs and the PCT PTSD program had staff in attendance. There was MH leadership present, but Dr. [redacted] person, Chief of MHS, was not present.

2. [redacted] I can provide a list of staff present at the meeting but will not do so here. However, I have corroborated the information of my notes of 5/7/14 with notes and conversations with some of the other providers present on 5/7/14.

3. Staff were informed that there was a "list" of Veterans waiting to be scheduled for appointments in MHS with prescribing providers.

4. We were told that the list was over 2,700 Veterans (however, in other sources, the number has varied, from 2000-2,900).

5. We were told that the scheduling of Veterans for appointments from this list had been ordered to be stopped.

6. We were told that the order came from MHS leadership/administration and that the scheduling had indeed been stopped, per orders.

7. We were told that MHS leadership ordered scheduling stopped, until there was an agreement by MHS leadership on a "triage" system for scheduling.

8. Staff were told that this was resulting in a "delay of care" for assessment and treatment of Veterans on the list. A staff member indicated "Administration delayed care by two months."

9. We were told that MHS leadership had still not decided on a triage system.

10. We were told that the order by MHS leadership had indeed stopped the process of scheduling Veterans with the order now resulting in a "waiting list" of Veterans, because there had been no scheduling of appointments for "weeks," resulting in Veterans who "could have been seen in August" now having a waiting time out to "October."

11. The staff member was critical of the way the process of scheduling/delays was being handled, and stated she had been left out of the loop by the staff in charge of "triage."

12. The staff member presenting this information appropriately expressed concern for the safety of Veterans because of delays in scheduling, even noting how many Veterans could have been scheduled during the ongoing delays.

13. The staff member indicated that three Veterans on the waiting list for an appointment had been hospitalized on an inpatient psychiatric unit here while still waiting for an outpatient appointment in MHS.

14. There was concern raised about the possible connection of these hospitalizations and the failure to have been treated in MHS.

15. It was also shared that an MSA/PSA in MHS had found that there were "37 deaths" of Veterans who were on the list awaiting appointments.

16. Staff present at the meeting expressed concern about the implications for Veterans' safety, care, and mental health because of the order to stop scheduling Veterans from the list. While the major emphasis was about concern for Veterans, there was also concern expressed about the potential implications of an adverse incident for a Veteran

...it becoming known in the news because of the waiting list and Veterans not being scheduled for appointments.

17. I recommended a system which could identify Veterans of higher need by last GAF and the last time seen in MHS (higher severity/lower GAF and longer since last seen could be scheduled first), with the hope that DSS could be assistance quickly.

18. Dr. Krenek also suggested the use of diagnosis in triage. A number of staff also made recommendations with the hope that the delay in scheduling Veterans for appointments would end. These included recommendations for immediate inquiry to DSS, CPRS, IRM, and even a recommendation of asking professional staff to volunteer evenings or Saturdays to assist with the list (This had previously been done with Mental Health "Clinic" consults in the past, with a number of staff from different disciplines volunteering).

19. As noted, there were a number of witnesses to the above meeting and information about the waiting list of 2700 Veterans. Of course, I will note that I have never seen the list of "2,700." I was never asked or included officially for it. The only discussion I heard about the list was at this meeting on 5/7, until I saw the information in the local news recently.

20. Those in MHS Leadership/Administration involved in the decision to stop the scheduling of appointments were not named at the meeting to my recollection. However, it should be noted that this is a very important issue.

Must have seen the information in the local news.

I believe that the caring and compassion and hard work and honesty are the norms for most at our VA, and within Mental Health Service. But not for all. And there are numerous other issues of concern in MHS leadership, and I will provide that information to you and the Chief of Staff in separate e-mail(s) next week, because they also relate to issues about scheduling, but other issues as well. This will also include information about delays in scheduling appointments in PCT PTSD in the past because comp time/overtime was not approved for the MSA/PSA, even while a select few in MHS were regularly being approved for comp time by the Operations Manager, while others were not (I informed the Chief of MHS about this issue on 8/29/2013).

...including Mr. Wilkes in this e-mail. I am not choosing sides. I'm choosing to share what I know and I believe his motivation is to help Veterans. Others can decide whether the 2700 was a waiting list. However, the information at the 5/7/14 meeting suggested very serious concerns in a process of halting the scheduling of appointments for Veterans, which was indeed affecting Veterans. When the order came to stop scheduling, Veterans were indeed waiting.

John Magee, Ph.D.

Lead Psychologist

From: Patterson, James C.

Sent: Friday, June 13, 2014 11:04 AM

To: VHASHR MH SERVICE

Cc: Mathew, Toby T.; McGaully, Patrick (SHR); Franks, Sandra J.; Owens, Michael W. - SHR; Wallace, Richard; Rader, John G; Daily, Lawrence C

Subject: Clarity and further information

000009

Good morning again, MHS!

I think it's important to provide clarity and information that is positive and encouraging so that you can be better equipped to take care of Veterans.

- Since October 2013, the Mental Health Assessment Consult Service (MHACS) has been providing 0-day access to specialty mental health care services for any veteran who presents to the clinic and desires that care.
- Veterans who walk into Primary Care can also request to be seen by a MH provider and get seen by MH providers imbedded in the Primary Care clinic – same day.
- These services continue through today, and these services along with our MHACS Single Point of Entry concept are the reasons why MHS has a “best practice” in patient care. This is true veteran-centric care at its best.
- Furthermore, in August 2013, the Behavioral Health Integrated Program (BHIP) action item was received from VISN.
 - Since that time we have been working towards creating our BHIP teams and getting patients assigned to those teams.
 - Creation of those teams has been completed and both our BHIP teams are in place.
 - The next challenge was assigning patients in the care of MHS to a team.
 - For some patients it was simple, as they were already being seen and followed by a provider, and simply followed their provider to the team they were on.
 - However, determining team and MHTC assignments for all patients proved to be somewhat of a challenge.
 - Patients change providers, get followed up at variable times, get seen by more than one MHS provider, and get followed by more than one MHS service. It's complicated!
 - We decided to review all patients cared for by MHS over the past several years that might need BHIP assignment by requesting a database of information from DSS.
 - This was a very large database of patient data – over 2700 Veterans were listed!
 - This database of Veterans is maintained by our clinical team on our shared

drive, and is accessible by all those working to determine who need BHIP and MHTC assignments.

- The problem we encountered was that this list had a variety of patient types receiving services from various locations and services on it, and so required review not only by clerks but also by clinical providers to determine who actually needed outpatient BHIP and MHTC services.
- As you may imagine, this was rather time consuming. To date this process is ongoing, and our outpatient clinical team is still working to first determine who needs assignment, and then to assign BHIP teams and MHTCs.
- To be clear and in the spirit of honesty - we also wanted to ensure that all of our providers were following our new policy of writing orders for patient appts as they were supposed to be doing.
 - The DSS database was used as a mechanism to verify this.
 - For the most part, patient appt orders were being completed as directed, and the few providers that were not doing this were educated.
 - If you recall, I sent out an email service-wide educating providers about this last month.
- In addition - to ensure continuity of care for all veterans seen in the past, we looked at when patients were last seen by a MHS provider of any type, at any time.
 - We have had some providers who have left - for example locum tenens physicians only stay with us about 3 months.
 - We also have quite a few of our Veterans who miss appointments.
 - Our no-show rate overall is about 20%, so 1 in 5 Veterans miss their appts!
 - Veterans move away, go back to Primary Care, change providers, etc.
 - We used the DSS database to give us an idea about who might need or want to come in to see us, **even if they had not requested an appointment.**

All of the above was done to improve the quality of care provided to veterans.

In summary, I am very proud of the high-quality work being done and the patient care being provided by our MH service line. You should all be proud, especially of our MHACS and PCMH teams that offer 0-day care to Veterans who want or need this. Once again, do not

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believe all that you hear or see in the media. Be strong, stand tall, stand together as one team, and be proud of how well we are all doing, and keep in mind that our primary goal is to take care of Veterans, and so I ask you to keep doing just that.

One last note - we are trying to set up an MHS All-Hands Meeting for Tuesday the 17th at noon, and have as our special guest our new Interim MCD, Toby Mathew. Location, date, and time are preliminary but I will let you know as soon as plans are finalized.

Kind regards,

JP

--

James C Patterson II, MD, PhD

Chief - Mental Health Service

Overton-Brooks VA Medical Center

510 East Stoner Avenue,

Shreveport LA 71101

907-501-5051 phone

907-501-5705 fax

jp.patterson3@va.gov

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Survey of Healthcare Experience of Patients (SHEP).

I want to encourage all employees to work together in developing solutions that address operational issues or challenges allowing Overton Brooks VAMC supervisors and leaders to address them. In addition, you may use the Talk to the Director on-line communication or use a Speak to the Director form to share your solutions. If you want a personal response, please include your contact information.

Let's continue to remain focused in making a difference by *Serving One Veteran at a Time*.

Very respectfully,

TOBY T. MATHEW

Interim Medical Center Director

Sandy Franks, VHA-CM

Public Affairs Officer

Overton Brooks VA Medical Center

510 East Stoner Avenue

Shreveport, LA 71101

Phone (318) 990-5249

Fax (318) 990-5349

000013

From: VA OIG Hotline <va.oighotline@va.gov>
Date: Tue, Jun 24, 2014 at 7:40 AM
Subject: 53E/06 VA OIG Hotline Case Opened
To: "march121973@gmail.com" <march121973@gmail.com>

The U.S. Department of Veterans Affairs Office of Inspector General (OIG) opened a case based on a review of the information you reported to our office regarding failure to report correct address. The case number assigned is 2014-02890-HL-0851.

Now that we have opened a case, our office will review the issues you reported, or ask an impartial VA official to conduct the review. If we ask another VA office to conduct the review, we will ensure the reviewer fully examines the issues before closing the case. Please be advised that once a case is opened, we cannot discuss its progress and or provide status updates.

We will contact you again only if we need additional information. Otherwise, we will notify you when the case is closed.

Thank you for your interest in the VA OIG Hotline.

smime.p7s
11K

000014

From: Patterson, James C.
Sent: Tuesday, June 24, 2014 10:34 AM
To: VHASHR MH SERVICE
Subject: FOIA request - you all need to know about this
Importance: High

Dear MHS,

KTBS has requested via FOIA the names of all providers in MHS, their part-time vs full-time status, whether they are contract or not, and their salaries. As you are aware as a government employee, this information is not private.

By reading the email requesting the information, it appears that someone has fed KTBS the information to request, as nobody else uses phrases like "prescribing providers" **except those internal to the VA.**

Please remember this:

We have done nothing wrong – in fact, after discussing our DSS database in Chief of Staff meeting yesterday, it was called a "best practice". We are going the extra mile to help patients.

<https://mail.google.com/mail/u/0/?ui=2&ik=87888e1ac5&view=pt&q=...&qs=true&search=query&th=146cf811e1ce1b66&siml=146cf811e1ce1b66>

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and it is unfortunate that others are twisting this to be the lies presented in the media.

The misrepresentations, misinterpretations, and other propaganda in the media are just that, never forget that.

Stand tall, be proud of the good job we are doing in MHS

Remember that we as a VA are one of the top leaders in our region for patient satisfaction and low patient wait times.

I am just as sick of the propaganda as you are. I would like to take this opportunity to remind you of this: YOU HAVE A VOICE.

JP

James C Patterson II, MD, PhD
Chief - Mental Health Service
Overton-Brooks VA Medical Center
510 East Stoner Avenue,
Shreveport LA 71101
8-990-5051 phone
8-990-5705 fax
james.patterson3@va.gov

~~~~~  
Vincit Omnia Veritas  
~~~~~

14-06080-F_Request_Letter.pdf
36K

000016

From: Franks, Sandra J.
Sent: Tuesday, June 24, 2014 3:32 PM
To: VHASHR All Users
Subject: News Release - Access to Care Remains Top Focus at Overton Brooks VA Medical Center

Sent on behalf of Mr. Toby T. Mathew, Interim Medical Center Director

News Release

Office of Public Affairs
Overton Brooks
VA Medical Center

520 E. Stoner Avenue
Shreveport, LA 71202
(318) 990-5249

VA



U.S. Department
of Veterans Affairs

FOR IMMEDIATE RELEASE

June 24, 2014

Access to Care Remains Top Focus at

<https://mail.google.com/mail/u/0/?ui=2&ik=87888e1ac5&view=pt&q=w...&qs=true&search=query&th=146cfb59472cccb0&siml=146cfb59472cccb0>

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Overton Brooks VA Medical Center

SHREVEPORT, LA – The Overton Brooks VA Medical Center employs over 1,400 dedicated staff who proudly serve more than 37,000 enrolled Veterans located in North Louisiana, East Texas, and South Arkansas. Our employees remain focused on providing exceptional health care to improve Veterans health and well-being. Additional access to care is offered through extended hours and Saturday clinics for Primary Care and Mental Health.

In mid-April 2014, the Secretary of Veterans Affairs directed the Veterans Health Administration (VHA) to establish site teams to complete a nation-wide Access Audit to ensure a full understanding of VA’s policy among scheduling staff. The purpose of this national audit was used to identify any inappropriate scheduling practices regarding Veteran preferences for appointment dates.

As a result of the audit conducted in May 2014 at Overton Brooks, the site team identified good scheduling practices along with additional opportunities for continuous improvement. A second team will arrive to assist the medical center in this improvement effort. “We are in constant review of our scheduling processes and welcome the teams who will assist in reviewing our practices. I am proud of Overton Brooks employees who demonstrate unwavering commitment to care for Veterans and their families every day,” said Toby T. Mathew, Interim Medical Center Director.

We plan to reach out to Veterans, elected and appointed officials, Veteran Service Organizations, and media partners this week to answer questions specifically related to the “lists” and databases used to manage the care of Veterans. We appreciate the support of our community partners who share in our commitment to serve Veterans.

For more information, please contact the OBVAMC Public Affairs Office (PAO) at 318-990-5249 (office) or 318-426-3169 (mobile). Ms. Franks can also be reached via email at Sandra.Franks@va.gov.

###

Sandy Franks, VHA-CM

Public Affairs Officer

Overton Brooks VA Medical Center

000018

From: Magee, John
Sent: Monday, June 23, 2014 7:50 AM
To: Wilkes, Christopher S.
Subject: Letters

On Thursday, June 19, 2014, two MHS employees approached me and asked me if I believed Dr. Barnes would be okay with release of his letters of 2012, including the April/May 2012 letter, and his letter of resignation in June 2012. The MHS employees believed that the 2012 letters show an ongoing pattern of problems in MHS and wondered if he would mind the letters going to members of Congress, media, etc.

While I believe the current problems about "scheduling" and hostile work environment have much more etiology in the current MHS leadership in 2013/2014, the employees are certainly correct that some of the same principals from 2012 are still involved. In addition, it also indicates that the prior COS and Medical Center Director had been clearly made aware of problems in MHS leadership previously. Of course, you may also be aware that Dr. Barnes is not the only staff member to go to facility leaders, either in 2012, or 2014.

I contacted Dr. Barnes by phone the evening of 6/19/14 and I explained the current situation in MHS, including recent news in the local media, and whistleblower information. Dr. Barnes indicated that he had no problem with anyone releasing his 2012 letters and providing them to others. He indicated that he himself would not directly do this, but that others are free to print them or forward the e-mails to others, if it will assist in improving Veteran care. It doesn't surprise me, as I believe Dr. Barnes remained committed to the Veterans and our mission until he left.

I appreciate your efforts in the behalf of all Veterans. I have additional information which will follow in a separate e-mail within the next two days.

Sincerely,

John Magee, Ph.D.

000020

From: Magee, John
Sent: Monday, June 23, 2014 11:27 AM
To: Wilkes, Christopher S.
Subject: RE: Letters

I forwarded both letters, the one from June 2012, as well as the letter from April/May 2012.

From: Wilkes, Christopher S.
Sent: Monday, June 23, 2014 10:27 AM
To: Magee, John
Subject: RE: Letters

I have copies of Dr. Barnes letters somewhere, but in an effort to save time in locating them is it possible to forward this information.

Thanks, Shea

From: Magee, John
Sent: Monday, June 23, 2014 7:50 AM
To: Wilkes, Christopher S.

mail.google.com/mail/u/0/?ui=2&ik=87888e1ac5&view=pt&q=...qs=true&search=query&th=146c9a366a906308&siml=146c9a366a906308

Page 1 of 2

000022

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Sincerely,

John Magee, Ph.D.

Lead Psychologist

Overton Brooks VA Medical Center

Shreveport LA

000023

From: Barnes, Allen C.
Sent: Friday, June 29, 2012 3:13 PM
To: Schneider, Ronald
Cc: Bealer, Shirley (SES) (SHR); Battar, Saraswathy S.; VHASHR MH SERVICE; Lewis-Payton, Rica; Henderson, Kathy (V16);
Subject: FW: Resignation

am resigning from the VAMC, but with very mixed feelings. I thank so many of you who compassionately care for our Veterans, who have given so much for us. To actively listen to them and hear their pain, anxiety, guilt, depression, and teach them respect for themselves and how they might live a little differently and gain some measure of peace and enjoyment from life is an honor that I have enjoyed.

Thank you for your compassion and empathy.

<https://mail.google.com/mail/u/0/?ui=2&ik=87888e1ac5&view=pt&q=...qs=true&search=query&th=146c9a148d102554&siml=146c9a148d102554> Page 1

000024

Allen C. Barnes, MD

From: [REDACTED]
Sent: Friday, June 29, 2012 2:43 PM
To: Barnes, Allen C.; Barnes, Allen C.
Subject:

 **VARetirementLetterDrSchneider081512.docx**
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Dr. Schneider,

June 15, 2012

I am reluctantly resigning from the VA medical center where I have been the leader of the PTSD clinical team for the past 12 years. As you know, an outstanding Psychologist, Dr. Price, is waiting to join the team as soon as HR can process the paperwork. He has excellent psychotherapy skills; Dr. Magee, Dr. Brown, and I have observed him. And he has the personal qualities of compassion and empathy which are necessary to counter the disturbances of the mind that lead to Veterans suicides.

At a recent staff meeting I asked you who would replace me, you said, "The on-call psychiatrist." I hope not! I recommended Dr. Hite, who is gentle, caring, and well received by the Veterans. I hope you reconsider. **During these past 12 years we in the PCT have had no suicides.** That is because Veterans have been treated with compassion and empathy, and Dr. Hite also possesses those qualities.

I have sent you three detailed analyses of our PTSD situation, the first sent a couple months ago to you, Dr. Glidewell, and Ms. McDaniel via e-mail. The second was more generalized and hand-delivered to you on the Wednesday morning you returned from Jury Duty. The third was e-mailed to the Mental Health Service. The fourth was a letter from my wife, whom you met at your Christmas party, expressing her concern about what you are doing. These four attempts to communicate have received no response from you.

Providers and Veterans need a healing environment; it is no longer possible here. I will not remain in a situation of blame and intimidation, which the MHS has become, leaving myself at risk for the vagaries that I know I cannot fix. At any given moment, 24 hours a day, any one of the patients in their form of PTSD may choose not to take the meds that were given to calm the horrors of their life and their past. And they may do something that is unpredictable to anyone. I've given medication to reduce the tendency, but the tendency is still there if they don't use the medications. If they choose not to use the medication, or they can't get it in time, or can't do the right thing, and don't know they don't know, I cannot really be held responsible for the step that they take. They are human beings and they have free choice and will do whatever they are going to do. Yet, Providers are being blamed.

What is changed in the last months is that there is now one amongst us that has no medical background, no clinical training and yet, the one who is supposed to be in charge has let her have the authority to blame and intimidate. Can this improve? Yes, but if the only thing that you know to do is undue and unjust authority, and you are given the power, the problems expand.

It is easy to look backward and say what should have been done. How terribly broken is this person who thinks that their rank qualifies them, that their educational background qualifies them. In the military, Operations Management of the Division is put upon the shoulders of a Sergeant, perhaps Warrant Officer, but the reality is that is a very simple logistics job. Food in, distributed, planned for. Bedding, sheets, cleaning, uniforms, weapons – all those things. But warriors need of medical care is more than just bandages and that you cannot stock on the shelf. She's treating it as though it's an out-of-control supply line. Just because an hour of a Providers time has a number to it does not mean that we are like shirts; it's not as simple as that. She's making choices and decisions she's actually not qualified for, and should never have been allowed to make. The position she's in is not a position she's capable of. She can

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do 90% of her job well, but not the 10% that counts. The 90% supports the 10%, implying there is some sense to it, so the system supports her. The longer she stays the more she thinks she's capable.

It stopped being a healing environment and it started being a party of egos. It's enough that the actual patients present as they do. It's another thing entirely when management begins presenting their own psychiatric symptoms which are directly contrary to the actual purpose, i.e. to support the Providers giving to the Veterans what they need. I see it as a recipe for disaster when someone with the power, because of their non-caring sociopathy, makes decisions which prevent Providers being able to give the therapy which patients acutely need.

When new Veterans cannot help themselves and cannot 'connect with' anyone to help them, sometimes they commit suicide. Over time others 'grind down' into several forms of chronic PTSD which we have seen for 40 years in Vietnam Veterans.

The thing that bothers me about staying is I'm far too old to watch the cycle return. The cycle where incompetent people are making decisions they should not be making and are put in positions of authority where they have no knowledge of their effect. I've seen it too often. It would be a different thing if they had an understanding of a psychiatry event; it would be another thing entirely if they understood the sympathy and empathy of it. But they don't know enough to understand the tortured minds that we deal with on a day-to-day basis. And that means they should not be making decisions about how we do it. Power has been relinquished to them by one who should know better.

If you want cooperation, don't start with intimidation. In our military at this time, what causes harm is being trapped in a situation of terror and horror by those who are exercising undue and unjust authority. That's why warriors are committing suicide. In the warrior's mind they want to 'take them out'. But because there are so many people doing this, instead they kill themselves.

I am in a similar position. I can't stop you from doing what you are doing, but I can take away from you the benefit of my part of balancing a dysfunctional system, which would perpetuate the trauma to the Providers and thereby to the Veterans. I have the freedom to resign.

Allen C. Barnes, M.D.
Chief Medical Officer, PCT, Mental Health Service
O. B. VAMC Shreveport, Louisiana 71101

Clinical Assistant Professor
Department of Psychiatry
Louisiana State University Health Sciences Center
Shreveport, LA 71103

000027

From: Barnes, Allen C.
Sent: Wednesday, May 09, 2012 4:07 PM
To: VHASHR MH SERVICE
Cc: Henderson, Kathy (V16)
Subject: Prevention of Chronic PTSD

Dr. Schneider and MHS Service:

4/15/12 & 5/9/12

As I have explained, there is a dysfunctional element in the MHS organizational chart. Although a 'PTSD clinic' is shown, there is not a PTSD clinic. PTSD consults are routed to the PCT which is not staffed to handle the patient load of a general clinic. The PTSD Clinical Team, originally composed of 6 Providers, now has 4 Providers, one Psychiatrist, now serving about 2,000 Veterans. USA TODAY reports, 4/5/12, "VA short of mental health specialists", to treat "10,000 (new Vets) every three months". Four Providers cannot do this. One Psychiatrist cannot be responsible for medication management or oversight of so many patients who still struggle with acute symptoms of terror and horror. What is the Command Structure of 2,000 troops?

"10,000 new pts a quarter" represents a 'Tsunami' of Veterans to come. In my opinion, we need to prepare by

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changing the MH Org. Chart and enlisting more of the MHS in response. Obviously one Psychiatrist cannot ensure the *standard of care needed by combat troops with acute stress*, many who are very young, many angry at the government, not compliant with medications or appointments, continuing to seek thrills, fighting, being impulsive, driving after drinking and drugging, with relationship problems with spouse, girl friend, family, job, and often the law. Most own guns, many carry guns. Some have seen death as a solution to problems. No outpatient Provider has control over patients, and with young troops, often not much influence.

I have organized the 'PTSD clinic' to be a consult sorting method to direct veterans who may have PTSD symptoms to the departments most likely to provide their first care, e.g. , SUDS for those who are self-medicating with substances; Veterans Service Officer for those primarily seeking benefits; MHC for those with other psychiatric needs; Psychology for those only seeking group therapy; PCMH-I for mild conditions that Primary Care can treat; as well as the PCT. Sorting consults requires broad experience, now done by a Psychiatrist, that could more efficiently be done by someone skilled in screening SUDS and benefits issues from CPRS. That would free the Psychiatrist to provide specific therapy that our warriors actually need to recover.

The PCT, actually PTSD Specialty Clinic/program, evaluates and treats acute aspects of PTSD to prevent Chronic PTSD by using an innovative program of Cognitive Psychotherapy. Without soon-as-possible treatment focused on their specific issues, hidden stress injuries 'echo' terror and horror experiences in the minds of our warriors, awake and asleep, continuing to reinjure them until they have Chronic PTSD and disability as we have seen in Vietnam veterans for more than 40 years. From experience I believe I know how to prevent a great deal of acute traumatic injury from becoming Chronic PTSD.

PTSD may be usefully grouped into Terror, Horror, and Maladaptive Personality Traits, which allows therapy to be focused on the actual needs of each veteran and delivered more efficiently. The symptoms of terror are well recognized – panic, anxiety, paranoia, and phobic avoidance. Less well recognized are the symptoms of horror – confusion, a deep sense of sadness, indecisiveness, and a vague sense of guilt that tends to keep veterans demoralized, depressed, and isolated. Horror can continue for the rest of their lives as a strong motivation to self-medicate with alcohol and drugs and for some to suicide. This form of Cognitive Therapy seeks to reverse the collapse of the personality in horror by awakening trust, to feel harmony and hope, and from that to begin to feel love and compassion. To engage these unique emotions patients are seen individually at first, with many continuing their recovery in time-limited Cognitive Group Psychotherapy.

Some patients can recover quickly with non-suppressive medications, from the symptoms of Sleep Deprivation Syndrome – impatience, irritability, quick anger, difficulty concentrating, with memory problems – and be ready to join a class/group to learn how to understand oneself while desensitizing their fears, including to be around non-veterans, an important step to really 'come home'. Then getting a job and having an ordinary family life becomes possible.

The PTSD Specialty Clinic needs operational help in the form of additional staff, another psychiatrist; a policy agreement with PC to accept medication management of a short list of meds, which is necessary to free appointments for new troops; an appropriate screener for PTSD consults who would also extend physician time in other ways; help for our single Program Support person who has so much to do for these Veterans.

Without help, we the PCT staff cannot provide the specialty treatment that warriors with hidden injuries actually need to stop the cascade of acute symptoms from becoming Chronic PTSD.

Allen C. Barnes, MD

Chief Medical Officer, PCT, Mental Health Service

Overton Brooks VAMC Shreveport, Louisiana 71101

000029

From: VACO ANNOUCEMENT [mailto:NoReply@va.gov]
Sent: Friday, June 20, 2014 1:09 PM
To: Undisclosed Recipients
Subject: MESSAGE FROM THE ACTING SECRETARY: Equal Employment Opportunity

MESSAGE FROM THE ACTING SECRETARY

Serving Veterans and eligible family members with the quality benefits and services they have earned and deserve relies on the complimentary efforts, the energy, the enthusiasm, and the potential of more than 341,000 of you, our VA employees. Your invaluable diversity empowers VA so that we can achieve our noble mission. You will get us to the *excellence* we describe in our core VA values—Integrity, Commitment, Advocacy, Respect, and Excellence.

VA is strongly and unequivocally devoted to Equal Employment Opportunity, diversity, inclusion, and the protection of your rights in the workplace. I am completely committed to all Federal laws that protect you, our employees, included but not limited to, the laws and principles enshrined in the Civil Rights Act of 1964, the Notification and Federal Employee Antidiscrimination and Retaliation (No Fear) Act, the Whistleblower Protection Act, Rehabilitation Act, Age Discrimination in Employment Act, and Pregnancy Discrimination Act. I believe the huge majority of VA employees are equally committed to these high ideals.

I will not tolerate discrimination, including workplace harassment, based on race, color, religion, national origin, sex—including gender identity, transgender status, sexual orientation, and pregnancy—age, disability, genetic information, marital or parental status, or political affiliation. We define workplace harassment as any unwelcome, hostile, or offensive conduct that is based on the characteristics above that interferes with your performance or creates an

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intimidating, hostile, or offensive work environment.

Nor will I tolerate retaliation against any employee for opposing discriminatory practices or for participating in the discrimination-complaint process. My clear position on these matters applies to all terms and conditions of employment, including recruitment, hiring, promotions, transfers, reassignments, training, career development, benefits, and separation.

Your VA executives, managers, and supervisors bear a special responsibility for enforcing our Nation's laws and our Department's policies related to Equal Employment Opportunity and for promoting the imperatives of equality, diversity, and inclusion in the workplace. Likewise, I expect that you will report workplace discrimination at an early stage to prevent its escalation.

If you are aware of these sorts incidents, your avenue of redress is VA's Office of Resolution Management (ORM), at 888-737-3361 or www.va.gov/orm), which will administer an impartial and effective complaints management process that includes receiving, investigating, and, if possible, resolving complaints.

Today, it is critical that we individually and collectively redouble our efforts to cultivate a safe, fair, and inclusive culture at VA. Our ability to deliver the best services and care to our Nation's Veterans is inextricably linked to sustaining an organizational culture that protects and empowers your voices and leverages the diverse talents you represent.

We will always depend on the service of VA employees and leaders who place the interest of Veterans above and beyond self-interest; who serve Veterans and treat each other with dignity, compassion, and dedication; who live by VA's core values; and who have the moral courage to help us serve Veterans better by keeping our workplace inclusive and productive.

Sloan D. Gibson

000031

From: Magee, John
Sent: Friday, June 20, 2014 3:03 PM
To: Mathew, Toby T.
Cc: Wilkes, Christopher S.
Subject: RE: Clarity and further information

Dear Mr. Mathew:

I think we all appreciated the time that you provided to us all on Tuesday 6/17/14. One of your last statements was "There's not anything we're doing that's secret. There's not anything we're doing that's not Veteran-centric."

I believe your heart is in the right place. And for the most part, and for the vast majority of employees at this VA, you are right. But I also hope you'll be willing to investigate and deal with issues that are not Veteran-centric, and that are secret. Unfortunately, there is a lot you don't know.

I've seen a number of e-mails recently related to "the 2700" and scheduling, which are the only topics I'll deal with in this e-mail, because I haven't seen this information shared to date.

Of the information that I've seen about the "2,700 List," I have not seen the information which I share below.

MENTAL HEALTH SERVICE WAITING LIST.

Regarding the issues of a "waiting list" in MHS:

There was a BHIT Meeting in the new wing in 2014 on Wednesday May 7, 2014 at 8 a.m. with 14 MHS staff present from different disciplines (including psychiatry, social work, psychology, psychology assistants, nursing). Both of the BHITs and the PCT PTSD program had staff in attendance. There was MH leadership present, but Dr. Patterson, Chief of MHS, was not present.

NOTE: I can provide a list of staff present at the meeting but will not do so here. However, I have corroborated the information of my notes of 5/7/14 with notes and conversations with some of the other providers present on 5/7/14.

000032

3. Staff were informed that there was a "list" of Veterans waiting to be scheduled for appointments in MHS with prescribing providers.
4. We were told that the list was over 2,700 Veterans (however, in other sources, the number has varied, from 2000 to 2,600).
5. We were told that the scheduling of Veterans for appointments from this list had been ordered to be stopped.
6. We were told that the order came from MHS leadership/administration and that the scheduling had indeed been stopped, per orders.
7. We were told that MHS leadership ordered scheduling stopped, until there was an agreement by MHS leadership on a "triage" system for scheduling.
8. Staff were told that this was resulting in a "delay of care" for assessment and treatment of Veterans on the list. A staff member indicated "Administration delayed care by two months."
9. We were told that MHS leadership had still not decided on a triage system.
10. We were told that the order by MHS leadership had indeed stopped the process of scheduling Veterans with the order now resulting in a "waiting list" of Veterans, because there had been no scheduling of appointments for "weeks," resulting in Veterans who "could have been seen in August" now having a waiting time out to "October."
11. The staff member was critical of the way the process of scheduling/delays was being handled, and stated she had been left out of the loop by the staff in charge of "triage."
12. The staff member presenting this information appropriately expressed concern for the safety of Veterans because of delays in scheduling, even noting how many Veterans could have been scheduled during the ongoing delays.
13. The staff member indicated that three Veterans on the waiting list for an appointment had been hospitalized on the inpatient psychiatric unit here while still waiting for an outpatient appointment in MHS.
14. There was concern raised about the possible connection of these hospitalizations and the failure to have been seen in MHS.
15. It was also shared that an MSA/PSA in MHS had found that there were "37 deaths" of Veterans who were on the list awaiting appointments.
16. Staff present at the meeting expressed concern about the implications for Veterans' safety, care, and mental health because of the order to stop scheduling Veterans from the list. While the major emphasis was about concern for Veterans, there was also concern expressed about the potential implications of an adverse incident for a Veteran and it becoming known in the news because of the waiting list and Veterans not being scheduled for appointments.
17. I recommended a system which could identify Veterans of higher need by last GAF and the last time seen in MHS (i.e. higher severity/lower GAF and longer since last seen could be scheduled first), with the hope that DSS could be of assistance quickly.
18. Dr. Krenek also suggested the use of diagnosis in triage. A number of staff also made recommendations with the hope that the delay in scheduling Veterans for appointments would end. These included recommendations for immediate inquiry to DSS, CPRS, IRM, and even a recommendation of asking professional staff to volunteer evenings or Saturdays to assist with the list (This had previously been done with Mental Health "Clinic" consults in the past, with a number of staff from different disciplines volunteering).
19. As noted, there were a number of witnesses to the above meeting and information about the waiting list of 2700 Veterans. Of course, I will note that I have never seen the list of "2,700." I was never asked or included officially for input. The only discussion I heard about the list was at this meeting on 5/7, until I saw the information in the local news recently.
20. Those in MHS Leadership/Administration involved in the decision to stop the scheduling of appointments were not

mentioned at the meeting to my recollection. However, it should be noted that this is a very important issue.

Most have seen the information in the local news.

I believe that the caring and compassion and hard work and honesty are the norms for most at our VA, and within Mental Health Service. But not for all. And there are numerous other issues of concern in MHS leadership, and I will provide that information to you and the Chief of Staff in separate e-mail(s) next week, because they also relate to issues about scheduling, but other issues as well. This will also include information about delays in scheduling appointments in PCT PTSD in the past because comp time/overtime was not approved for the MSA/PSA, even while a select few in MHS were regularly being approved for comp time by the Operations Manager, while others were not (I informed the Chief of MHS about this issue on 8/29/2013).

including Mr. Wilkes in this e-mail. I am not choosing sides. I'm choosing to share what I know and I believe his motivation is to help Veterans. Others can decide whether the 2700 was a waiting list. However, the information at the 6/24 meeting suggested very serious concerns in a process of halting the scheduling of appointments for Veterans, which was indeed affecting Veterans. When the order came to stop scheduling, Veterans were indeed waiting.

John Magee, Ph.D.

Lead Psychologist

From: Patterson, James C.

Sent: Friday, June 13, 2014 11:04 AM

To: VHASHR MH SERVICE

Cc: Mathew, Toby T.; McGaully, Patrick (SHR); Franks, Sandra J.; Owens, Michael W. - SHR; Wallace, Richard; Rader, John G; Daily, Lawrence C

Subject: Clarity and further information

Good morning again, MHS!

I think it's important to provide clarity and information that is positive and encouraging so that you can be better equipped to take care of Veterans.

Since October 2013, the Mental Health Assessment Consult Service (MHACS) has been providing 0-day access to specialty mental health care services for any veteran who presents to the clinic and desires that care.

Veterans who walk into Primary Care can also request to be seen by a MH provider and get

seen by MH providers imbedded in the Primary Care clinic – same day.

- These services continue through today, and these services along with our MHACS Single Point of Entry concept are the reasons why MHS has a “best practice” in patient care. This is true veteran-centric care at its best.

- Furthermore, in August 2013, the Behavioral Health Integrated Program (BHIP) action item was received from VISN.

- Since that time we have been working towards creating our BHIP teams and getting patients assigned to those teams.
- Creation of those teams has been completed and both our BHIP teams are in place.
- The next challenge was assigning patients in the care of MHS to a team.
- For some patients it was simple, as they were already being seen and followed by a provider, and simply followed their provider to the team they were on.
- However, determining team and MHTC assignments for all patients proved to be somewhat of a challenge.
- Patients change providers, get followed up at variable times, get seen by more than one MHS provider, and get followed by more than one MHS service. It’s complicated!
- We decided to review all patients cared for by MHS over the past several years that might need BHIP assignment by requesting a database of information from DSS.
- This was a very large database of patient data – over 2700 Veterans were listed!
- This database of Veterans is maintained by our clinical team on our shared drive, and is accessible by all those working to determine who need BHIP and MHTC assignments.
- The problem we encountered was that this list had a variety of patient types receiving services from various locations and services on it, and so required review not only by clerks but also by clinical providers to determine who actually needed outpatient BHIP and MHTC services.
- As you may imagine, this was rather time consuming. To date this process is ongoing, and our outpatient clinical team is still working to first determine who needs assignment, and then to assign BHIP teams and MHTCs.

- To be clear and in the spirit of honesty - we also wanted to ensure that all of our providers

000035

were following our new policy of writing orders for patient appts as they were supposed to be doing.

- The DSS database was used as a mechanism to verify this.
- For the most part, patient appt orders were being completed as directed, and the few providers that were not doing this were educated.
- If you recall, I sent out an email service-wide educating providers about this last month.

In addition - to ensure continuity of care for all veterans seen in the past, we looked at when patients were last seen by a MHS provider of any type, at any time.

- We have had some providers who have left - for example locum tenens physicians only stay with us about 3 months.
- We also have quite a few of our Veterans who miss appointments.
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All of the above was done to improve the quality of care provided to veterans.

In summary, I am very proud of the high-quality work being done and the patient care being provided by our MH service line. You should all be proud, especially of our MHACS and PCMH teams that offer 0-day care to Veterans who want or need this. Once again, do not believe all that you hear or see in the media. Be strong, stand tall, stand together as one team, and be proud of how well we are all doing, and keep in mind that our primary goal is to take care of Veterans, and so I ask you to keep doing just that.

One last note - we are trying to set up an MHS All-Hands Meeting for Tuesday the 17th at noon, and have as our special guest our new Interim MCD, Toby Mathew. Location, date, and time are preliminary but I will let you know as soon as plans are finalized.

Kind regards,

000036

From: Wilkes, Christopher S.
Sent: Friday, June 20, 2014 4:26 PM
To: Magee, John
Cc: Mathew, Toby T.
Subject: RE: Clarity and further information

John

Thank you for bringing this information forward.

You are correct!

I presented the information in the manner I did, because I care about Veteran's and I had exhausted all other means.

The bottom line is there were numerous lists with Veteran's names on them because Mental Health did not have the providers to see the Veterans.

No matter how things are turned and twisted Veterans were not provided the proper f/u care.

Providers were not allowed Comp Time to see these Veterans.

Veterans were not fee based out to receive the proper care they needed.

Veterans were not put on the EWL due to their f/u being over 90 days.

Veterans were placed on a list that is not supposed to exist and some I am sure still do not have appts.

Even after the incident in Phoenix and the auditors came through OBVAMC these list were not addressed and schedulers throughout the hospital were continuing improper scheduling practices.

Thank You again for this information and I hope others that attended this meeting will step forward and tell the truth as

000038

you have.

Christopher Shea Wilkes, LCSW

OEF/OIF/OND Mental Health Social Worker

Army Values

“Loyalty, Duty, Respect, Selfless Service, Honor, Integrity, Personal Courage!”

From: Magee, John
Sent: Friday, June 20, 2014 3:03 PM
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Cc: Wilkes, Christopher S.
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Sent: Friday, June 13, 2014 11:04 AM

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In summary, I am very proud of the high-quality work being done and the patient care being provided by our MH service line. You should all be proud, especially of our MHACS and PCMH teams that offer 0-day care to Veterans who want or need this. Once again, do not believe all that you hear or see in the media. Be strong, stand tall, stand together as one team, and be proud of how well we are all doing, and keep in mind that our primary goal is to take care of Veterans, and so I ask you to keep doing just that.

One last note - we are trying to set up an MHS All-Hands Meeting for Tuesday the 17th at noon, and have as our special guest our new Interim MCD, Toby Mathew. Location, date, and time are preliminary but I will let you know as soon as plans are finalized.

Kind regards,

000043



Ricky John

OIG Special Agents

message

Ricky John

Thu, Jun 19, 2014 at 8:17 PM

To: "Rafferty, Palmer (Vitter)" <Palmer_Rafferty@vitter.senate.gov>

I have attached the contact information for the Special Agents from the OIG who were in Shreveport and interviewed Mr. Wilkes, Mrs. Alexander and Mr. Antoniou.

**Richard M. John
Smith & John
Attorneys at Law
3646 Youree Drive
Shreveport, Louisiana 71105**

 **OIG Special Agents20140619_20142962.pdf**
14K

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UNITED STATES
DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL
CRIMINAL INVESTIGATIONS DIVISION

SPECIAL AGENT
BOYD LAWRENCE

1515 POYDRAS, RM 738
NEW ORLEANS, LA 70112

OFC: (504) 586-8413
FAX: (504) 586-8417
CELL: (214) 208-0608
Boyd.Lawrence@va.gov

000046

VINCIT OMNIA VERITAS

I've added this to my email signature as I think that this is a message that should serve both as a reminder of this time that we are all going through, as well as something that is just good.

It means TRUTH CONQUERS ALL.

And while I can't say anything about any meeting I may have had with anyone, I can say this:



JP

--

James C Patterson II, MD, PhD

Chief - Mental Health Service

Overton-Brooks VA Medical Center

510 East Stoner Avenue,

Shreveport LA 71101

15090-5051 phone

15090-5705 fax

James.patterson3@va.gov

~~~~~  
VINCIT OMNIA VERITAS

000049

**From:** Patterson, James C.  
**Sent:** Wednesday, June 18, 2014 8:02 AM  
**To:** VHASHR MH SERVICE  
**Subject:** State of the MHS

On the one year anniversary of my presence as your Service Chief, I would like to provide some further information for you! It truly has been a pleasure to serve you, and I promise to keep doing so.

To begin, I want to remind you of the definition of propaganda:

**PRO-pa-gan-da** *noun* \prə-pə-gan-də, prō-\  
Ideas or statements that are often false or exaggerated and that are spread in order to help a cause, a political leader, a government, etc.

Keep this definition firmly in mind when reviewing media about our service, **because** **it most definitely applies**. Keep in mind also the following numbers:

## Veterans Served

|            | FY12   | FY13   | Difference |
|------------|--------|--------|------------|
| Encounters | 113724 | 110762 | -2962      |
| Visits     | 80758  | 78863  | -1895      |
| Uniques    | 8178   | 8293   | +115       |

That is some amazing stuff right there – almost 79,000 visits with over 8000 uniques in the last FY. So please be aware of ALL the hard work that YOU – the Mental Health Service Line - are doing.

Now, here’s an update on the “secret waiting list” – in actual fact a DSS database of the 2707 Veterans under our care. We have been working very hard on this list to get our BHIP team assignments and MHTC assignments completed.

|             |                                                                                                                                                                                                         |
|-------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>10%</b>  | Still need review (we typically are finding that about 50% of these don’t need further care)                                                                                                            |
| <b>75%</b>  | Don’t need further care because they are already in care, or moved, or went back to PCP, or other reasons.                                                                                              |
| <b>6.5%</b> | Need assignment and care in the CBOCs.                                                                                                                                                                  |
| <b>8.5%</b> | About 230 Veterans - in process of assignment to BHIPs/MHTCs, <b>and being offered appts if they desire one.</b> Some of these patients were lost to follow-up and need to have contact re-established. |

Let’s take a close look at something that is of critical importance in trying to assess these patient’s lost to follow-up.

000051

Over the past year we have had some turnover:

Losses:

Satyajeet Lahiri, MD

Shirley Briscoe, NP

Locum Tenens MDs (2x at a time, but two different sets)

Anne Shields, NP (LCBOC, but she came back)

Additions:

Samuel Fam (went to full time from 0.2)

James Van Meter, NP (CBOC fee basis)

James Patterson, MD -- here 1 year as of 06/17/14 ☺

Shirley Briscoe, NP (but then left)

Yolanda Burnom, LCSW (back from active duty)

Mary Davis, LMSW

Stacey Dillahunty, PA

Sandra Haley, LCSW

Tiffany Jennings, PhD

Jeff Kinderdietz, PhD

Aja Menard, MD (but will be inpatient)

Anne Shields, NP (came back!)

Libbie Stokke, NP

Arvind Yekanath, MD (in process)

9 MDs that make up 1.1 FTE including Meek, Jani, Hogue, Susano, Wheat, Gabriel, Orellana, Singh, and Wagner

000052

We have had some amazing additions and quite a bit of turnover to our clinical treatment team over the past year. In addition over the past year, we have:

1. Created the MHACS service from scratch and launched in October 2013 – an innovative program that is designed to provide immediate access to care for any Veteran who needs it.
2. Created the structure and are still in process of filling out two “super-BHIP teams”.
3. Integrated Behavioral Medicine providers into the BHIPs and the PTSD program.

It is also very important to keep this in mind: the average no-show rate is ~20% nationally. So, about 20% of our 110K encounters are no-shows. That is about 89 Veterans that do not show for their appointments per day, **every day**. That is why we have missed opportunity and re-engage initiatives, no-show clerks, and software that tracks high probable no-shows.

We are still working on keeping track of no-shows, and that DSS report is definitely helping.

From my own personal review of clinic availability in the BHIP and PTSD clinics, we have plenty of slots open in July, so there is not an access problem at this time.

So, keep working hard, keep standing tall, be proud of the MHS, and be proud of the quality patient care we are providing to our Veterans.

JP

--

James C Patterson II, MD, PhD

Chief - Mental Health Service

Overton-Brooks VA Medical Center

510 East Stoner Avenue,

Shreveport LA 71101

818-990-5051 phone

000053

**From:** Patterson, James C.  
**Sent:** Wednesday, June 18, 2014 2:32 PM  
**To:** VHASHR MH SERVICE  
**Cc:** Mathew, Toby T.; McGaully, Patrick (SHR); Franks, Sandra J.; Owens, Michael W. - SHR; Wallace, Richard  
**Subject:** absolutely amazing - Shreveport Times article  
**Importance:** High

I want to share this with the entire MHS immediately, because quite a few of you

<https://mail.google.com/mail/u/0/?ui=2&ik=87888e1ac5&view=pt&q=...&q5=true&search=query&th=146b1b1a4ab536af&siml=146b1b1a4ab536af>

Page

000055

now have your names out there on the front page of the Shreveport Times web page. See the enclosed Shreveport Times article by Melody Brumble. Be aware they now have posted – online – private emails from within the MHS purporting to document that we have 2400 patients that haven't been seen.

Those names of course include my own. Once again, with feeling, and for the record:

1. There is no secret wait list. It is a DSS report.
2. There are not 2700, 2400, or even 600 patients waiting to be seen. **Many do however need assigned to BHIPs.** Nowhere in any media report do you see anything about the formation of treatment teams, and the assignment of patients to those teams. To do that is a HUGE undertaking that is STILL underway today. I sent those numbers out this AM.
3. Be aware that casual language used in an email may not adequately describe the processes that are needed. The words "schedule" and "appointments" are being twisted to imply that patients have not or did not receive care.
4. Patients we were tracking in February because of clinic provider turnover are being cared for. We have open slots now.
5. Patients that hadn't been seen "in 12 months or more" were not 2400 in number, nor anywhere close to that. Again, patients get lost to follow-up because they stop coming, cancel appts, etc.
6. The VAMC is not obligated to reply to these types of stories in the media, and to do so would be inappropriate, given that the OIG is investigating. We can and will let the OIG determine what is true.
7. While I realize that these stories are troubling, I urge you not to take action, not even to comment in the comments section of the news articles.

Once again, stand tall, be proud of the service that we have provided and continue to provide, and **SPEAK THE TRUTH to anyone who asks, but do so with gentleness and respect, in a positive manner.**

Thanks!

JP

000056

James C Patterson II, MD, PhD  
Chief - Mental Health Service  
Overton-Brooks VA Medical Center  
510 East Stoner Avenue,  
Shreveport LA 71101  
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318-990-5705 fax  
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**3 attachments**

-  **newspaper-emails.pdf**  
121K
-  **Original-email.pdf**  
37K
-  **STimes\_061814.pdf**  
45K

000057

**From:** Patterson, James C.  
**Sent:** Monday, June 16, 2014 4:07 PM  
**To:** Antoniou, Paul E.  
**Cc:** LaCour, Hope; McDaniel, Ruthie L.; Herpin, Kelly - SHR; Glidewell, Reba S.; Radcliffe, Nancy J.; Alexander, Stephanie - SHR  
**Subject:** Open clinic appts in July

Paul,

I want you to look at something and let's be sure we are where we need to be in regards to assignments and scheduling. I just finished looking at what we have available for appts in the 37 clinics in the BHIP and PTSD programs. Of these, there are 12 Rx provider clinics, 12 group clinics, and 13 Ind. Therapy clinics.

Be aware this is a rough estimate across the board based on VISN standard performance data for providers. I've taken into account known issues (Jennings is on maternity leave) and admin time, and partial FTEs. However it's still a rough estimate.

| Clinic      | Std  | act  | Diff |
|-------------|------|------|------|
| Rx provider | 627  | 418  | 209  |
| Group Tx    | 240  | 286  | -46  |
| Ind Therapy | 910  | 318  | 592  |
| Total       | 1777 | 1022 | 755  |

What this table shows is that we have 755 slots open and available for patient care in the month of July in our clinics.

Let's just call that an overestimate to be conservative, and say that it's actually only 500.

I know that we keep some slots open for high-risk, and we keep some slots open for qmonth or q2week follow-up, so let's just say 300 slots open, for the sake of argument.

Given that we appear to have a minimum of 300 slots open in our clinics for the month of July, I want to be certain that there are no patients who desire an appt and have not received one.

000058

While we all know that there is no "secret wait list with 2700 names on it", we do have a DSS report that we are still parsing to complete assignments for team assignments and MHTCs.

Please give me a report by the end of the week on the status of the assignments.

Thanks,

JP

--  
James C. Patterson II, MD, PhD  
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james.patterson3@va.gov

.. 000059

**From:** Patterson, James C.

**Sent:** Friday, June 13, 2014 11:04 AM

**To:** VHASHR MH SERVICE

**Cc:** Mathew, Toby T.; McGaully, Patrick (SHR); Franks, Sandra J.; Owens, Michael W. - SHR; Wallace, Richard; Rader, John G; Daily, Lawrence C

**Subject:** Clarity and further information

Good morning again, MHS!

I think it's important to provide clarity and information that is positive and encouraging so that you can be better equipped to take care of Veterans.

Since October 2013, the Mental Health Assessment Consult Service (MHACS) has been providing 0-day access to specialty mental health care services for any veteran who presents to the clinic and desires that care.

000060

· Veterans who walk into Primary Care can also request to be seen by a MH provider and get seen by MH providers imbedded in the Primary Care clinic - same day.

· These services continue through today, and these services along with our MHACS Single Point of Entry concept are the reasons why MHS has a "best practice" in patient care. This is true veteran-centric care at its best.

· Furthermore, in August 2013, the Behavioral Health Integrated Program (BHIP) action item was received from VISN.

- Since that time we have been working towards creating our BHIP teams and getting patients assigned to those teams.
- Creation of those teams has been completed and both our BHIP teams are in place.
- The next challenge was assigning patients in the care of MHS to a team.
- For some patients it was simple, as they were already being seen and followed by a provider, and simply followed their provider to the team they were on.
- However, determining team and MHTC assignments for all patients proved to be somewhat of a challenge.
- Patients change providers, get followed up at variable times, get seen by more than one MHS provider, and get followed by more than one MHS service. It's complicated!
- We decided to review all patients cared for by MHS over the past several years that might need BHIP assignment by requesting a database of information from DSS.
- This was a very large database of patient data - over 2700 Veterans were listed!
- This database of Veterans is maintained by our clinical team on our shared drive, and is accessible by all those working to determine who need BHIP and MHTC assignments.
- The problem we encountered was that this list had a variety of patient types receiving services from various locations and services on it, and so required review not only by clerks but also by clinical providers to determine who actually needed outpatient BHIP and MHTC services.
- As you may imagine, this was rather time consuming. To date this process is ongoing, and our outpatient clinical team is still working to first determine who needs assignment, and then to assign BHIP teams and MHTCs.

000061

To be clear and in the spirit of honesty – we also wanted to ensure that all of our providers were following our new policy of writing orders for patient appts as they were supposed to be doing.

- The DSS database was used as a mechanism to verify this.
- For the most part, patient appt orders were being completed as directed, and the few providers that were not doing this were educated.
- If you recall, I sent out an email service-wide educating providers about this last month.

In addition – to ensure continuity of care for all veterans seen in the past, we looked at when patients were last seen by a MHS provider of any type, at any time.

- We have had some providers who have left - for example locum tenens physicians only stay with us about 3 months.
- We also have quite a few of our Veterans who miss appointments.
- Our no-show rate overall is about 20%, so 1 in 5 Veterans miss their appts!
- Veterans move away, go back to Primary Care, change providers, etc.
- We used the DSS database to give us an idea about who might need or want to come in to see us, **even if they had not requested an appointment.**

All of the above was done to improve the quality of care provided to veterans.

In summary, I am very proud of the high-quality work being done and the patient care being provided by our MH service line. You should all be proud, especially of our MHACS and PCMHI teams that offer 0-day care to Veterans who want or need this. Once again, do not believe all that you hear or see in the media. Be strong, stand tall, stand together as one team, and be proud of how well we are all doing, and keep in mind that our primary goal is to take care of Veterans, and so I ask you to keep doing just that.

One last note – we are trying to set up an MHS All-Hands Meeting for Tuesday the 17<sup>th</sup> at noon, and have as our special guest our new Interim MCD, Toby Mathew. Location, date, and time are preliminary but I will let you know as soon as plans are finalized.

000082

**From:** Blair, Michael H.  
**Sent:** Monday, May 19, 2014 12:01 PM  
**To:** Wilkes, Christopher S.; Williams, David (SHR)  
**Subject:** RE: Waiting list

With your e-mail I now have to ask the question do you have or know of the use of any paper waiting lists being used here at 5 Shreveport VA or any of our CBOC's?

Mike Blair

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**From:** Wilkes, Christopher S.  
**Sent:** Monday, May 19, 2014 11:02 AM  
**To:** Blair, Michael H.; Williams, David (SHR)  
**Subject:** Waiting list

Mike & David,

The big issue here is not waiting list! The issue is manipulation of the 14 day appt. measure. Paper waiting lists are just one tool used to manipulate the 14 day measure. There are other methods used to manipulate the 14 day measure. This is one reason while in Mental Health I stressed reorganizing into teams long before it became a mandate. It is also why I researched and came up with the idea of bringing in Psychiatrist as consultant in 4 hour shifts. There were indeed paper waiting list while waiting for the consult Dr.'s to go through the long drawn out process of getting them on board. This stuff is not new guys I have been telling folks about it for over a year and a half and we did nothing.

000064

Christopher Shea Wilkes, LCSW  
OIF/OND Mental Health Social Worker  
Everton Brooks VAMC  
119 E. Stoner Ave  
Threveport, LA 71101  
909-990-4978

Classification: Internal and External Use\Not VA Sensitive\

This message has been categorized by Wilkes, Christopher S. on Monday, May 19, 2014 at 11:02:03 AM in accordance with VA Handbook 6000

000065

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**From:** Antoniou, Paul E.  
**Sent:** Friday, March 07, 2014 12:26 PM  
**To:** Alexander, Stephanie - SHR  
**Cc:** Patterson, James C.  
**Subject:** FW: Scheduling Backlog  
**Importance:** High

Stephanie, you and your folks are working this with the MSAs??

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**From:** McDaniel, Ruthie L.  
**Sent:** Thursday, March 06, 2014 4:12 PM  
**To:** Harris, Lynn F.; Murphy, Angela E.; Cooper, Holly E.  
**Cc:** LaCour, Hope; Patterson, James C.; Antoniou, Paul E.; Herpin, Kelly - SHR  
**Subject:** Scheduling Backlog  
**Importance:** High

000066

Lynn, Angela, Holly,

After speaking with Dr. Patterson, he has decided that you may schedule the patients based on the order they appear on the lists you have received. Literally, the name at the top of the list gets scheduled first.

MSAs are NOT to enter into the chart to review historical information on the Veteran. Simply schedule the Veterans first come, first serve based off the lists you have. Veterans are to be scheduled with the Fee Basis MDs only.

Those already assigned to Dr. Hite – schedule likewise (first come, first serve).

Please let me know if you have any questions or need further clarification.

Ruthie L.H. McDaniel, MBA, VHA-CM

Operations Manager

Mental Health Service

Overton Brooks VA Medical Center

318-990-5331

They that wait upon the Lord shall renew their strength. They shall mount up on wings like eagles; they shall run and not grow weary, they shall walk and not grow faint! Psalm 40:31

000067

**From:** Antoniou, Paul E.

**Sent:** Thursday, February 27, 2014 3:18 PM

**To:** McDaniel, Ruthie L.; Patterson, James C.; Glidewell, Reba S.; LaCour, Hope; Peck, Shannon; Herpin, Kelly - SHR; Fuller, Janice N.

**Subject:** RE: Scheduling Patients

Ok I support Janice's recommendation. Thanks, Paul.

Paul E. Antoniou, ACSW, LCSW, BCD

Outpatient Clinics Director

Mental Health Service Line

Overton Brooks VA Medical Center

510 East Stoner

Shreveport, LA 71101

Cell 904-825-9012/ Work 318-221-8411 ext 5408.

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**From:** McDaniel, Ruthie L.

**Sent:** Thursday, February 27, 2014 3:16 PM

**To:** Antoniou, Paul E.; Patterson, James C.; Glidewell, Reba S.; LaCour, Hope; Peck, Shannon; Herpin, Kelly - SHR; Fuller, Janice N.

**Subject:** RE: Scheduling Patients

**Importance:** High

000068

Paul,

As discussed this morning, Janice does NOT recommend and I do NOT approve comp time.

As stated in this morning's meeting, the workload is not as such that comp time is warranted. This can be done during the normal tour of duty and again, as Janice mentioned this morning – it is possible for other outpatient nurses to provide assistance.

Additionally, there needs to be clear guidance on the expectation of how to determine which of these Veterans are seen first.

Just FYI – I have communicated with DSS to see if there is a query that can be ran to assist with the dates, identification of HR Veterans, etc...

I will share on Monday.

Comp time is NOT approved.

Ruthie L.H. McDaniel, MBA, VHA-CM

Operations Manager

Mental Health Service

Overton Brooks VA Medical Center

719-990-5331

They that wait upon the Lord shall renew their strength. They shall mount up on wings like eagles; they shall run and not grow weary, they shall walk and not grow faint! Psalm 40:31

**From:** Antoniou, Paul E.

000069

**Sent:** Thursday, February 27, 2014 9:55 AM  
**To:** Patterson, James C.; Glidewell, Reba S.; LaCour, Hope; Peck, Shannon; McDaniel, Ruthie L.; Herpin, Kelly - SHR; Fuller, Janice N.  
**Subject:** FW: Scheduling Patients  
**Importance:** High

Team. I have been intimately involved with this process which started in April 13 and want to move forward with it.. any comments before I let the providers know? Thanks for your input and support. If I don't hear from you all before the end of today I will assume all is well and we will launch the effort. Paul.

Paul E. Antoniou, ACSW, LCSW, BCD  
 Outpatient Clinics Director  
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**From:** Alexander, Stephanie - SHR  
**Sent:** Wednesday, February 26, 2014 4:21 PM  
**To:** Antoniou, Paul E.; Moore, Anntez Y.; Anderson, Lois B.; Harris, Lynn F.; Murphy, Angela E.  
**Subject:** Scheduling Patients  
**Importance:** High

As we all know, there are a "few" (>2400) patients that need to be scheduled. They are currently on multiple lists and some on paper. It is imperative that we start this scheduling process so that these patients can be seen in a timely fashion. This is the process that I have brainstormed with several of the BHIT workgroup:

--The patients that are assigned to therapists—psychology, LCSW...will remain with that therapist and thus be assigned to the BHIT that therapist is assigned to.

--There are many patients that have been assessed as needing an "asap" appointment.

--Dr. Hite will be seeing some of his previous patients (max panel= )—I will work with him to see which of the more complicated patients he will be keeping and the others will be reassigned.

--Dr. Patterson has expressed that he will be keeping the patients he has been seeing since he's been here

--MHiCM patients will be seen by S. Derivas and Dr. Fort

000076

The RNs will work on assigning BHITS/providers—if questions we will clarify any decisions that need further assistance with Paul or Dr. Patterson.

For the rest:

The majority have either been seen via MHACS or not seen in 6, 12 or more months. To isolate when each patient's last visit is would be manually time consuming so this is what I think will work the most efficiently:

1. Take the patients who are marked as "asap" or High Risk and schedule them first in with the new providers.
2. Identify as many OEF/OIF patients as possible and assign them to BHIT 1
3. Take the remaining and split the patients into BHIT 1 and 2 on rotating basis
4. Start filling the contract providers schedules now as they come on board and orient—Dr. Patterson had given verbal guidelines that they could have 2 patients their first patient day, 1 per hour the next week then graduate up to 2 per hour and then to the 3 per hour—total 12 patients per assigned day.
5. I would like to leave one appointment per hour that we DO NOT fill with this back log of patients so that we have room for urgent appointment needs identified in MHACS or inpatient or if a patient has a problem that needs to be addressed prior to first available appointment.
6. As the week (prior) goes by, if those appointments are not filled (not likely scenario), we can call patients in, have the provider review some of the records of patients identified as needing transitioning back to Primary Care and start that process.

This is a starting process—if it is not efficient, we will re-group and try again, but if we don't get started, we will only delay having these patients seen.

Please review and add any other steps, comments, etc that you can think of.

The new patients will be handled differently because MHACS will have a hand in assigning the patients based on the above criteria.

Thank you,

Stephanie Alexander, RN

000071

**From:** Antoniou, Paul E.  
**Sent:** Thursday, February 27, 2014 11:51 AM  
**To:** Patterson, James C.  
**Subject:** RE: BHIT scheduling

I understand Doc and I think we need to work more collaboratively together, which I am committed to do. Paul.

Paul E. Antoniou, ACSW, LCSW, BCD

Inpatient Clinics Director

Mental Health Service Line

Madison Brooks VA Medical Center

111 East Stoner

Greenville, LA 71101

Cell 904-825-9012/ Work 318-221-8411 ext 5408.

000072

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**From:** Patterson, James C.  
**Sent:** Thursday, February 27, 2014 11:47 AM  
**To:** Antoniou, Paul E.  
**Subject:** RE: BHIT scheduling

You cannot approve comp time. That is written into the functional statement of our Operations Manager.

I appreciate their desire to do this, and they do need to work hard. I am not going to micromanage comp time, and am not going to get involved.

James C Patterson II, MD, PhD  
Chief - Mental Health Service  
Horton-Brooks VA Medical Center  
311 East Stoner Avenue,  
Shreveport LA 71101  
318-990-5051 phone  
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james.patterson3@va.gov

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**From:** Antoniou, Paul E.  
**Sent:** Thursday, February 27, 2014 8:34 AM  
**To:** Patterson, James C.  
**Subject:** FW: BHIT scheduling  
**Importance:** High

000073

Doc. Generally Alexander, Harris and Anderson are assets that we need to continue to recognize and continue to utilize in leadership roles. They are gems. Doc. Thanks for your support as I pursue their involvement in these endeavors. One of my strengths to recognize ability; employ it and energize it to work to its fullest capacity to serve the mission. There has been resistance, I know. In a related matter, I want to approve CTE for Harris and Alexander on the work mentioned below. I will take responsibility for their work. Any objections? Thanks and sincerely, Paul.

Paul E. Antoniou, ACSW, LCSW, BCD

Outpatient Clinics Director

Overton Brooks VA Medical Center

Cell 004-825-9012

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**From:** Alexander, Stephanie - SHR  
**Sent:** Wednesday, February 26, 2014 4:34 PM  
**To:** Fuller, Janice N.; McDaniel, Ruthie L.; LaCour, Hope  
**Cc:** Patterson, James C.; Antoniou, Paul E.  
**Subject:** BHIT scheduling  
**Importance:** High

As you are aware, there are multiple lists, excel sheets, papers that contain names of patients that need to be scheduled—just a few at approximately 2400 existing patients—some have not been seen in as long as 12-15 months.

It is time to start assigning the BHIT teams/patients and getting appointments set as the new providers come on board. I am assigned to the BHIT work team as facilitator and thus am assigned to assist in getting the BHITS up and running efficiently.

This assignment of patients is going to involve: combing the lists, identifying "asap" patients, identifying high risk patients, identifying the oof/oif patients. If the patients are with a therapist level provider, they will go to the BHIT that the therapist is assigned as these have been the patients' "constant" throughout our multiple changes in service staffing (this was agreeable to Dr. Patterson).

Request:

To be allotted some CTE to work on this in quiet/non-interrupted sessions—first one tomorrow pm for 2 hours. Ms. Harris has requested to stay as well—the process identified is that the RN will make the assignments based on criteria identified (that process pending approval of Mr. Antoniou) and the MSA will be working the excel sheets updating and making the appointments based on provider clinic specs. The excel sheet will remain important to maintain at first as each provider will have a cap to their panels based on the percentage of FTEE they are.

000074

Please discuss and advise if this is approved or if you have any other suggestions to get this done. If you have any questions, please advise.

Thank you,

Stephanie Alexander, RN

OPT MHC

000075

**From:** Patterson, James C.

**Sent:** Wednesday, December 11, 2013 11:58 AM

**To:** Beighley, Julie A.; Martin, Genethia C.; McDaniel, Ruthie L.; Herpin, Kelly - SHR; Rios-Biedsoe, Martha; Farley, Herb; Antoniou, Paul E.; Glidewell, Reba S.; McDaniel, Alesia; LaCour, Hope

**Cc:** Shaver, Harold D.; Ing, Susan - SHR; Radcliffe, Nancy J.; Cooper, Holly E.; Wright, Tonya A.; Busenbarrick, Steven; Webb, Mariyn J.; Melton, Krista R. (SHR)

**Subject:** RE: Mental Health Service Consults Greater Than 90 Days

I don't know if these are further out than 90 days, as there is no list attached, Julie. The last email I have on unresolved consults is the one from Herb (attached) - sent on 12/09/13, and the spreadsheet in that email is from Nov 7<sup>th</sup>. In that email, these are the MHS entries of note:

|                   |  |  |
|-------------------|--|--|
| <u>Unresolved</u> |  |  |
|-------------------|--|--|

000076

| <u>Consults</u> | <u>Person Responsible</u>     | <u>Service</u>                        |
|-----------------|-------------------------------|---------------------------------------|
| 24              | Susan Ing, Tonya Wright       | LONGVIEW MENTAL HEALTH CLINIC CONSULT |
| 20              | Nancy Radcliffe, Holly Cooper | MENTAL HEALTH (OUTPATIENT) SERVICE    |
| 16              | Don Shaver, Marilyn Webb      | MONROE SMOKING CESSATION CONSULT      |

Please note that our unresolved consults have decreased dramatically in the past few months, thanks in large part to the MHACS service. Good job MHACS!

Now, one of the questions we have been trying to answer among ourselves is what to do with consults if the appt has to be rescheduled. For instance, the patient doesn't show, and then misses the next appt, etc. Or, we have to reschedule them on our end.

Some locations are administratively closing consults - before the patient is seen, and once the appt is scheduled. **I do not feel that this is an adequate mechanism.** While this may get patients off this list - it is not best for patient care.

The consult should only be closed:

1. After the patient has been seen by the provider and that provider answers the consult via a note (and thus closes it)
  - a. This should be within a short period of time to meet the metric and should not result in an "unresolved" issue.
2. Once we determine that the patient does not really want to come to MHS (often PCP makes appt and doesn't discuss w patient)
  - a. This will likely be discovered after the Vet misses one appt and is called.
3. After the patient has missed two appts due to no-shows
4. Administratively due to inappropriate or erroneous consult.

000077

I am asking the persons responsible above to address why we have these consults still open - I know the answer to

one, but let's work through this anyway to see how it jibes with the above guidelines.

Now there were some issues in Monroe with smoking cessation - but thought they were addressed and so was surprised to still see these on here.

Thanks,

James C Patterson II, MD, PhD

Chief - Mental Health Service

Wootton-Brooks VA Medical Center

40 East Stoner Avenue,

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318-990-5705 fax

[jcpatterson3@va.gov](mailto:jcpatterson3@va.gov)

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**From:** Beighley, Julie A.

**Sent:** Wednesday, December 11, 2013 10:18 AM

**To:** Martin, Genethia C.; Patterson, James C.; McDaniel, Ruthie L.; Herpin, Kelly - SHR; Rios-Bledsoe, Martha

**Subject:** RE: Mental Health Service Consults Greater Than 90 Days

Please advise me when these have been reviewed and appropriate actions taken.

Thank You.

Julie Beighley

Administrative Assistant to the Chief of Staff

Wootton Brooks VA Medical Center

Phone: 318-990-5125

000078

318-990-5349

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**From:** Martin, Genethia C.  
**Sent:** Tuesday, December 10, 2013 3:54 PM  
**To:** Patterson, James C.; McDaniel, Ruthie L.; Herpin, Kelly - SHR; Rios-Bledsoe, Martha  
**Cc:** Martin, Genethia C.; Beighley, Julie A.  
**Subject:** Mental Health Service Consults Greater Than 90 Days

Please have these reviewed and appropriate action taken.

Thanks, Genethia

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 **Copy of CONSULTS PENDING RESOLUTION NOV 6 2013.xlsx**  
34K

000079

**From:** Patterson, James C.

**Sent:** Monday, November 25, 2013 4:33 PM

**To:** McDaniel, Ruthie L.; Herpin, Kelly - SHR; Antoniou, Paul E.; Peck, Shannon; Burnett, Alicia D.; Cooper, Holly E.; Rios-Bledsoe, Martha

**Subject:** follow-up scheduling

A practice has come to my attention that I want to track...and I am working on a means to track it.

That practice is the continued scheduling of outpatients for follow-up that are consistent or reasonably consistent no-shows, to pad one's clinic schedule with empty slots that don't appear empty.

I don't like that.

<https://mail.google.com/mail/u/0/?ui=2&ik=87888e1ac5&view=pt&q=w...&qs=true&search=query&th=146aa68c0bcfd9a&siml=146aa68c0bcfd9a> Page

000080

I am aware that one can't track no-show rates on a per patient basis. BUT:

Alicia do you have a current no-show rate per clinic?

If I can get an updated list of no-show rates for the clinics, I can run DCARs and include no-shows for the past year. I can then format and import to excel, sort by name, and see who is problematic.

This may help.

A more immediate solution would be to start overbooking. Are we overbooking now?

JP

James C Patterson II, MD, PhD

Chief - Mental Health Service

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jpatterson3@va.gov

1800081

From: Wilkes, Christopher S CPT USARMY 807 MED DSC (US)  
Sent: Tuesday, June 11, 2013 8:37 PM  
To: va.ighotline@va.gov  
Subject: Reference # 2013-12958 (UNCLASSIFIED)

Classification: UNCLASSIFIED  
Caveats: NONE

This response is late but due to the increased amount of travel for the Army reserve and VA I was unable to respond in 2 weeks.

I know that the IG has been looking into Overton Brooks VAMC in Shreveport and found things.

If you want the truth about mental health concerning the Assistant Chief and Chief Positions I have information dating back over a year.

The main persons involved are:

Ruthie McDaniel  
Ron Schneider  
Reba Gildewell  
Susan Lott  
Dr Sarah Battar

I understand Dr. Richard Wallace along with others have been complaining but they are far from saints.

There has been years of crooked hiring at OBVAMC.

000082

Ron Schneider should have never been hired as chief. He should have never been in the final group. It was set-up as he had zero leadership experience anywhere. Look into it.

Reba Glidewell I here has complained about Dr. Battar stopping her from getting the Asst. Chief job. I have proof they were trying to pre-select Glidewell 2x's and I gave it to Battar.

I also have proof of an attempted reprisal against me when I turned Ruthie McDaniel, Ron Schneider, and Glidewell in.

If you really want to see a joke look into the recent Mental Health Chief Selection. I was one of 4 on the interview committee and the overwhelming #1 on 3 of the 4 was passed over for not being an M.D. Which is clearly against VHA Handbook. To top it off I was given 50+ applications to grade. After grading them all and turning them in I was told a day later HR forgot to send one application to everyone. This application was the eventual #2 that was selected. Can you say preselect ion and not following proper protocol.

This is however not new as it happens so often at OBVAMC people think it is OK and normal.

Like I said before I have a stack of evidence to much to send. I have provided names as asked but if you want the paperwork tell me where to send or pick it up next time your down.

Also, I can show you how our psychology department manipulates the 14 day measure to see veterans and how they cook their numbers to make it look as if they are seeing tons of veterans when only seeing a huge amount of the same veterans in groups weekly for years.

Thanks  
Christopher S. Wilkes

Classification: UNCLASSIFIED  
Caveats: NONE

000083

From: VA OIG Hotline [va.ig.hotline@va.gov]

Sent: Tuesday, June 11, 2013 8:37 PM

To: Wilkes, Christopher S CPT USARMY 807 MED DSC (US)

Subject: Out of Office: Reference # 2013-12958 (UNCLASSIFIED)

The U.S. Department of Veterans Affairs Office of Inspector General (OIG) Hotline received your email. The VA OIG mission is to detect and prevent fraud, waste, and abuse within VA programs. The Hotline accepts tips or complaints that, on a select basis, result in reviews of:

- VA-related criminal activity.
- Systemic patient safety issues.
- Gross mismanagement.
- Waste of VA resources.
- Misconduct by senior VA officials.

Because we receive more complaints than the OIG has resources to review in depth, we limit investigative efforts to issues that have the most serious potential risk to Veterans and VA operations. Your correspondence has been assigned to one of our analysts for review.

Our Hotline is not staffed to support emergency responses. In the case of a life-threatening emergency, please call 911 or, if appropriate, your local VA police.

The following list describes what you may expect depending on the nature of your submission.

- **NEW COMPLAINT.** If you submitted a new complaint about an issue within the VA OIG's jurisdiction, then the Hotline staff will contact you within 30 days regarding the disposition of your complaint. While waiting to hear if the OIG will become involved, you should continue working with the responsible VA office to resolve your concerns, if possible.
- **ADDITIONAL INFORMATION.** If you submitted additional information or a release of identity for your complaint, then Hotline staff will process this information upon receipt. However, we cannot provide a personalized response confirming receipt of this information.
- **STATUS REQUEST.** Due to limited resources, we cannot respond to requests for status on a complaint. Our

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notifications are limited to when a hotline action is opened, when a case is closed, or when a complaint is non-selected for review.

- OTHER SUBMISSION. We do not respond to contacts that do not concern the VA OIG mission or Federal law enforcement.

The Hotline does not accept complaints that are unrelated to VA or are addressed in another legal or administrative forum. Additional information concerning the types of complaints the OIG accepts for review may be found at: <http://www.va.gov/oig/contacts/hotline.asp>. Contact information for other organizations which may be of assistance is listed under "Complaints not accepted." Finally, information on whistleblower protections for Federal employees may be found at: <http://www.va.gov/oig/hotline/whistleblower-protection.asp>.

Please do not respond to this automatically-generated response. Thank you for your interest in the VA OIG Hotline.

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**Department of  
Veterans Affairs**

**Memorandum**

**Date:** October 15, 2013  
**From:** Chief, Mental Health Service (116)  
**Subject:** Fee for Service Providers – Mental Health Clinic  
**To:** COS, Business Office

I am once again faced with an even more severe shortage of prescribing providers in the general mental health clinic. As you know, Lee Hite is on extended medical leave, and likely will not come back. I actually will not allow him to come back unless he has an extensive medical workup and clearance. Now, I have another psychiatrist who is going to resign or take extended medical leave in November, due to both his wife and his mother having major medical illnesses. That leaves me with me three nurse practitioners. One of these nurse practitioners apparently has severe medical problems as she is calling in on a near daily basis.

Given that it is nearly impossible to hire psychiatrists full time, I would like to offer community psychiatrists the following:

- 1. A half-day of fee for service work, at the following rates for medication management:

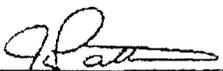
2.

| Medication Management |       |    |        |
|-----------------------|-------|----|--------|
| established           | 99213 | \$ | 75.00  |
| established           | 99214 | \$ | 100.00 |
| new pt                | 99203 | \$ | 175.00 |
| new pt                | 99204 | \$ | 200.00 |

- 3. Established patient time slots of 20 minutes
- 4. New patient evaluations time slots of 40 minutes
- 5. 20% overbook to match the 20% no show rate

For four hours of work, that would be at maximum about \$1200.00, and for five hours, \$1500.00.

I think that would be an attractive offer that would draw attention and get us needed service.

  
James C. Patterson II, M.D., PhD  
Chief, Mental Health Service

**Patterson, James C.**

---

**From:** Patterson, James C.  
**Sent:** Tuesday, October 15, 2013 10:33 AM  
**To:** Battar, Saraswathy S.; McGaully, Patrick; Herpin, Kelly - SHR; McDaniel, Ruthie L.  
**Subject:** FFS memo to hire psychiatrists  
**Attachments:** FeeForService\_memo\_101513.pdf  
  
**Importance:** High

I know I can ask Kelly who this needs to be routed to, but wanted to give COS a heads up - things are getting grim.

**I need the Business Office to approve this I think?**

If I understand correctly, the current fee for service rates are at 75% of Medicare. For a psychiatrist, that is a ridiculously low number. Many MDs, especially psychiatrists, already will not take Medicare because it is too low.

If I am going to get MDs for mental health, my best bet is Fee For Service.

If I am going to get FFS MDs for mental health, the only way is to pay them adequate amounts of money.

See enclosed...

JP

James C Patterson II, MD, PhD  
Chief - Mental Health Service  
Overton-Brooks VA Medical Center  
510 East Stoner Avenue,  
Shreveport LA 71101  
318-990-5051 phone  
318-990-5705 fax  
[james.patterson3@va.gov](mailto:james.patterson3@va.gov)

DAVID VITTER  
LOUISIANA

DEPUTY WHIP

Environment and Public Works  
Top-Ranking Republican

Armed Services

Banking, Housing, and Urban Affairs

Small Business and Entrepreneurship

## United States Senate

WASHINGTON, DC 20510

June 17, 2014

WASHINGTON, D.C.  
HARRY SENATE OFFICE BUILDING  
SUITE 5H-516  
WASHINGTON, DC 20510  
(202) 224-4623  
FAX: (202) 228-5061

BATON ROUGE  
868 CONVENTION STREET  
BATON ROUGE, LA 70802  
(225) 383-0331  
FAX: (225) 383-0952

Website with E-Mail Address:  
vitter.senate.gov

Richard J. Griffin  
Acting Inspector General  
VA Office of Inspector General  
810 Vermont Avenue, NW  
Washington, DC 20420

Dear Acting Inspector General Griffin,

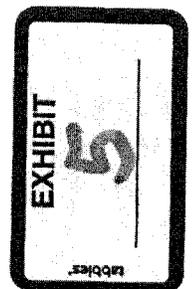
As I am sure you are aware, Shea Wilkes, a whistleblower and licensed clinical social worker at the Overton Brooks Department of Veterans Affairs Medical Center in Shreveport, LA, has come forward with specific allegations that Overton Brooks manipulates veteran wait time data. Mr. Wilkes claims there is a secret list with over 600 patients at Overton Brooks who have not been treated and are also not being counted in any Veterans Health Administration (VHA) audit. I request that you launch a full review about these claims immediately.

Mr. Wilkes has bravely come forward, risking his own job security, to bring these allegations to light. It has come to my attention that he has sent you a copy of this secret list, and I urge you to immediately and thoroughly investigate these allegations at Overton Brooks.

The VHA uses an Electronic Wait List (EWL) for all the scheduling of care for its patients. There should be absolutely no other form of wait list used by VA administrators. Mr. Wilkes alleges, however, that the administrators and staff at Overton Brooks blatantly disregarded this mandate, maintaining a "secret" wait list and manipulating the EWL in the following other ways:

- In addition to maintaining this secret list, he claims schedulers at Overton Brooks have been instructed in the use of "gaming strategies" to manipulate reported wait times. He asserts this includes holding appointments without scheduling until capacity opens or entering into the system that the patient requested the out-of-date appointment.
- He also claims existing mental health patients are often provided appointments to therapy in large groups. Such an appointment is counted as being scheduled for an appointment to a primary care provider.

Additionally, if certain wait time goals are not met, VA administrators don't receive bonuses and auditors from the VHA will descend on the facility. So clearly they have plenty of incentive to participate in this egregious activity.



**ACADIANA**

111 QUINCY SALOOM ROAD  
SUITE 201  
LAFAYETTE, LA 70508  
(337) 993-9502  
FAX: (337) 993-9507

**CENTRAL LOUISIANA**

5501 COLBIERRE BOULEVARD  
PLAZA 28, SUITE 200-A  
ALEXANDRIA, LA 71303  
(318) 449-0169  
FAX: (318) 448-0189

**NORTHEAST LOUISIANA**

1051 LOUISVILLE AVENUE  
SUITE 148  
MONROE, LA 71201  
(318) 325-8120  
FAX: (318) 325-9105

**NORTHWEST LOUISIANA**

920 PIENREMOIT ROAD  
SUITE 119  
SHREVEPORT, LA 71106  
(318) 881-0437  
FAX: (318) 881-4895

**SOUTHEAST LOUISIANA**

2800 VETERANS BOULEVARD  
SUITE 201  
METairie, LA 70002  
(504) 889-2753  
FAX: (504) 889-2607

**SOUTHWEST LOUISIANA**

1424 RYAN STREET  
SUITE A  
LAKE CHARLES, LA 70601  
(337) 436-0453  
FAX: (337) 436-3163

Given the systematic failures of the VA across this country, as evidenced in your own multiple OIG reports, I demand a full investigation into these startling allegations. No veteran of this country should be put on any secret waiting list so a VA bureaucrat can receive a bonus. I trust you will use all resources available to your office to launch a full investigation. Please respond by June 27, 2014, with a detailed plan on how your office will handle these allegations. Veterans of North Louisiana are counting on you.

Sincerely,

A handwritten signature in black ink, appearing to read 'D. Vitter', with a horizontal line extending to the right.

David Vitter  
United States Senate



DEPARTMENT OF VETERANS AFFAIRS  
Office of Inspector General  
Washington DC 20420

June 30, 2015

Christopher Shea Wilkes  
9328 Stonebriar Circle  
Shreveport, LA 71115

Dear Mr. Wilkes:

This responds to your request for "a copy of any and all documents containing knowledge of any reports and/or claims made that Mr. Christopher Shea Wilkes illegally obtained and/or breached confidentiality or privacy for securing and/or obtaining the Mental Health Waiting list. . . ." We assigned case no. 15-00197-FOIA to this request.

This release of information decision is issued pursuant to the Freedom of Information Act (FOIA), 5 U.S.C. § 552 and the Privacy Act, 5 U.S.C. § 552a. For the following reasons, the Office of Inspector General, United States Department of Veterans Affairs will grant in part your request for information.

We have released information pertaining to you that is found in a Privacy Act system of records.

The FOIA directs federal agencies to disclose records unless the information is protected by any of the nine statutory exemptions. FOIA Exemption 7(C) protects personal information in investigative records. 5 U.S.C. § 552(b)(7)(C). This exemption protects the disclosure of information that could reasonably be expected to constitute an unwarranted invasion of personal privacy.

In considering whether Exemption 7(C) may be applied to withhold records or information, an agency must weigh the interest in public disclosure against the rights of individuals to privacy. Courts have explained that FOIA is intended to allow people to learn about the operations of agencies, not to discover personal information about others. Addressing the intent of the FOIA, the U.S. Supreme Court held that "the statutory purpose [of FOIA] is not fostered by disclosure of information about private citizens that is accumulated in various governmental files, but that reveals little or nothing about an agency's own conduct." *U.S. Department of Justice v. Reporters Committee for Freedom of the Press*, 489 U.S. 749, 773 (1989).

Our analysis requires us to determine whether we are able to (1) identify whether a privacy interest exists in the information and (2) identify whether release would further the public interest by shedding light on the operations and activities of the government. Additionally, we must weigh the identified privacy interests in the information against the public interest in disclosure.



000001

Applying the analysis described above, we have withheld certain identifying information and other personal information found in the enclosed documents. We do not find that disclosure of the information would further any public interest by shedding light on the operations and activities of the U.S. Department of Veterans Affairs. Consequently, the privacy interests at stake here outweigh any public interest.

We appreciate your patience. You may appeal this decision concerning release of information within 60 calendar days of the date of this determination by submitting a signed, written statement by mail, fax, or email. You may submit your appeal by using either of the following addresses or fax number:

U.S. Department of Veterans Affairs  
Office of Inspector General  
Office of the Counselor (50C)  
810 Vermont Avenue, N.W.  
Washington, DC 20420

[VAOIGFOIA-Appeals@va.gov](mailto:VAOIGFOIA-Appeals@va.gov)

(Fax) 202.495.5859

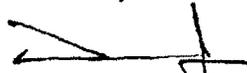
The appeal should include:

1. The name of the FOIA Officer.
2. The date of the determination, if any
3. The precise subject matter of the appeal

If you choose to appeal only a portion of the determination, you must specify which part of the determination you are appealing.

The appeal should include a copy of the request and VA's response, if any. The appeal should be marked "Freedom of Information Act Appeal".

Sincerely,



DARRYL JOE  
Chief, Release of Information Office

000002

Referral Transaction Report

03/25/2015 11:14:02 AM

Page: 1

MCI Number 2014-02890-DD-0357

Fiscal Year 2014

Agent

[Redacted]

Subregion NO Southcentral Fld Off Referral (INV/Da)

Receive Date 05/17/2014

Title WILKES, CHRISTOPHER - DATA BREACH - SHREVEPORT VAMC

Referral Due Dt. 09/15/2014

Source XE VA EMPLOYEE

Disp. Date 03/24/2015

Fraud Amount

Fraud Unknown Y Substantiated N

Cong Int

State TX Zipcode

Case Initiated Filed for info Y

White House

Business Lines VHA Medical Care

Special Course

Synopsis Reference Hotline Complaint: Unknown File Number

This referral is initiated based upon information provided to VA OIG Hotline Division from Shreveport VAMC employee Christopher WILKES. In his written complaint to the Hotline Division, WILKES admitted that he was able to obtain a nurse's password so he could access a shared network drive that allegedly contained a copy of what he reported to be a "secret" wait list of patients. WILKES provided this list with his complaint.

Preliminary investigation revealed that WILKES accessed and printed a password protected Microsoft Excel document that was located on the Shreveport VAMC Mental Health Service's shared network drive. The Excel document contained spreadsheets with the names and social security numbers of approximately 2,700 VA patients. WILKES was a former employee of the Shreveport VAMC Mental Health Service. His access to the shared network drive was to have been revoked when he left the department, but it was not (he could still access the drive). WILKES stated he obtained the password to the Excel document from [Redacted], [Redacted], [Redacted], Shreveport VAMC; he accessed and saved a copy of it onto his work computer's hard drive; and he printed two copies of it (he provided both copies to VA OIG agents, who also took possession of his computer's hard drive). WILKES said that he did not provide a copy of the Excel spreadsheets to anyone else and the two copies that he made never left the Shreveport VAMC grounds. [Redacted] was the author of the Excel document and she denied providing WILKES with the password. She explained that it was common for employees of the Shreveport VAMC Mental Health Service to use their last name to password protect documents saved on the department's shared network drive, and that she used her last name to password protect the Excel document that WILKES accessed without authorization. She believed that because WILKES was formerly an employee of the Mental Health Service, he would have known that she used her last name to password protect the Excel document.

[Redacted] and WILKES agreed to participate in a polygraph examination, but both subsequently declined, under the advisement of legal representation.

There is no indication that WILKES disseminated the information on the Excel spreadsheets to anyone. As a result, this matter will not be referred to the U.S. Attorney's Office for a prosecutive decision, and is considered closed.

Station 667 SHREVEPORT  
Referred To

000003

MCI Number 2014-02890-DD-0357

Fiscal Year 2014

Agent

[Redacted]

Southcentral Fld Off Referral (INV/Da)

Cross Reference

Program Area Nature of Complaint  
 H 64 PRIVACY ACT VIOLATIONS  
Program Area Nature of Complaint  
 H 150 HIPAA VIOLATION  
Program Area Nature of Complaint  
 H 166 DATA BREACH

Name CHRISTOPHER SHEA WILKES Subject  
DOB SSN  
Street: Subject Type Suspect  
City State Zipcode  
Phone Work Phone

Name [Redacted] DOB SSN  
Street Subject Type Witness  
City Shreveport State LOUISIANA Zipcode  
Phone Work Phone [Redacted]

Start Date End Date Suspended  
Reason

Subpoenas

Company/Address FPA Date Issued Date Served Subpoena Type

Attached Documents

| <u>Date</u> | <u>Doc Name</u>    | <u>Owner</u> | <u>Desc</u>              |
|-------------|--------------------|--------------|--------------------------|
| 09/19/2014  | MOI-[Redacted].doc | [Redacted]   | MOI-[Redacted] 6/19/2014 |
| 09/19/2014  | MOI-Wilkes.doc     | [Redacted]   | MOI-Wilkes 05/18/2014    |
| 09/19/2014  | MOI-wilkes 2.doc   | [Redacted]   | MOI-Wilkes 2 05/19/2014  |

Consensual Monitorings

U/C Operations

Approval Date

000004



Department of Veterans Affairs  
Office of Inspector General  
Criminal Investigations Division  
New Orleans Resident Office  
1515 Poydras St, Rm 738  
New Orleans, LA 70112

MEMORANDUM OF INTERVIEW

Date: August 5, 2014  
Appr: RAC [REDACTED]

Case File: 2014-2890-DD-357  
Date of Interview: June 18, 2014  
Time: Approximately 1:06 p.m.  
Place of Interview: VAMC Shreveport, LA  
Interviewee: Christopher Shea WILKES  
Interviewed By: SA [REDACTED] and SA [REDACTED]

On the above date, Special Agent [REDACTED] and I, Department of Veterans Affairs (VA), Office of Inspector General (OIG), conducted an interview of Christopher WILKES at the VAMC Shreveport, LA. Once we identified ourselves using our credentials, WILKES was informed of his Garrity Rights and that his statements were voluntary. WILKES agreed to answer questions and that the interview could be recorded. The interview was recorded and placed onto a compact disc, which is maintained in the case file. (Special Agent's Note: Approximately the last five minutes of the interview was not recorded due to the recorder running out of power.) WILKES provided the following information:

Since February 2014, WILKES has been an OEF/OIF OND, Mental Health Social Worker at VAMC Shreveport. From December 2011 until February 2014 he was the Local Recovery Coordinator in Mental Health Services at VAMC Shreveport.

When asked about the "list" that WILKES contacted the VA OIG Hotline about, he explained it was an excel spreadsheet with multiple tabs containing the names and social security numbers of approximately 2,700 veterans that were patients of the Mental Health Services at VAMC Shreveport. The list was maintained on the Mental Health Services' share drive and it was password protected. (WILKES was no longer an employee of Mental Health Services, but he was still able to access the Mental Health services' share drive.) [REDACTED] [REDACTED] VAMC Shreveport, told WILKES there were 600 out of the 2,700 patients that needed appointments with one of the new providers.

WILKES explained that he learned of the excel spreadsheet in the fall of 2013. Also in the fall of 2013, he heard one of the clerks in Mental Health Services inform a patient that his/her name was going on a list and when a new provider was available, the

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(Public Availability to be Determined Under 5 USC 552 and 552a)

File Number: 2014-2890-DD-357  
Case Name: Data Breach – Shreveport VAMC

patient would be scheduled with the new provider. The clerk told WILKES the department was short of providers. WILKES believed that because of the shortage of providers, the excel spreadsheet was used to manipulate getting veterans in for appointments; although he was unsure exactly how the list was being used to do this.

On June 2, 2014, WILKES provided [REDACTED] information regarding comp time distribution in Mental Health Services (that he gained via a FOIA request) in exchange for the password, which was [REDACTED]'s last name in all lower case letters, to the excel spreadsheet. [REDACTED] was not given help or awarded comp time to schedule the patients that were listed on the excel spreadsheet, but others in the department were granted comp time for various other reasons. He opened the excel spreadsheet using the password provided by [REDACTED], but it was locked. He could not download or print it, so he took pictures of it on the computer screen with his cellular phone. Four days later, he opened the excel spreadsheet without the password (password protection was removed from the document). He saved it to his work computer's hard drive and printed two copies of it. After he saved and printed it, he deleted the pictures from his phone. WILKES obtained a copy of the excel spreadsheet because he was going to be a whistleblower and he was concerned someone may delete the list.

WILKES provided reporter [REDACTED], Shreveport Times Newspaper, with information about the manipulation of numbers and wait times at VAMC Shreveport. He did not provide her with a copy of the excel spreadsheet or any patient information. WILKES stated the article was published on June 8, 2014.

After the newspaper article, WILKES conducted an interview regarding secret wait list at VAMC Shreveport with reporters Elsa Gillis and Laura Ashley Overdyke, KTBS Channel 3. WILKES stated the interview was broken into a three part series that aired on KTBS new (June 12, 15, and 16). He stated he did not provide a copy of the excel spreadsheet or patient information to the reporters, so the reporters referred to the information that he provided as alleged.

WILKES stated that during a meeting (he did not recall the date); he heard [REDACTED] [REDACTED] VAMC Shreveport, instruct [REDACTED] VAMC Shreveport, to not use the electronic wait list.

WILKES provided both hard copies of the excel spreadsheet to SA [REDACTED], and the hard drive to his work computer was confiscated. WILKES stated that he no longer had any copies (hard copy or electronic) of the excel spreadsheet, that he did not provide a copy of it to anyone else, and that he never took a copy of it off of VAMC Shreveport grounds.

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(Public Availability to be Determined Under 5 USC 552 and 552a)

DEPARTMENT OF VETERANS AFFAIRS  
OFFICE OF INSPECTOR GENERAL

----- x  
: Case No.  
INTERVIEW OF : 2014-02980-DD-0357  
CHRISTOPHER WILKES :  
: June 18, 2014  
Mental Health Social :  
Worker : 01:05:55  
: **ORIGINAL**  
----- x

Wednesday,  
June 18, 2014

VA Medical Center  
Shreveport, Louisiana

The above-entitled matter came on for interview,  
pursuant to notice at 1:06 p.m.

BEFORE:

MR.   
MR.

Special Agents  
Office of Inspector General  
Department of Veterans Affairs

This transcript produced from a sound file  
provided by Department of Veterans Affairs Office of  
Inspector General.

Diversified Reporting Services, Inc.  
(202) 467-9200

000008

Page 2

1                    PROCEEDINGS

2                    1:06 p.m.

3                    SPECIAL AGENT [REDACTED] This is Special Agent

4                    [REDACTED] and Special Agent [REDACTED] It is

5                    June 18th, 2014. The time is 1:06. We're at the VA

6                    Medical Center in Shreveport, Louisiana, and we'll be

7                    speaking with Christopher Wilkes.

8                    SPECIAL AGENT [REDACTED] Okay. Do you want to

9                    go to it?

10                    SPECIAL AGENT [REDACTED] What is your date of

11                    birth?

12                    MR. WILKES:

13                    SPECIAL AGENT [REDACTED] Your Social?

14                    MR. WILKES:

15                    SPECIAL AGENT [REDACTED] And what's your address?

16                    MR. WILKES:

17                    Circle -

18                    SPECIAL AGENT [REDACTED] Okay.

19                    MR. WILKES:

20                    SPECIAL AGENT [REDACTED] Zip

21                    MR. WILKES:                    Where, that was

22                    quick.

Page 3

1                    SPECIAL AGENT [REDACTED] And what's your live

2                    phone numbers like a home and a cell? Do you have a

3                    cell?

4                    MR. WILKES: Cell is                    When is

5                    my home? I think my home is                    if that

6                    that's right

7                    SPECIAL AGENT [REDACTED] Okay.

8                    SPECIAL AGENT [REDACTED] What was the number I

9                    just got that I called you on?

10                    SPECIAL AGENT [REDACTED] That's my cell

11                    SPECIAL AGENT [REDACTED] That's your cell?

12                    SPECIAL AGENT [REDACTED] (handible) and I don't

13                    ever use it.

14                    SPECIAL AGENT [REDACTED] Yeah.

15                    MR. WILKES: That's right.

16                    SPECIAL AGENT [REDACTED] And what is your title

17                    right now?

18                    MR. WILKES: I am the OEP, OIF, OND -

19                    SPECIAL AGENT [REDACTED] Okay. Well so OEP?

20                    MR. WILKES: OIF.

21                    SPECIAL AGENT [REDACTED] OIF.

22                    MR. WILKES: OND.

Page 4

1                    SPECIAL AGENT [REDACTED] OM?

2                    MR. WILKES: N, November. Mental health

3                    social work. I think that's what they call me

4                    SPECIAL AGENT [REDACTED] How long have you been

5                    doing that?

6                    MR. WILKES: Oh, ever since I pretty much made

7                    them move me up here, January or February, I think.

8                    SPECIAL AGENT [REDACTED] Of this year?

9                    MR. WILKES: Uh-huh.

10                    SPECIAL AGENT [REDACTED] And before that, how

11                    long have you been in VA, with the VA?

12                    MR. WILKES: I was the local Recovery

13                    Coordinator in Mental Health December 2011 until then

14                    SPECIAL AGENT [REDACTED] Okay.

15                    MR. WILKES: Before that I was at the Vet

16                    Center, which is right down the street, 08 to 011,

17                    and then before that I was in the Mental Health in the

18                    PTSD Program, 07 to 08, and I had a deployment to

19                    Afghanistan 04-09 in the middle of that, yeah, while

20                    I was at the Vet Center.

21                    SPECIAL AGENT [REDACTED] Okay.

22                    SPECIAL AGENT [REDACTED] Hey, I was up and

Page 5

1                    down with the number

2                    MR. WILKES: Well, that's what I said.

3                    SPECIAL AGENT [REDACTED] Okay. That's what

4                    you -

5                    MR. WILKES: Yeah.

6                    SPECIAL AGENT [REDACTED] Okay.

7                    MR. WILKES: Didn't I say?

8                    SPECIAL AGENT [REDACTED] Yeah.

9                    SPECIAL AGENT [REDACTED] Yeah.

10                    MR. WILKES: Ew, man, you make me nervous now.

11                    SPECIAL AGENT [REDACTED] Oh, yeah, yeah. Don't

12                    be nervous.

13                    MR. WILKES: Yeah, I'm cool.

14                    SPECIAL AGENT [REDACTED] You're good. You're

15                    good.

16                    MR. WILKES: I know. Trust me. I've - I've

17                    passed the nervous now.

18                    SPECIAL AGENT [REDACTED] So you got an email

19                    through the hotline?

20                    MR. WILKES: Last year.

21                    SPECIAL AGENT [REDACTED] Was it last year?

22                    MR. WILKES: Yeah.

1 00:03:11  
 2 SPECIAL AGENT (b)(7)(C) Okay. So tell us about  
 3 one, what is this list. What was the purpose of the  
 4 list? You mentioned a name of somebody who said you  
 5 had to keep a record of the list or that the -- we also  
 6 -- and (b)(7)(C) who gave you a password. We need to  
 7 know about that as well.

8 MR. WILKES: Yeah.

9 SPECIAL AGENT (b)(7)(C) But tell us about the  
 10 list.

11 MR. WILKES: Yeah, man, I -- I started -- I  
 12 learned about the list. I've been hearing it from  
 13 folks, and I -- and I never -- I knew they were -- I  
 14 saw one in the fall when I was doing --

15 SPECIAL AGENT (b)(7)(C) What type of list is it?

16 MR. WILKES: Damn. The one I have now?

17 SPECIAL AGENT (b)(7)(C) Uh-huh.

18 MR. WILKES: Is an Excel spreadsheet. All  
 19 right? Now, the Excel spreadsheet, it has several tabs  
 20 on it. So from when they gave it to me, what I was  
 21 told is these were -- there was 2,700 on there that the  
 22 list is the last 15, two years 15 months, somewhere in

1 on here are those that we've been through of the 2,700  
 2 that need appointments."

3 And I said okay, and I said, "Are these the  
 4 other list and stuff?"

5 She said yeah, because I remember back in the  
 6 fall when I was still there I was up front and one of  
 7 the clerks, one of the (b)(7)(C) had a veteran,  
 8 "Well, we've got a bunch of new providers in," which  
 9 are the consult providers, which I basically came up  
 10 with that idea, but they were putting them on the list.  
 11 They said, "We're going to put you on this list, and  
 12 when we get our new providers, we're going to make you  
 13 appointments."

14 And I was like, "What is that?" you know,  
 15 after.

16 And she said, "Well, we don't have any  
 17 providers so we've got to put them on this list by the  
 18 time."

19 I was like, "Really?" And I said, "Huh."

20 So I went, and at the time that was

21 probably -- man, I was on my way out. I had really --

22 SPECIAL AGENT (b)(7)(C) And what time period was

1 there of veterans that were seen in Mental Health.

2 SPECIAL AGENT (b)(7)(C) They're just veterans  
 3 that had been seen --

4 MR. WILKES: Right.

5 SPECIAL AGENT (b)(7)(C) -- or are currently  
 6 being seen?

7 MR. WILKES: Right.

8 SPECIAL AGENT (b)(7)(C) Both?

9 MR. WILKES: Or both, yeah.

10 SPECIAL AGENT (b)(7)(C) So it's a VA patient  
 11 list.

12 MR. WILKES: Right.

13 SPECIAL AGENT (b)(7)(C) Purpose being for?

14 MR. WILKES: To go through and identify like  
 15 veterans that maybe were being seen, hadn't been seen  
 16 in a while, fallen through the cracks, things like  
 17 that.

18 Now, that was all that, and this is where

19 (b)(7)(C) gave it to me because when I went  
 20 to her, I said, "Okay. Is this something that was  
 21 did?"

22 She said, "No, these are all these -- the 600

1 this?

2 MR. WILKES: This was in the fall.

3 SPECIAL AGENT (b)(7)(C) Fall of --

4 MR. WILKES: Yeah.

5 SPECIAL AGENT (b)(7)(C) Okay.

6 MR. WILKES: I mean I was on my way out

7 SPECIAL AGENT (b)(7)(C) Fall of 2013?

8 MR. WILKES: Yeah. I knew that my days were  
 9 numbered. I mean, I asked before I didn't get the job,  
 10 the recovery job, because they're going to say I'm  
 11 disgruntled. I asked the --

12 SPECIAL AGENT (b)(7)(C) All right.

13 MR. WILKES: -- to move me. So --

14 SPECIAL AGENT (b)(7)(C) Is this list a  
 15 tracking list so it's to take the place of the  
 16 electronic waiting list or something?

17 MR. WILKES: Yeah, well, yes. It's a mixture  
 18 of all of it.

19 SPECIAL AGENT (b)(7)(C) Okay.

20 MR. WILKES: From what I understand, and I  
 21 have now emails that (b)(7)(C) or that someone gave me  
 22 yesterday. (b)(7)(C) and (b)(7)(C) gave me yesterday. I have

00:06:15

1 emails actually showing them addressing with leadership  
2 that hey, we've got these Excel sheet lists. We've  
3 got these paper lists. We've got all these lists, and  
4 I'm combining them into this one list."

5 So that one list is what she gave me. Now,  
6 this was -- these emails were back in February, and I  
7 have those, too. We got copies.

8 SPECIAL AGENT [REDACTED] Okay. We'll need that.

9 MR. WILKES: I knew last year they were --  
10 they -- when the whole thing in Atlanta hit. I started  
11 reading about it because I knew our Psychology  
12 Department -- this is back when we were kind of siloed.  
13 We had all of our psychologists (inaudible) --  
14 (Knock at the door.)

15 MR. WILKES: -- all our -- hey, can you give  
16 me a few minutes?

17 PARTICIPANT: (Inaudible.)

18 SPECIAL AGENT [REDACTED] If you want to answer  
19 the door, you can answer the door. Just it's up to  
20 you.

21 (Pause in proceedings.)

1 MR. WILKES: They put it in a new patient  
2 group. Everybody had one, and I was like okay. So I  
3 started saying, "Hold on a minute here."

4 So they went in that group and I asked him. I  
5 said, "Well, what's this group about?"

6 And they said, "Well, you know, they just go  
7 in there and they tell us about services and  
8 everything, and they offer these big groups. We can go  
9 to these or if you want an individual appointment, they  
10 automatically tell you it's going to be 60 to 90 days,"  
11 basically just telling you what services we have.

12 So what happens then is I was like, "So hold  
13 on a minute," and then that's when I originally  
14 reported it. I said, "This is -- this is crap because  
15 these veterans are coming in. They're fixing this 14-  
16 day thing, and then they're originally if they need an  
17 individual appointment, they're getting it like--

18 SPECIAL AGENT [REDACTED] Ninety days.

19 MR. WILKES: -- 90 days out.

20 SPECIAL AGENT [REDACTED] So in other words, what  
21 you're saying is they used this list so that nobody  
22 knows that they're having to wait 60 to 90 days.

1 MR. WILKES: Okay. So I noticed, you know,  
2 started looking at it, you know. I was like, you know,  
3 Atlanta was just getting smoked, and then I like to  
4 read IG reports and stuff, and I was -- well, you're --  
5 I was trying to get things going, and I knew we were  
6 doing something sketchy in there, and so I read it, and  
7 I was like --

8 SPECIAL AGENT [REDACTED] Let me ask you  
9 something. Why is this sketchy? Why do you feel it's  
10 sketchy?

11 MR. WILKES: Because you're manipulating your  
12 veterans in for appointments.

13 SPECIAL AGENT [REDACTED] Okay. How so? That's  
14 what I'm trying to understand, how this list works and  
15 what the purpose of it is.

16 MR. WILKES: The original thing that I looked  
17 at, what was going on in Psychology was -- had  
18 developed a new patient group, and they put -- when  
19 they got a consult, they were booked up 60, 90 days  
20 out. They got a consult and they put it in a new  
21 group. This is what originally got me tracking this.

22 SPECIAL AGENT [REDACTED] Uh-huh.

1 (Pause)

2 MR. WILKES: This is original. That's not --  
3 we ain't got to the list yet. This is --

4 SPECIAL AGENT [REDACTED] Okay.

5 MR. WILKES: -- when I first noticed it back  
6 in 2013. That is when I reported it, and I told the  
7 Chief of Staff. He was the acting Chief of Staff at  
8 the time, [REDACTED] (phonetic). He's the Chief of Staff  
9 now.

10 And I went down to him and I said, "You've got  
11 a serious problem."

12 I actually called [REDACTED] who was  
13 the psychologist who testified on Capitol Hill, through  
14 AFG and talked to her, and she was like, "Yeah."

15 So I went to [REDACTED] and I heard he told the  
16 leadership that he was going to record it, and then he  
17 told me in the hudget like every year he recorded it.

18 So I just kind of let it go, and then  
19 [REDACTED] kind of -- we went from a silo. We move to  
20 what we call Behavior Health Integration Teams, to  
21 teams. So that kind of busted that up. And I was like  
22 okay.

1 00:10:04  
 2 So then I started noticing the -- we didn't  
 3 have any providers, and I was like how in the hell are  
 4 we taking this (inaudible), and so I started looking at  
 5 it, and then about in the fall is when I saw that list  
 6 that she had that I told you about. I was like that is  
 7 what it is, and I knew they had lists because even  
 8 recently we were doing a reintegration loop down here,  
 9 and [REDACTED] said something about a list, and I said,  
 10 "I don't want to hear about a list." This is before I  
 11 -- before I did.

12 So basically what happened is I kept hearing  
 13 about a list. I knew there was a list, and I said,  
 14 "What's going on. They don't have a lot of providers.  
 15 Why are they scheduling these?"

16 Well, then I started asking a few questions  
 17 and it came to, well, there is a list, and I was like,  
 18 "What?"

19 And they said, "Well, [REDACTED] has got it."

20 My old assistant [REDACTED] --  
 21 SA [REDACTED] [REDACTED] who?  
 22 THE WITNESS: [REDACTED] My old --

1 SPECIAL AGENT [REDACTED] Okay.  
 2 MR. WILKES: So I filed comp time Freedom of  
 3 Info and got comp time. She had over 300-something.  
 4 I went down there, and this is how I got the  
 5 list. They refused to give [REDACTED] help for comp  
 6 time to schedule these items [REDACTED] was pissed  
 7 off. I went down there and I told. I said,  
 8 [REDACTED] I've got [REDACTED]'s comp time and it shows  
 9 200, 300-something hours of comp time she gave herself.  
 10 I'll give you this, but I know you've got that list,  
 11 and I'll need that list."

12 And she said, "You know, I'm scared to report  
 13 it."

14 I said, "You don't have to worry about it."  
 15 (Telephone ringing)

16 MR. WILKES: "If you give me the password to  
 17 that list," I said, "you give me that list. I will do  
 18 what's right, and I will not (inaudible) anyone." I  
 19 said, "but this can't go on any longer." I said, "I  
 20 know about those lists before."

21 So I gave her that comp time and she gave  
 22 me -- she said, "Well, this is on the share drive."

1 SPECIAL AGENT [REDACTED] She's [REDACTED].  
 2 THE WITNESS: Yeah, she gave it, too.  
 3 SPECIAL AGENT [REDACTED] Yeah, how did she give  
 4 it to you? You said you heard something about a --

5 THE WITNESS: Yeah, okay. This is -- now  
 6 [REDACTED] my old assistant told me. Now, I've had to  
 7 protect [REDACTED] and because she as on the original team to  
 8 assign these patients. So what happen is as [REDACTED] told  
 9 me, I finally got to the point I went down there to  
 10 [REDACTED] because I had talked to them about  
 11 manipulation of the numbers. I hadn't gone to the TV  
 12 yet, but I talked to the paper. They had called me,  
 13 and I went down there, and I have [REDACTED]  
 14 [REDACTED], who was a bona fide crook, bottom  
 15 line, a vicious person.

16 I had done a Freedom of Information Act  
 17 because I figured out something was going on with comp  
 18 time. She wouldn't let any -- just being an old  
 19 commander, she wouldn't let anybody touch it. She --  
 20 when she was gone, she wouldn't let anybody touch it.

21 SPECIAL AGENT [REDACTED] The list?  
 22 MR. WILKES: No, this is comp time.

1 So what I did is I got her password, which was  
 2 lower case [REDACTED], her last name, and I came up here  
 3 on the share drive. Well, this is what happened. It  
 4 was locked. You couldn't download it. You couldn't  
 5 print it. You couldn't do anything. All right?

6 So what I did is I took screen shots with my  
 7 phone, and so I took screen shots, and I sent them to  
 8 my email through my phone, and I went to LDI. That was  
 9 on Monday, Leadership Development Institute in Little  
 10 Rock.

11 All right. I came back on Friday, and I came  
 12 up here, and I was really -- I said, "God, there's got  
 13 to be a way to print these lists or whatever." And so  
 14 I came back up here, and it was unlocked.

15 SPECIAL AGENT [REDACTED] Okay.

16 MR. WILKES: The list was unlocked and  
 17 everything. That was when I saved it to my computer.

18 SPECIAL AGENT [REDACTED] So it's on your  
 19 computer?

20 MR. WILKES: Un-buh.

21 SPECIAL AGENT [REDACTED] Okay.

22 MR. WILKES: That's when I saved it there, and

1 00:14:09  
 2 that's when I printed a copy. Actually I printed a  
 3 copy, and there was a copy here, and there's actually  
 4 one of them --  
 5 SPECIAL AGENT [REDACTED] How many total copies  
 6 have you printed?  
 7 MR. WILKES: Let's see. One, two.  
 8 SPECIAL AGENT [REDACTED] Okay. We need both  
 9 of those.  
 10 MR. WILKES: Yeah.  
 11 SPECIAL AGENT [REDACTED] Okay. Can you bring  
 12 it up on your computer?  
 13 SPECIAL AGENT [REDACTED] What were you taking  
 14 screen shots of? You couldn't open the document?  
 15 MR. WILKES: Yeah, originally, when I first  
 16 got --  
 17 SPECIAL AGENT [REDACTED] Like the first time?  
 18 MR. WILKES: -- it was they had locked it  
 19 where nobody could download it or print it  
 20 SPECIAL AGENT [REDACTED] But you could open  
 21 it.  
 22 SPECIAL AGENT [REDACTED] You could open it.

1 MR. WILKES: Yeah, I could view it.  
 2 SPECIAL AGENT [REDACTED] Okay Okay  
 3 MR. WILKES: That's why I look -- and this is  
 4 where I was trying my -- the HIPAA part of it -- I was  
 5 trying not to, you know, and that's why I took screen  
 6 shots of the (inaudible), but I knew that that thing  
 7 might not be back when I came back from Friday.  
 8 SPECIAL AGENT [REDACTED] All right. Why don't  
 9 you turn on the computer? Why don't you log on,  
 10 whatever you've got to do, and let's take a look at  
 11 that?  
 12 MR. WILKES: Boy, they are scrambling now on  
 13 hiding and hiding. That's why --  
 14 SPECIAL AGENT [REDACTED] When you show this to  
 15 us, I want you to explain how it's utilized if you can  
 16 or if you don't know how it's utilized, then that's  
 17 fine.  
 18 MR. WILKES: Yeah, [REDACTED] can explain to  
 19 you more, but now I understand it somewhat, and  
 20 actually there was three of them on there, but this is  
 21 the 5/6. It was dated May 6.  
 22 SPECIAL AGENT [REDACTED] Hold on a second. I

1 want to let him catch up here so he can take a look at  
 2 this, too.  
 3 MR. WILKES: This is July 2 here. So let me  
 4 bring it down.  
 5 SPECIAL AGENT [REDACTED] The light?  
 6 MR. WILKES: Yeah.  
 7 SPECIAL AGENT [REDACTED] I'll keep you on back  
 8 here.  
 9 MR. WILKES: All right. This is what -- what  
 10 it was, and I couldn't save it at first. So I took  
 11 photos. I've got those photos on my email somewhere.  
 12 All right?  
 13 SPECIAL AGENT [REDACTED] What is this showing us?  
 14 MR. WILKES: This is -- this is the 2,700 that  
 15 supposedly they went through, pulled off for the last  
 16 two years. All right? And [REDACTED] can go into this  
 17 really in detail. All right.  
 18 And it's in alphabetical order. What was  
 19 weird and I didn't actually see this until I got back  
 20 Friday. I didn't look at the tabs because I was in a  
 21 hurry. I had to get out of here. This was the 2,700.  
 22 This is the times that need appointments. Okay? It

1 is about 620.  
 2 All right. These are the ones that the  
 3 doctors, they aren't here. They kind of fell through.  
 4 These are the ones from what I -- from what I  
 5 understand, and you just have to verify this -- these  
 6 are the ones that they kind of took all those lists,  
 7 waiting lists, and they kind of gave them to them and  
 8 told them to put them together. So from what I'm  
 9 understanding, this is like a combined of all those  
 10 lists.  
 11 SPECIAL AGENT [REDACTED] And the tab, for the  
 12 record since we're on the recording, the tab is called  
 13 "appointments needed."  
 14 MR. WILKES: Needed, right. Now, the next tab  
 15 is seen recently but no follow-up. Okay? So basically  
 16 they were just seen recent, I guess, but --  
 17 SPECIAL AGENT [REDACTED] But there's no follow-up  
 18 appointments.  
 19 MR. WILKES: -- scheduled appointments, right,  
 20 right. So they threw them on here.  
 21 This one is now -- this goes back to 2,700  
 22 from what I understand. They were -- while they were

1 00:17:11  
 2 going through, they also were checking to see if  
 3 they -  
 4 SPECIAL AGENT [REDACTED] They moved over to  
 5 another VA.  
 6 MR. WILKES: Right.  
 7 SPECIAL AGENT [REDACTED] Was getting seen there.  
 8 MR. WILKES: Right, and then what I asked  
 9 what caught me, and I just - I guess I turned pale  
 10 white when she told me - is the deceased, and I said,  
 11 "Hold on a minute," and she said - she said, "Don't  
 12 worry. None of them like committed suicide or  
 13 something." But she said, "It wasn't because of  
 14 anything we did."  
 15 SPECIAL AGENT [REDACTED] People pass away.  
 16 MR. WILKES: Right.  
 17 SPECIAL AGENT [REDACTED] We're just keeping  
 18 track of it.  
 19 MR. WILKES: Right. Now, whoa, and I don't  
 20 even want to know if I find out, but - that none of  
 21 them were for that reason.  
 22 So that's what I did, and so -

1 SPECIAL AGENT [REDACTED] So we had - we had -  
 2 that's the deceased tab, which is the last tab.  
 3 MR. WILKES: Right.  
 4 SPECIAL AGENT [REDACTED] The one before that was  
 5 followed by another VA. Is that - am I reading that  
 6 right?  
 7 MR. WILKES: Right.  
 8 SPECIAL AGENT [REDACTED] And then - and then the  
 9 first tab was the total 2,700.  
 10 MR. WILKES: Right.  
 11 SPECIAL AGENT [REDACTED] So the total 2,700  
 12 was the different teams -  
 13 MR. WILKES: Yeah.  
 14 SPECIAL AGENT [REDACTED] - combining all of  
 15 their individual lists of patients.  
 16 MR. WILKES: Yeah.  
 17 SPECIAL AGENT [REDACTED] To this, to -  
 18 MR. WILKES: From what I understand, and this  
 19 is the way they're trying to go back now and just  
 20 they're saying they're not but they're lying actually.  
 21 They went back, and they got everybody they've seen in  
 22 the last two years, let's say, I think it was, and they

1 got a list, and they started going through them because  
 2 there is actually another measure called mental health  
 3 treatment quarter, which we're supposed to be doing for  
 4 the last four or five years and nobody has done, but  
 5 where you assign yourself.  
 6 So they went back out and they were going  
 7 through to see if anybody had fallen through the  
 8 cracks. So that's where they started -  
 9 SPECIAL AGENT [REDACTED] I'm not following.  
 10 Would you explain what you mean by falling through the  
 11 cracks?  
 12 MR. WILKES: What I understand is like let's  
 13 say we didn't have enough providers, and we did have  
 14 enough providers, and let's say, okay, well, the  
 15 closest appointment that we have may be - they need to  
 16 come in in six months. Okay? So if we set up  
 17 something in six months, if we even have it, or if they  
 18 put it on the list, if they set it up in six months,  
 19 let's say the veteran does no-shows or cancels and they  
 20 don't schedule another one.  
 21 They were just -- they were actually trying to  
 22 go through and see --

1 SPECIAL AGENT [REDACTED] Who still needed -  
 2 MR. WILKES: Who still needed it and who  
 3 didn't and things like that.  
 4 Now, what they also did and what the emails I  
 5 showed you meant is they had all these other papered  
 6 lists that people were making about they were just wait  
 7 lists for people, not necessarily new appointments that  
 8 I know of. You have to ask about that, but they were  
 9 people that needed appointments that they were putting  
 10 on a list. It wasn't that EWL, or however, which -  
 11 SPECIAL AGENT [REDACTED] Well, was it mentioned.  
 12 EWL, at all as far as you know?  
 13 MR. WILKES: Well -  
 14 SPECIAL AGENT [REDACTED] You don't know?  
 15 MR. WILKES: - recently the numbers show we  
 16 had five on it. So I doubt it very seriously.  
 17 SPECIAL AGENT [REDACTED] Oh.  
 18 MR. WILKES: I have sat in meetings in the  
 19 past, and I'm not kidding you, when individuals,  
 20 operations manager, I have heard [REDACTED] tell [REDACTED]  
 21 [REDACTED] "No, don't put them on the electronic waiting  
 22 list."

1 00:19:57  
 2 SPECIAL AGENT [REDACTED] [REDACTED] said this?  
 3 MR. WILKES: No, this is [REDACTED]  
 4 SPECIAL AGENT [REDACTED] [REDACTED]  
 5 MR. WILKES: She said, "Don't put them on the  
 6 electronic wait list. You put them on another  
 7 different list."  
 8 SPECIAL AGENT [REDACTED] She told [REDACTED]  
 9 that  
 10 MR. WILKES: Yes [REDACTED] questioned --  
 11 SPECIAL AGENT [REDACTED] You were present? Were  
 12 you present?  
 13 MR. WILKES: Yes, oh, yeah.  
 14 SPECIAL AGENT [REDACTED] Okay.  
 15 MR. WILKES: -- questioned and she said, "Are  
 16 you sure?"  
 17 And [REDACTED] said, "Yeah."  
 18 And [REDACTED] said, "Okay." [REDACTED] is not going to  
 19 not do what [REDACTED] says, bottom line, because it will  
 20 be (inaudible). You know, other people have come to me  
 21 since then like [REDACTED] who was in those  
 22 meetings. She's a nurse. She was [REDACTED] on

1 MR. WILKES: This ain't my first rodeo.  
 2 Imbedded team member.  
 3 SPECIAL AGENT [REDACTED] Is this a copy now?  
 4 SPECIAL AGENT [REDACTED] (Inaudible.)  
 5 MR. WILKES: I believe it's a copy  
 6 (inaudible)  
 7 SPECIAL AGENT [REDACTED]: Are they exactly the  
 8 same?  
 9 MR. WILKES: They're -- those are the list. I  
 10 did have some (inaudible).  
 11 SPECIAL AGENT [REDACTED] Wait. I want to make  
 12 sure I keep them straight. Is this the one that you  
 13 took from there that [REDACTED] --  
 14 MR. WILKES: Yeah  
 15 SPECIAL AGENT [REDACTED] Okay. And this is the  
 16 one that came from the drawer.  
 17 MR. WILKES: Right  
 18 SPECIAL AGENT [REDACTED] This has some emails  
 19 with it. This one doesn't  
 20 MR. WILKES: Right  
 21 SPECIAL AGENT [REDACTED] But these lists are the  
 22 duplicate

1 [REDACTED] which is in-patient, and she say, "Jay, I sat  
 2 in those meetings with you when they said that"  
 3 A lot of people have started coming forwards  
 4 since I came out and sending me stuff, but so this is  
 5 the combined list.  
 6 SPECIAL AGENT [REDACTED] [REDACTED] still here?  
 7 MR. WILKES: Oh, gosh, yes.  
 8 SPECIAL AGENT [REDACTED] It's [REDACTED] is it really  
 9 [REDACTED] or [REDACTED]  
 10 MR. WILKES: [REDACTED]  
 11 SPECIAL AGENT [REDACTED] And [REDACTED] common  
 12 spelling?  
 13 MR. WILKES: Yeah, [REDACTED] I can  
 14 almost spell your name  
 15 SPECIAL AGENT [REDACTED] And the other one is  
 16 [REDACTED]  
 17 MR. WILKES: [REDACTED]  
 18 SPECIAL AGENT [REDACTED] -- how do you spell  
 19 her last name?  
 20 MR. WILKES: [REDACTED]  
 21 SPECIAL AGENT [REDACTED] Okay.  
 22 (Pause.)

1 MR. WILKES: Yes  
 2 SPECIAL AGENT [REDACTED] The same --  
 3 MR. WILKES: And I wrote the tabs on here  
 4 because they didn't print out.  
 5 SPECIAL AGENT [REDACTED] Okay.  
 6 MR. WILKES: Like -- like the tab --  
 7 SPECIAL AGENT [REDACTED] Okay. I see what you  
 8 did  
 9 MR. WILKES: And stapled  
 10 SPECIAL AGENT [REDACTED] Okay (inaudible.)  
 11 SPECIAL AGENT [REDACTED] What was [REDACTED]'s last  
 12 name?  
 13 MR. WILKES: [REDACTED] (phonetic). I'm going to  
 14 have to look that up, man. He is a good -- they are  
 15 after him. They've been after him, but he sent me a  
 16 lot of these emails yesterday and all, and I was  
 17 really --  
 18 SPECIAL AGENT [REDACTED] These emails?  
 19 MR. WILKES: Yeah. Because now they're trying  
 20 to be friends with him, yeah. He was the [REDACTED]  
 21 [REDACTED] and they moved him out of there. He's got a huge  
 22 EEO case on them from what I understand.

1 00:22:48  
 2 SPECIAL AGENT [REDACTED] All right. This is  
 3 about comp time.  
 4 SPECIAL AGENT [REDACTED]: Okay.  
 5 MR. WILKES: Oh, this is one they were  
 6 refusing to give comp time to schedule those veterans.  
 7 Read this right here.  
 8 SPECIAL AGENT [REDACTED]: The 600, the ones that  
 9 still needed their appointments?  
 10 MR. WILKES: That talks to probably the Excel  
 11 sheets, the papers. Here's some emails where they're  
 12 trying to backtrack and scramble.  
 13 SPECIAL AGENT [REDACTED]: Go ahead.  
 14 MR. WILKES: I will tell you this. They  
 15 trained all the -- in the last two weeks since I came  
 16 out, my first was the newspaper article in the Times,  
 17 and it came out last Sunday, not this past Sunday but  
 18 the Sunday before, and it didn't talk about wait lists,  
 19 but it talked about manipulation of numbers. Since  
 20 that time they were scrambling. Okay?  
 21 SPECIAL AGENT [REDACTED]: Who did you talk to at  
 22 the paper?

1 MR. WILKES [REDACTED] (phonetic)  
 2 SPECIAL AGENT [REDACTED]: And when was this that  
 3 was --  
 4 MR. WILKES: We worked on that article for a  
 5 couple weeks actually. It came out not this past  
 6 Sunday but the Sunday before. It was  
 7 the 8th. Was that it?  
 8 SPECIAL AGENT [REDACTED]: And what was that  
 9 article on?  
 10 MR. WILKES: It was manipulation of numbers  
 11 and I actually sent them some data on wait times and  
 12 stuff. I actually had some data that I gave them.  
 13 There was no patient name or any of that. It was just  
 14 data on wait times and all that.  
 15 SPECIAL AGENT [REDACTED]: Did you send them any of  
 16 these lists?  
 17 MR. WILKES: No.  
 18 SPECIAL AGENT [REDACTED]: Okay.  
 19 SPECIAL AGENT [REDACTED]: And what paper was that?  
 20 MR. WILKES: The Shreveport Times.  
 21 SPECIAL AGENT [REDACTED]: Shreveport Times. And  
 22 the share drive that that was on, can you show us where

1 that is?  
 2 MR. WILKES: Yes, and it's been changed and  
 3 there's a new list on there. So you see all the junk I  
 4 have.  
 5 SPECIAL AGENT [REDACTED]: So that list is no  
 6 longer there?  
 7 MR. WILKES: No.  
 8 SPECIAL AGENT [REDACTED]: Okay.  
 9 MR. WILKES: Here. Then you go here. All  
 10 right, and it's under mental health. Then it was under  
 11 SIP.  
 12 SPECIAL AGENT [REDACTED]: That's where it was?  
 13 MR. WILKES: Yep, and this is the next one  
 14 they put up. I'm telling you they're scrambling.  
 15 SPECIAL AGENT [REDACTED]: Can I see something real  
 16 quick?  
 17 (Pause in proceedings.)  
 18 MR. WILKES: Do you want me to show you what  
 19 it said? I have some screen shots.  
 20 SPECIAL AGENT [REDACTED]: All right. It's not  
 21 here.  
 22 SPECIAL AGENT [REDACTED]: He's taking down some --

1 MR. WILKES: Yes.  
 2 SPECIAL AGENT [REDACTED]: He's doing "computerly"  
 3 things that are beyond my --  
 4 SPECIAL AGENT [REDACTED]: I'm just writing it  
 5 all down so that --  
 6 (Simultaneous conversation.)  
 7 SPECIAL AGENT [REDACTED]: All right.  
 8 MR. WILKES: You know, I really know we've  
 9 only got a hundred of them (things in house, but I  
 10 tried. I swear to you I tried, I did. That changed.  
 11 SPECIAL AGENT [REDACTED]: Yeah.  
 12 MR. WILKES: I want to say last Friday after  
 13 my first (pause) --  
 14 SPECIAL AGENT [REDACTED]: Could you show us where  
 15 it's at on your hard drive, the list, you copied it?  
 16 SPECIAL AGENT [REDACTED]: Yeah. It's on your  
 17 hard drive, right?  
 18 MR. WILKES: Right here. I just have it here  
 19 and then I have one sage (phonetic) in here, too, under  
 20 a file, and then -- oh, this is another one that was  
 21 originally only -- remember I told you there was three.  
 22 I saved it here, too.

1 00:29:17  
 2 I don't know what this is [REDACTED] could  
 3 tell you more.  
 4 SPECIAL AGENT [REDACTED]: Well, let me ask you  
 5 this. How would she have it if it's not on the share  
 6 drive anymore?  
 7 MR. WILKES: She probably wouldn't.  
 8 Let me -- something happened the week I was in  
 9 ODI. It was locked. It was locked, and the  
 10 password -- I couldn't download it. I couldn't do  
 11 anything. That's why I originally took the snapshots  
 12 on my phone.  
 13 SPECIAL AGENT [REDACTED]: Uh-huh.  
 14 MR. WILKES: Because I knew. I said I'm going  
 15 to get one shot at this.  
 16 SPECIAL AGENT [REDACTED]: And when was that, that  
 17 Friday? What Friday was that you were talking about?  
 18 MR. WILKES: When I first got the list, it was  
 19 Monday, the 2nd. I got the list Monday, the 2nd, when  
 20 I traded her that comp time paperwork for the --  
 21 SPECIAL AGENT [REDACTED]: Second of February?  
 22 MR. WILKES: June.

1 SPECIAL AGENT [REDACTED]: February, right?  
 2 MR. WILKES: June.  
 3 SPECIAL AGENT [REDACTED]: That's right.  
 4 MR. WILKES: Yeah.  
 5 SPECIAL AGENT [REDACTED]: Then you came --  
 6 MR. WILKES: This has been out of there since  
 7 February.  
 8 SPECIAL AGENT [REDACTED]: Okay.  
 9 SPECIAL AGENT [REDACTED]: So then that's June 2nd.  
 10 Monday. You couldn't print or copy.  
 11 MR. WILKES: Right.  
 12 SPECIAL AGENT [REDACTED]: You could just see it.  
 13 MR. WILKES: I was going to LDI in Little  
 14 Rock, which is three hours, and it was a weeklong  
 15 leadership development. It's something that our VISN  
 16 puts on for leaders selected at each hospital. There's  
 17 three of them.  
 18 I came in that morning, and I had decided -- I  
 19 can't remember what it was everybody -- you know what?  
 20 I had been talking in the paper, and I didn't have a  
 21 list, and I told -- I said, you know -- I keep fearing  
 22 a list, and I said, "Well, you know, I'm going to check

1 and see if someone's got a list."  
 2 And [REDACTED] told me there was  
 3 a list, and there's a list of all that. And I said,  
 4 "Really?" And I said, "Well, I know they're  
 5 manipulating number," and I said, "We've got to do  
 6 something. This is the time to do it because of all  
 7 the things coming out," and I said, "You know, I've  
 8 taken a pounding over the last year and stuff, and  
 9 basically -- basically systematically lost my  
 10 position."  
 11 I mean I didn't lose any money or any of that,  
 12 but now, I said, "You know what? This isn't right." I  
 13 said, "None of this" -- I mean, I'll be honest with  
 14 you. When I didn't get it, I filed an EEO and all of  
 15 that and people were asking me. It was like, "How much  
 16 money are you going" -- you know, and I even told them.  
 17 I was like, "I don't give a shit about money." I  
 18 said, "This stuff isn't right, what they're doing down  
 19 there."  
 20 And you know, so I decided. I said I've got  
 21 to get a list. I said, because if I -- if you get your  
 22 hands on that -- so I came in and that's when I went

1 down there and I said, "I know you've got the" -- I  
 2 mean, I walked in there and she looked at me, and she  
 3 said, "(inaudible) I have the comp time."  
 4 I said, "I know you've got the list." And I  
 5 said, "I need that list." I said, "I'm fixing to  
 6 report this stuff and I'm fixing to do a whistleblower,  
 7 and I need it." And I said, "I've heard from several  
 8 people what it is."  
 9 And she said, [REDACTED] (phonetic) had took it  
 10 from me in May."  
 11 And I said, "What do you mean, took it from  
 12 you?"  
 13 SPECIAL AGENT [REDACTED]: And who are you talking  
 14 to now?  
 15 MR. WILKES: [REDACTED]  
 16 SPECIAL AGENT [REDACTED]: And when was this?  
 17 MR. WILKES: This was the 2nd of June. It was  
 18 in the morning because I had to get -- I had to be over  
 19 there at one. So it was about three hours, and I had  
 20 told [REDACTED] that I wasn't going to go in government  
 21 cars. I was going to drive my own car because I needed  
 22 to finish some things up here, and I walked down there,

1 00:32:33  
 2 and she looked at me when I walked in and she said,  
 3 "Whoa, you look like" - I can't remember. I must have  
 4 been pale because I was nervous.  
 5 And I said to her, I said, you know, "I know  
 6 you had a list. I've heard from several people that  
 7 there is a waiting list," and I said, "I need it." I  
 8 said, "I really do." I said, "I'm going to go do a  
 9 whistleblower." I said, "This is not right."  
 10 And I knew [REDACTED] is a caring person, and  
 11 she told me - she may have mentioned [REDACTED] - can't  
 12 remember. She said, "They took it away from me."  
 13 And I said, "What do you mean?"  
 14 She said, "The last one I put in there was May  
 15 5th."  
 16 And I said, "Now this is a list that has got  
 17 people that have been waiting for appointments."  
 18 She said, "Yeah, for a while."  
 19 And I said, "What do you mean?"  
 20 They said, "Well, you know" -  
 21 SPECIAL AGENT [REDACTED] Who took it away?  
 22 MR. WILKES: [REDACTED] and he

1 said, "Well, I went to him and I mentioned something  
 2 about this is giving veterans or veterans don't have  
 3 access to care or this is hampering veterans' access to  
 4 care." She said something like that.  
 5 SPECIAL AGENT [REDACTED] She told [REDACTED] that?  
 6 MR. WILKES: Right, and I said, "So he took it  
 7 from you?"  
 8 She said, "Yeah," and she said, she said,  
 9 "It's some shit."  
 10 I said, "Well, look. I know that they  
 11 wouldn't give comp time in that jar of comp time," and  
 12 I said, "I'm out of Mental Health now." I said, "I  
 13 went through the Freedom of Information, and I got comp  
 14 time from Mental Health, and I know that somebody,  
 15 [REDACTED] is getting 300 or 200 and something hours, 300  
 16 and something hours, and I reported that to the IG."  
 17 I've got a number on it, and then the person  
 18 that replaced me had 500 overtime hours in the last  
 19 year. But yeah.  
 20 But I said, "I'll trade you this for that. I  
 21 need that password."  
 22 And she said - well, she said, "I need that

1 list." And she said, "Well, it's on the share drive,  
 2 Can you still get on the share drive?"  
 3 And I said, "Yeah. I don't know why they  
 4 didn't take me off, but they didn't. I'm still on  
 5 there." And I said -  
 6 She said, "Well, go to it. It's my last name  
 7 lower case."  
 8 I said, "Okay," and she pulled it up.  
 9 She said -  
 10 SPECIAL AGENT [REDACTED] So her last name. You  
 11 could get on the share drive, but to open that document  
 12 you needed her last name -  
 13 MR. WILKES: Right.  
 14 SPECIAL AGENT [REDACTED] - as a password?  
 15 MR. WILKES: Right.  
 16 SPECIAL AGENT [REDACTED] Was there a user name?  
 17 Did you have to put in a user name and password or  
 18 just a password?  
 19 MR. WILKES: Right. Just [REDACTED] lower  
 20 case.  
 21 SPECIAL AGENT [REDACTED] Okay. So was it her  
 22 list on there or -

1 MR. WILKES: It was a list. What they had if  
 2 you read the emails is they had, I guess, taken all the  
 3 lists and they had developed it and they went back and  
 4 they took all the lists of - of veterans on them that  
 5 were waiting, and this is - this - she can explain a  
 6 little bit more than I can, and they combined them all  
 7 to this one, and then they were going to go back and  
 8 try to assign doctors or something.  
 9 SPECIAL AGENT [REDACTED] But how would somebody  
 10 else get on that share drive and look at that document?  
 11 MR. WILKES: Only certain people had access.  
 12 SPECIAL AGENT [REDACTED] And each one had a  
 13 different password?  
 14 MR. WILKES: I can't - I don't know. I can't  
 15 tell you.  
 16 SPECIAL AGENT [REDACTED] That's what I'm  
 17 trying - what we're trying to understand.  
 18 MR. WILKES: Yeah.  
 19 SPECIAL AGENT [REDACTED] Because it sounded like  
 20 her -  
 21 SPECIAL AGENT [REDACTED] It sounds like it's  
 22 her document

1 00:15:24  
 2 SPECIAL AGENT [REDACTED] That's right.  
 3 SPECIAL AGENT [REDACTED] With her last name  
 4 that she set up as the password.  
 5 MR. WILKES: Well, I think she only could  
 6 read. I don't think she could even change it, and  
 7 you'll have to ask her, but there may be several. I  
 8 don't know how that works. So --  
 9 SPECIAL AGENT [REDACTED] Okay.  
 10 MR. WILKES: -- all I know is she gave me  
 11 that, and then when I came back up here my goal was to  
 12 get it and put it in there.  
 13 SPECIAL AGENT [REDACTED] When you went on the  
 14 share drive, did you go -- once you were on the share  
 15 drive, was there a file under her name that you had to  
 16 go into?  
 17 MR. WILKES: Huh-uh. It was just like I  
 18 showed you.  
 19 SPECIAL AGENT [REDACTED] Okay.  
 20 MR. WILKES: And it was three different files.  
 21 SPECIAL AGENT [REDACTED] Okay.  
 22 MR. WILKES: This is what I probably -- I took

1 SPECIAL AGENT [REDACTED] Do you still have them  
 2 with your email?  
 3 MR. WILKES: I can look. I don't know. I  
 4 think I erased all of them actually. When it opened  
 5 up, I erased them. I may -- that's what I want to go  
 6 look and see.  
 7 SPECIAL AGENT [REDACTED] What's your gmail  
 8 address?  
 9 MR. WILKES: March(2th1973@gmail.  
 10 SPECIAL AGENT [REDACTED] The word "March"?  
 11 MR. WILKES: Yeah.  
 12 SPECIAL AGENT [REDACTED] Twelve?  
 13 MR. WILKES: 1973.  
 14 SPECIAL AGENT [REDACTED] So like --  
 15 MR. WILKES: Yeah. M-a-r-c-h-(1-2-1-9-7-3.  
 16 SPECIAL AGENT [REDACTED] At gmail?  
 17 MR. WILKES: Yeah.  
 18 SPECIAL AGENT [REDACTED] Like that?  
 19 MR. WILKES: Yeah.  
 20 SPECIAL AGENT [REDACTED] Okay.  
 21 (Pause.)  
 22 MR. WILKES: I couldn't get in. I couldn't --

1 pictures, man. I'm telling you I couldn't get on  
 2 there, and I know -- I knew. Took one on my phone.  
 3 like teh, teh, teh (phonetic)  
 4 SPECIAL AGENT [REDACTED] Yeah, that might be a  
 5 little bit of a problem.  
 6 MR. WILKES: Yeah, I was wondering, but I  
 7 couldn't -- I couldn't --  
 8 SPECIAL AGENT [REDACTED] Are they still on your  
 9 phone, those pictures?  
 10 MR. WILKES: No.  
 11 SPECIAL AGENT [REDACTED] You put them onto the  
 12 computer or you just deleted them once you had access  
 13 to the main --  
 14 MR. WILKES: I took them and --  
 15 SPECIAL AGENT [REDACTED] You emailed them to  
 16 yourself.  
 17 MR. WILKES: I emailed them to my -- now,  
 18 that's what the problem would be. I emailed them to my  
 19 gmail account.  
 20 SPECIAL AGENT [REDACTED] Okay. And where  
 21 is -- are those still on your gmail account, on an  
 22 email on your gmail account?

1 they're really savvy about that. They will send emails  
 2 and they'll lock it where nobody can forward it or  
 3 print it. So I did that because I couldn't download  
 4 it. I couldn't do anything, and so I was like, all  
 5 right.  
 6 Do you know I don't know if I kept -- let me  
 7 look. I'm trying to -- I don't know that I -- I might  
 8 not have sent it to my gmail. I might have sent it to  
 9 this.  
 10 SPECIAL AGENT [REDACTED] We need to know every  
 11 place that you sent this stuff.  
 12 MR. WILKES: I took -- I'll look.  
 13 (Pause.)  
 14 MR. WILKES: Let me see.  
 15 SPECIAL AGENT [REDACTED] Now, are you into  
 16 your gmail account now?  
 17 MR. WILKES: Yeah. Scheduling, that's my --  
 18 SPECIAL AGENT [REDACTED] What about that one? It  
 19 says "Christopher me to," and it says at BHIT, and it  
 20 had that -- scroll back up. What's this "forward BHIT  
 21 scheduling," BHIT right here?  
 22 MR. WILKES: Oh, those are emails.

1 00:39:34  
 2 SPECIAL AGENT [REDACTED] Okay.  
 3 MR. WILKES: That what [REDACTED] sent to me.  
 4 SPECIAL AGENT [REDACTED] Okay.  
 5 MR. WILKES: Yeah. I understand. This is  
 6 that one where it says -- yeah. That email, I don't  
 7 know if I actually sent them because I had them on my  
 8 phone, and when I came back and I could get in there, I  
 9 think I wrote (pause) --  
 10 SPECIAL AGENT [REDACTED] From your phone?  
 11 MR. WILKES: Yeah.  
 12 SPECIAL AGENT [REDACTED] So they're not on the  
 13 phone anymore and you didn't email them to the gmail.  
 14 MR. WILKES: I don't see them. Because I took  
 15 them because I couldn't download them and I left and I  
 16 went to Little Rock, and then I know I came back and I  
 17 could get on there. So that's when I think I saved it.  
 18 I may have saved this one. It was that Friday when  
 19 they were late  
 20 Yep, see, 6/6. It was that Friday. I saved  
 21 it there, 5:39.  
 22 SPECIAL AGENT [REDACTED] Un-huh.

1 MR. WILKES: Now, I could -- that's right. I  
 2 could save one because I saved -- that's right. There  
 3 was three on there. It was one for 4/22. Okay, yeah.  
 4 There was three on there. There was one from 4/22.  
 5 There was another one, but this was the most updated,  
 6 and it wouldn't download, but I saved that one here  
 7 because I put it on --  
 8 SPECIAL AGENT [REDACTED] Four, twenty-two.  
 9 MR. WILKES: Right. I put it under LEIF.  
 10 SPECIAL AGENT [REDACTED] Un-huh.  
 11 MR. WILKES: I FI Faith.  
 12 SPECIAL AGENT [REDACTED] Un-huh.  
 13 MR. WILKES: Because I didn't want them -- and  
 14 then when I came back, that's right. This one wouldn't  
 15 open or this one would open with a password. It would  
 16 open with a password.  
 17 SPECIAL AGENT [REDACTED] The six --  
 18 MR. WILKES: Yeah, the 5/6. I don't know why  
 19 I put 5/5. It would open with a password, but you  
 20 couldn't download it or say -- you couldn't print it or  
 21 do any of that, but when I came back on Friday, I  
 22 looked at it and I was going to try because my thing

1 was I said, "I've got to -- I've got to get this  
 2 printed out. I've got to figure out how to save it and  
 3 to print it."  
 4 So what I did is then I opened it and I was  
 5 like, well, hold on a minute. Now it will save, and  
 6 it'll print, and you know, here's the thing, too.  
 7 [REDACTED] (phonetic) is a [REDACTED] and she  
 8 used to be my boss, and --  
 9 SPECIAL AGENT [REDACTED] [REDACTED] ?  
 10 MR. WILKES: [REDACTED]  
 11 SPECIAL AGENT [REDACTED] [REDACTED]  
 12 MR. WILKES: [REDACTED]  
 13 She -- I texted her from up there, and I said  
 14 -- I said, "Can you do me a favor and go in the share  
 15 drive?" And I said, "There's a list in there," and I  
 16 said, "Can you see if you can save it?" Or, no, I  
 17 wanted her to look at it. I said, "Can you look at it  
 18 because I need somebody to also be able to -- to  
 19 identify this if something happens?" And I trusted  
 20 her.  
 21 SPECIAL AGENT [REDACTED] Un-huh.  
 22 MR. WILKES: And I said, "I need you to be

1 able to just -- to back me up because there's a list in  
 2 there."  
 3 And she did, and she said, "Well, shut, you  
 4 know, you can save it now."  
 5 That's -- and then when I came back on Friday,  
 6 that's why I came up here after I got back, and I went  
 7 in there and saved it and I printed it out  
 8 SPECIAL AGENT [REDACTED] How did she know you  
 9 could save it now?  
 10 MR. WILKES: Because she went in. When I was  
 11 texting her, she went in there and looked at it.  
 12 SPECIAL AGENT [REDACTED] Yeah, but looking at it  
 13 is not going to tell you whether you can save it or  
 14 not. Did she save it?  
 15 MR. WILKES: I don't know.  
 16 SPECIAL AGENT [REDACTED] You don't know. Okay.  
 17 SPECIAL AGENT [REDACTED] And she was your old  
 18 boss from where?  
 19 MR. WILKES: The Vat Center.  
 20 SPECIAL AGENT [REDACTED] And she's located here?  
 21 MR. WILKES: Yeah, she's in Mental Health  
 22 That's it. I'm sorry. I'm trying to --

00 44.13

SPECIAL AGENT [REDACTED] That's all right

MR. WILKES: Yeah, and then that's when I came back Friday. She said, "Well, you know, you can save," dah, dah, dah.

And I said, "Okay." I said, "Really?"

And so then I got to wondering -- So somewhere in there they opened it up. I don't know what happened, if somebody found out that I got access, if [REDACTED] told them or I don't know what happened, but when I got back on Friday, boom, boom

SPECIAL AGENT [REDACTED]: And then you deleted them off the phone?

MR. WILKES: Yes. I didn't want to do the pictures because, trust me, I don't know about all that, but I knew if somebody got wind they were going to wax that list. That's the way they roll.

SPECIAL AGENT [REDACTED]: Un-huh

MR. WILKES: And really, I don't -- I can't -- I can't remember. I couldn't tell you if I -- I know I took a picture of how -- I don't even know if I took a picture of risk. I can't remember because this is what

MR. WILKES: Nope. All right.

(Pause.)

MR. WILKES: The -- on the list part, like I said, the Times article I didn't even mention anything on it --

SPECIAL AGENT [REDACTED]: Yes.

MR. WILKES: -- because -- and then the news, I -- I mentioned the list, and that's when I kind of -- because I went back and I asked [REDACTED] I said -- I said, "Hey, are we sure that this is the people that needed appointments?"

And she said, "Yeah, it is. It is."

And I said okay

SPECIAL AGENT [REDACTED]: All right. Now, about the news, when did you go talk to them and who, which news?

MR. WILKES: I told the paper I would not talk to anyone.

SPECIAL AGENT [REDACTED]: You told the Shreveport News you couldn't talk to anyone?

MR. WILKES: Shreveport Times, I said, "Look. If you talk to me," I said, "I won't talk to anybody

-- see here's the -- I forwarded it to the IG when I caught it and did it, they said send it, and I said, "Are you sure? Can I do that?"

And they said, "Yes, you can." Okay, and I did that.

SPECIAL AGENT [REDACTED]: Yes.

MR. WILKES: Okay

SPECIAL AGENT [REDACTED]: We have that.

MR. WILKES: All right

SPECIAL AGENT [REDACTED]: We're aware of that.

MR. WILKES: See, I've been trying. You all, I swear to you I've been trying, but you know, I remember -- here's the thing. I know I went in to show me. I know I took a picture of -- I remember I wanted to know here, and then there was three here. I took pictures and then I'll show you. This is where -- this is the new one. See, this is how the other one was actually, and the password was lower case [REDACTED]

SPECIAL AGENT [REDACTED]: Um,

MR. WILKES: Does that make sense?

SPECIAL AGENT [REDACTED]: Yeah. Try lower case

[REDACTED] now and see what happens.

until you do your" -- and you know, I can't remember when I first talked to her. I really can't. It was a couple of weeks before it went out, I think

SPECIAL AGENT [REDACTED]: Okay. And so the article came out somewhere? Would you say it was early or something maybe?

MR. WILKES: Sunday.

SPECIAL AGENT [REDACTED]: About eight, 6/8?

MR. WILKES: Yeah.

SPECIAL AGENT [REDACTED]: And so after that, you went and talked to the news about this same stuff?

MR. WILKES: Well, they made a deal, yeah, and I think I went and talked to them Tuesday

SPECIAL AGENT [REDACTED]: That following Tuesday? So the 10th?

MR. WILKES: Yeah, the article went out on the 8th, and I talked to them Tuesday.

SPECIAL AGENT [REDACTED]: And who did you talk to?

MR. WILKES: Elsa Gillis and Laura Ashley Overdyke

SPECIAL AGENT [REDACTED]: Elsa Gillis?

MR. WILKES: Yeah, E-I-S-A G-I-L-L-I-S.

1 00:49:03  
 2 SPECIAL AGENT [REDACTED] Is that E-I-S-a G-1?  
 3 (Inaudible) E-I-S-a  
 4 MR. WILKES: E-I-S-a G-1-I-I-S.  
 5 SPECIAL AGENT [REDACTED] And the other name?  
 6 MR. WILKES: [REDACTED] (Inaudible), Ashley  
 7 Overdyke, O-v-e-r-d-y-k-e  
 8 SPECIAL AGENT [REDACTED] And what news are they  
 9 with?  
 10 MR. WILKES: KTRS, Channel 3  
 11 SPECIAL AGENT [REDACTED] And what did you discuss  
 12 with them?  
 13 MR. WILKES: I just -- with the news?  
 14 SPECIAL AGENT [REDACTED] Yeah.  
 15 MR. WILKES: I told them, I said, "You know, I  
 16 have a -- I told you I'd do the interview after that"  
 17 I said, "You know, I can come up and do an interview."  
 18 And then they asked questions, and I told  
 19 them, I said, "Well, you know I have a secret wait  
 20 list."  
 21 And they were like, you know, "What does it  
 22 have on it?" basically kind of the same stuff you did

1 SPECIAL AGENT [REDACTED] Un-huh.  
 2 MR. WILKES: I told them, I said, "You know,  
 3 it has veterans that were identified as needing  
 4 appointments," and I said, "There's 2700." I said --  
 5 and at the time I hadn't really looked at it real  
 6 close, and I said 500 when I went up there.  
 7 SPECIAL AGENT [REDACTED] Un-huh.  
 8 MR. WILKES: I mean, I kind of printed it off,  
 9 put it in there, put it in there, and kind of saved it  
 10 here, and then I went and talked to him. I said, "It's  
 11 got 500 close or something like that."  
 12 And then I came back like and looked at it  
 13 like on Wednesday, and it was like 620, and I said,  
 14 "Well, you know, I said 500 in the interview, but it's  
 15 really got 620 on there."  
 16 And they were like, "Okay." And so -- now, I  
 17 mean (Inaudible) and I told you like, you know, I can't  
 18 -- the list is not going -- you know, and this and  
 19 that.  
 20 And so they said, "Well, you know, you're  
 21 alleging that."  
 22 And I said, "Well, that's fine." I mean --

1 SPECIAL AGENT [REDACTED] Un-huh.  
 2 MR. WILKES: -- whatever. And so we just  
 3 talked, and mostly we talked about exactly like what  
 4 the tabs were, and I said, you know, I said from what I  
 5 understand there's 2,700. That was the ones that have  
 6 been seen in 15 months.  
 7 And then we talked about, you know, the 500.  
 8 I said, "There's 500 plus that need appointments."  
 9 And then they were like, "Well, we're  
 10 confused. Are these 500 that they just went back  
 11 through here and they selected them and they hadn't  
 12 been seen in a while?"  
 13 And I said, "Well," I said, "this from what I  
 14 understand these are something like that," and I said,  
 15 "They're also from other lists."  
 16 And then they were really skeptical about  
 17 (things. I said, "Well, I'm telling you this is the  
 18 real deal."  
 19 SPECIAL AGENT [REDACTED] Un-huh.  
 20 MR. WILKES: And, you know, I said, I said,  
 21 "I'm coming out on a limb here." I said, "I've already  
 22 put this in there and they're already backtracking and

1 doing stuff," because the Tuesday after it went out in  
 2 the paper, that evening I talked to the news [REDACTED]  
 3 had already come at [REDACTED] with some nasty-ass email  
 4 or something like that. So I said, "You know, this is  
 5 the story if you want it. Nobody has got a list. I've  
 6 got a list in my office, and I've got it on my  
 7 computer," and I said, you know  
 8 And they said, "Well, we believe you and  
 9 everything, and we're going to -- we're going to run  
 10 with it, but we're going to" -- I sat there for a  
 11 couple hours, and then they said, "We're going to run  
 12 with it," and then that's why they went with the  
 13 alleged list or something like that.  
 14 SPECIAL AGENT [REDACTED] So they did do a news  
 15 article on TV about it?  
 16 MR. WILKES: Oh, yeah. It was a three-part  
 17 series.  
 18 SPECIAL AGENT [REDACTED] All three are done  
 19 now or --  
 20 MR. WILKES: Yeah. They did one on Thursday,  
 21 and then they did one on Sunday night that was part of  
 22 the interview, and then the other part of the interview

1 00:53:56  
 2 was Monday  
 3 SPECIAL AGENT [REDACTED] Of this -- just this  
 4 past --  
 5 MR. WILKES: Un-huh  
 6 SPECIAL AGENT [REDACTED] This past Thursday,  
 7 Sunday, Monday?  
 8 MR. WILKES: Un-huh, yeah. Like a week.  
 9 Tomorrow is Thursday, right?  
 10 SPECIAL AGENT [REDACTED] Yeah  
 11 SPECIAL AGENT [REDACTED] Tomorrow is Thursday.  
 12 MR. WILKES: Tomorrow will be a week when the  
 13 first one went  
 14 SPECIAL AGENT [REDACTED] Okay.  
 15 MR. WILKES: The second part went Sunday.  
 16 SPECIAL AGENT [REDACTED] Okay.  
 17 MR. WILKES: And then the third part went  
 18 Monday.  
 19 SPECIAL AGENT [REDACTED] And were you like in any  
 20 of those, with them talking to you, or just --  
 21 MR. WILKES: Oh, yeah. I'm in all three. I  
 22 was like -- it was like the interview

1 SPECIAL AGENT [REDACTED] Okay.  
 2 MR. WILKES: There was -- I did that on --  
 3 that's what I'm saying. On Tuesday I was up there for  
 4 a couple hours, and we talked  
 5 SPECIAL AGENT [REDACTED] And they took what  
 6 you said in that and made it into a three-part series  
 7 or you --  
 8 MR. WILKES: Exactly.  
 9 SPECIAL AGENT [REDACTED] -- more?  
 10 MR. WILKES: Exactly  
 11 SPECIAL AGENT [REDACTED] Okay.  
 12 MR. WILKES: We did everything like in on day  
 13 SPECIAL AGENT [REDACTED] Okay.  
 14 SPECIAL AGENT [REDACTED] Did you provide any  
 15 of the lists or anything for them to use?  
 16 MR. WILKES: No. That's why if you watch the  
 17 videos they say "alleged." They were like --  
 18 SPECIAL AGENT [REDACTED] yeah  
 19 MR. WILKES: Because I was like, man. I was  
 20 careful on that  
 21 SPECIAL AGENT [REDACTED] is [REDACTED] here today?  
 22 MR. WILKES: Yeah, she was here. [REDACTED]

1 [REDACTED]  
 2 SPECIAL AGENT [REDACTED] Who all would have  
 3 had access to that file, that would have the password  
 4 and all that?  
 5 MR. WILKES: Yeah. If I had to -- this would  
 6 be a guess  
 7 SPECIAL AGENT [REDACTED] You don't know?  
 8 MR. WILKES: Yeah. I mean, [REDACTED] I  
 9 would assume [REDACTED] has it, probably [REDACTED]  
 10 SPECIAL AGENT [REDACTED] Who [REDACTED]  
 11 MR. WILKES: [REDACTED] is the [REDACTED]  
 12 [REDACTED]  
 13 SPECIAL AGENT [REDACTED] What's her last name?  
 14 MR. WILKES: [REDACTED]  
 15 SPECIAL AGENT [REDACTED] [REDACTED]  
 16 MR. WILKES: [REDACTED]  
 17 SPECIAL AGENT [REDACTED] Like Liquor only  
 18 different?  
 19 MR. WILKES: Yeah, French, yeah. Hope is --  
 20 how do I say this [REDACTED] alleged or  
 21 that's what we -- yeah  
 22 SPECIAL AGENT [REDACTED] Okay.

1 MR. WILKES [REDACTED]  
 2 [REDACTED] [REDACTED]  
 3 [REDACTED]  
 4 [REDACTED] when it came upon over all  
 5 the clerks that had come in this (inaudible) -- more  
 6 experienced than her.  
 7 SPECIAL AGENT [REDACTED] So and what is [REDACTED] ?  
 8 What's her title?  
 9 MR. WILKES: She's the [REDACTED]  
 10 Somehow over the -- you need to talk to a guy named  
 11 [REDACTED] (phonetic) who's in Boston now. He was the  
 12 [REDACTED] before. He could tell you all about her. They hid  
 13 her as a program analyst and somehow she's move to --  
 14 into the [REDACTED] and all kinds of stuff.  
 15 She is -- let me tell you something. She is  
 16 not a very nice person. She's an intimidating person.  
 17 She rules by intimidation, and she hates me because  
 18 I'm not very intimidated. I mean, I don't -- I don't  
 19 play.  
 20 She's bribed me before. I'll put it that way.  
 21 Like I reported the Assistant Chief job here has been  
 22 a big thing, and the first time they did it, they were

00:56:11

1 putting (inaudible) who they just preselected and  
2 manipulated the hiring practice to put it in. I've got  
3 all that. I can show you exactly how they did it.

4 I complained the first time they did it  
5 because -- just became. I mean, I caught them and she  
6 actually came to the phone and said -- what did she say  
7 that day? -- she said kind of like, "Why are you  
8 fooling with it?"

9 Because I told them, I said -- this is a long  
10 story. But I told them. I went down to HR and said,  
11 "Hey, how did I not get interviewed for the Assistant  
12 Chief job?" I had just come over here so I really  
13 wasn't worried about it, but a lot of other people  
14 didn't get one. So like this sucks.

15 So I said, well, I'll pull my string and say,  
16 "Hey, I've got a vet preference. How come I didn't get  
17 interviewed?" you know. Plus I had just had an  
18 interview in Fresno for the Chief of Social Services  
19 out there. I knew I wasn't going to get it at that  
20 time, but I wanted the practice.

21 Well, that stirred up a big deal, and  
22

1 (inaudible) called me and she said, "Hey, what are you  
2 doing?" you know.

3 I said, "What do you mean?"

4 She said, "Well, you know, hey, you know  
5 there's a PT -- PTSD supervisor position coming up, and  
6 you know, that's going to be very competitive," dah,  
7 dah, dah.

8 And I'm sitting here and I'm thinking, well,  
9 hey, somebody in HR is -- and I'm saying [REDACTED] wants an  
10 update here, but I think she'd bribe me. So this is  
11 what I said. My wife works here, too. I said, "Well,  
12 you know, that's a leadership position, a supervisor.  
13 I'll talk to my wife on that."

14 "No, no, no, no, no, no, no. Don't talk to  
15 anybody on that." That's how I verified that she was  
16 sketchy, and she is. Let me tell you something about  
17 her. They are scared of her down there. She runs  
18 that. She is a deviant, mischievous and crooked  
19 person. I'm telling you. I'm just telling you.

20 SPECIAL AGENT [REDACTED]: All right.

21 MR. WILKES: And you know, I know you all are  
22 going to take it for a grain of salt, but you'll see.

1 But [REDACTED] would; her, [REDACTED] I'm sure does. I  
2 don't know. [REDACTED] I would probably say [REDACTED]  
3 would maybe. I mean I can't tell you.

4 SPECIAL AGENT [REDACTED]: Did [REDACTED] do  
5 scheduling? She's [REDACTED] So she --

6 MR. WILKES: See, you'd have to ask her that.  
7 I don't know. She probably can, but I think that was  
8 one of the big arguments, too, is like, "Well, we need  
9 somebody. You won't let us schedule, but we need  
10 somebody to work comp time to get them in here to  
11 schedule."

12 She'll have to go into that with you.

13 SPECIAL AGENT [REDACTED]: Right.

14 MR. WILKES: I was just -- man, here's the  
15 deal. They were all scared, and I'm not really. I  
16 mean, what more can they do? They basically  
17 manipulated me out, put me up here, which I'm slated  
18 this position. I mean, I kind of made them give me  
19 this position, but you know, and I was like, you know,  
20 this has got to stop.

21 And then when this stuff came out of Phoenix,  
22 I said this is going on here, which I kind of already

1 had looked at it from Atlanta and all that before. So  
2 I was like, okay, let's do this, and that's when I went  
3 down there because I knew they were scared, and they  
4 still have to deal with them.

5 And [REDACTED] will tell you that. He said, "I  
6 don't know how in the hell you got out of here."

7 Well, I had an exit route. I knew if I had  
8 stayed in there after they -- it went to a front line  
9 position, I was going to get it, dude. It was just  
10 that bad, but you know, and that's why I really came  
11 forward with all of it, because, you know, it's  
12 hampering veterans' care, and I'm just like we can't do  
13 this.

14 I mean, I've sat in meetings and said, "We  
15 cannot do this, guys." We -- I told them one day. I  
16 said -- and it was even in the interview. I sat there  
17 and I told them we are putting a Band-Aid on a gaping  
18 wound. I said we are being reactive instead of  
19 proactive.

20 Because it's like every time something came  
21 out we could figure a way to fix it or they would, and  
22 then it would just -- you do the management and it

00:59:58

1 would go, and I was just like, "This is crap," and  
2 that's probably one of the reasons that they wouldn't  
3 ever -- I mean, they kind of kept me -- and now you see  
4 it now because I'm a guy that I just -- I get things  
5 done, man. I mean, if you look at [REDACTED]'s thing,  
6 he says his six months to the end of the year, he  
7 finishes like four things and like three of them I gave  
8 them.

9 Those consult docs, that's my idea. I mean, I  
10 researched that. I went out here and talked to people  
11 in the community, and I kept telling them for two  
12 years. I said you're never going to get psychiatrists  
13 in here, guys, doing it this way we do it.

14 And they said, "Well, what do we do?"

15 I said, "Well, you know, I've talked to these  
16 guys in the community and I said to them, I said,  
17 Hey."

18 I mean, I met with a guy named [REDACTED]  
19 [REDACTED] (phonetic), and I said, "How do you get  
20 psychiatrists?" He runs a lot of stuff out in the  
21 private sector.  
22

1 probing around and I said, "Do you have the paper wait  
2 list?" because I knew down there they have. I said,  
3 "You don't have any of those around," you know, just  
4 asking when I went down there.

5 SPECIAL AGENT [REDACTED] Knowing they did.

6 MR. WILKES: Knowing that they do. And they  
7 said, "Well, you (inaudible)."

8 I just, "I know you all had one before." And  
9 I even told one of them, [REDACTED] was it? [REDACTED] was her  
10 name. I said, "Don't let these people put your mores  
11 and values at risk," because I know it and you know  
12 what I'm talking about, because she's the one that saw  
13 it, had it back in the fall I told you about.

14 SPECIAL AGENT [REDACTED] Un-huh

15 MR. WILKES: And I told her that because I  
16 think she's a good person and she really cares, and I  
17 said, "Don't let them put your mores and values at  
18 risk."

19 And you know -- and now I was messing around  
20 with them up here. This is where it really pushed me.  
21 This is what really hurt my feeling as a leader and  
22 had been a leader in the past. I went over here to

1 He said, "She's (phonetic), if you've got 20  
2 veterans. I can get them seen by a psychiatrist  
3 tomorrow."

4 I said, "How do you do that?"

5 He says, "We pay them X amount of dollars for  
6 four hours," dah, dah, dah, dah.

7 So I came back. I tried to get it done here  
8 and I couldn't. Now, I gave that to [REDACTED] and he  
9 actually got it done, and those are those consult docs  
10 that are here now. They come in for a four-hour shift,  
11 a four-hour shift there.

12 SPECIAL AGENT [REDACTED] Un-huh.

13 MR. WILKES: So I've always known --

14 SPECIAL AGENT [REDACTED]: Excuse me for a  
15 moment

16 MR. WILKES: -- that we were really behind on  
17 the scheduling, and I've always been trying to do it,  
18 and it just -- it's just fighting the thing, man. It's  
19 just not right. You've got veterans. We've got a  
20 freaking suicide rate that's incredible, and here we  
21 are doing this crap

22 I mean, what pushed me too is I was just

1 these guys, and I asked them. I said, "Man, you're  
2 going in the system and coming out, going in and coming  
3 out."

4 And they -- and he said, "What do you mean,  
5 man? What do you mean?"

6 I said, "You know there's that 14-day thing,"  
7 and one of the other ones, he said, "You know how we go  
8 in," and he said, "Ah, that's what all this is about?"

9 They didn't even know. This is a couple weeks  
10 -- that's why I went to the paper. I said this is  
11 bullshit. I said we being -- me being a leader, being  
12 a leader in combat, you don't do that to your people  
13 You don't put them in that situation to where they  
14 don't know when they're doing something in this  
15 freaking (inaudible), and that really made me mad. I  
16 mean, it really hurt me.

17 And you know, because he didn't know, man.  
18 These people need their jobs. Shea Wilkos, you know  
19 I'm going to make it. I'm a little bit more secure  
20 than they are. It's just like me -- I mean, and you  
21 know, it just got to the point where, you know, I've  
22 been fighting them for so long, man, and you just -- I

1 01:03:25  
 2 didn't know what else to do, and again, I took a  
 3 pounding.  
 4 I mean, they moved me. They systematically  
 5 moved me out of there, and everything, every avenue I  
 6 went, the EEO, the OSC, it just didn't do anything. I  
 7 even sent -- listen to this -- Mr. -- you're going to  
 8 love this. Let me find it. I'll make you all a copy.  
 9 (Inaudible) very careful who knew it. Trust  
 10 me, I knew.  
 11 SPECIAL AGENT [REDACTED] You sent the -- you sent  
 12 the hotline email in 2013 in the fall, and then  
 13 recently, the one that had --  
 14 MR. WILKES: Yeah.  
 15 SPECIAL AGENT [REDACTED] -- the list.  
 16 MR. WILKES: Yeah.  
 17 SPECIAL AGENT [REDACTED] When was that one sent  
 18 that you attached a list to it?  
 19 MR. WILKES: Maybe Wednesday.  
 20 SPECIAL AGENT [REDACTED] This past Wednesday?  
 21 MR. WILKES: Yeah.  
 22 SPECIAL AGENT [REDACTED] Is that yesterday?

1 SPECIAL AGENT [REDACTED] Okay.  
 2 MR. WILKES: [REDACTED] was, and he sent out an  
 3 email (inaudible). He sent out an email, man. He said  
 4 if you know of any paper (inaudible) or anything, email  
 5 the business office. So -- the business office chief.  
 6 So I emailed him, and I said (inaudible).  
 7 (Whereupon, the interview was concluded at  
 8 approximately 2:12 p.m.)  
 9 \* \* \* \* \*

1 MR. WILKES: No, last week.  
 2 SPECIAL AGENT [REDACTED] Last week?  
 3 MR. WILKES: Yeah.  
 4 SPECIAL AGENT [REDACTED] Last Wednesday?  
 5 MR. WILKES: Yeah.  
 6 SPECIAL AGENT [REDACTED] Okay. Ten --  
 7 MR. WILKES: Two -- I don't -- I was trying to  
 8 see if I actually have something here. You know, I  
 9 thought at one time this was one, but I don't think it  
 10 is. I think this is like a group list from years ago.  
 11 SPECIAL AGENT [REDACTED] Yeah.  
 12 MR. WILKES: I think that's what --  
 13 SPECIAL AGENT [REDACTED] I think that's okay.  
 14 MR. WILKES: Yeah.  
 15 SPECIAL AGENT [REDACTED] That's okay.  
 16 SPECIAL AGENT [REDACTED] (Inaudible) grab it  
 17 (inaudible).  
 18 MR. WILKES: I've got something here you're  
 19 going to want to see. I actually sent [REDACTED]  
 20 (phonetic) was the [REDACTED] --  
 21 SPECIAL AGENT [REDACTED] I know the name.  
 22 MR. WILKES: -- before [REDACTED] just got here.

C E R T I F I C A T E

MATTER: Interview of CHRISTOPHER WILKES

DATE: Wednesday, June 18, 2014

I hereby certify that the attached transcription of pages   1   to   72   inclusive is, to the best of my belief and ability a true, accurate, and complete record of the above-referenced proceedings as contained in the provided audio recording.

Signature: \_\_\_\_\_

(b)(7)(C)  
[Redacted Signature]

(b)(7)(C)  
[Redacted Title]

Date:   12/2/14



Department of Veterans Affairs  
 Office of Inspector General  
 Criminal Investigations Division  
 New Orleans Resident Agency  
 1515 Poydras Street #738  
 New Orleans, LA 70112

MEMORANDUM OF INTERVIEW

Date: September 8, 2014  
 Appr: RAC [redacted]

Case File: 2014-02890-DD-0356  
 Date of Interview: June 18, 2014  
 Time: 3:48 p.m.  
 Place of Interview: VA Medical Center  
 Shreveport, Louisiana

Interviewee: [redacted]  
 Interviewed By: [redacted], Special Agent, VA OIG  
 [redacted], Special Agent, VA OIG

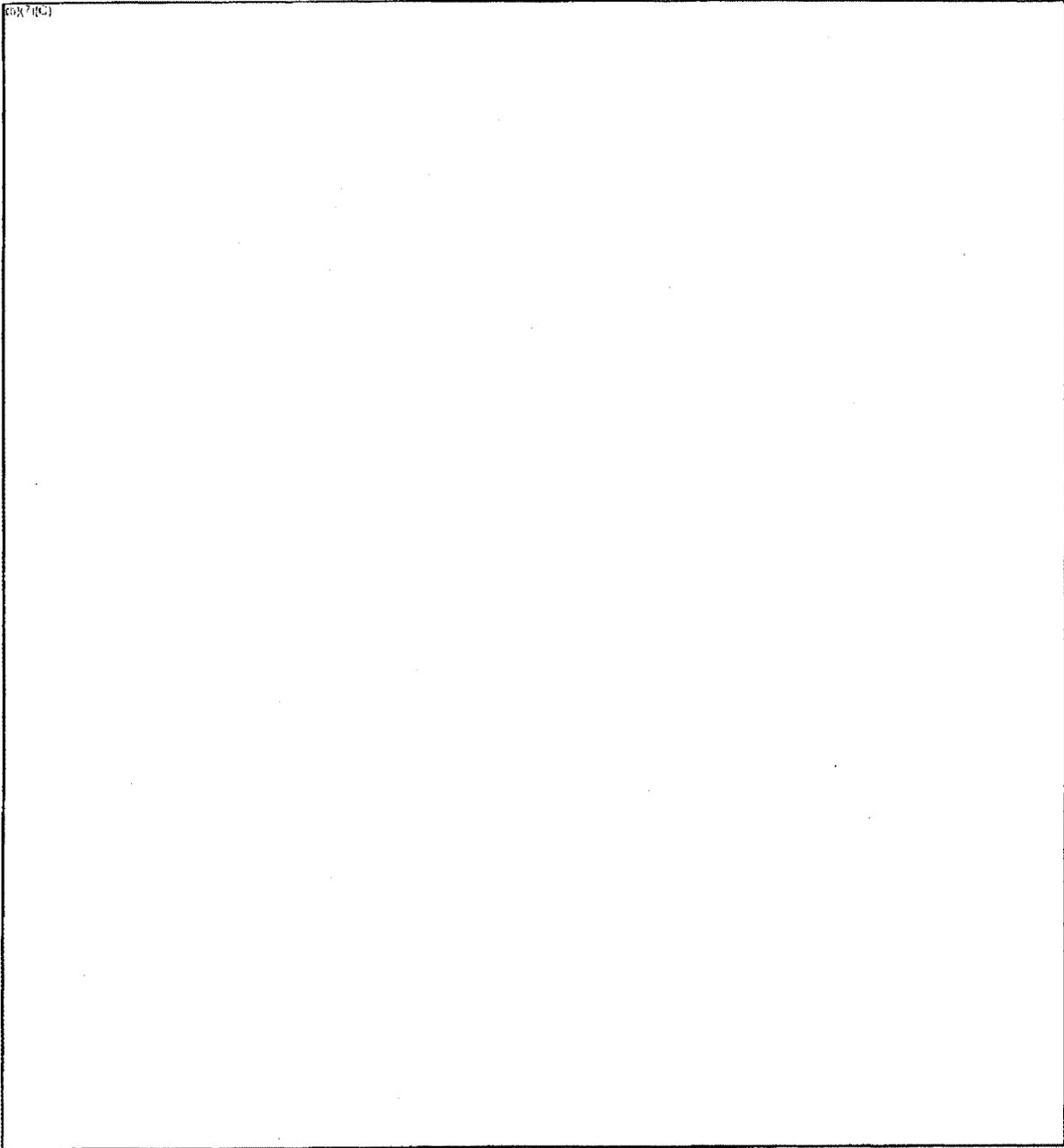
On June 18, 2014, I, along with Special Agent (SA) [redacted] interviewed [redacted] at the above-identified location. Prior to the interview, SA [redacted] and I clearly identified ourselves as Special Agents from the Department of Veterans Affairs (VA), Office of Inspector General (OIG) and presented our respective credentials. The purpose of the interview was to obtain information about a list that had been developed in the Mental Health Department at the VA Medical Center (VAMC), Shreveport, Louisiana. Prior to the interview, [redacted] was given Garrity Rights which were subsequently waived. The interview was audio recorded with [redacted]'s knowledge. [redacted] stated substantially as follows:

[redacted]

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File Number: 2014-02890-DD-0356

Case Name: Alleged Secret Wait List – Shreveport Louisiana



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Department of Veterans Affairs  
Office of Inspector General  
Criminal Investigations Division  
New Orleans Resident Agency  
1515 Poydras Street #738  
New Orleans, LA 70112

### MEMORANDUM OF INTERVIEW

Date: September 8, 2014  
Appr: RAC [REDACTED]

Case File: 2014-02890-DD-0356  
Date of Interview: June 19, 2014  
Time: 2:27 p.m.  
Place of Interview: [REDACTED]

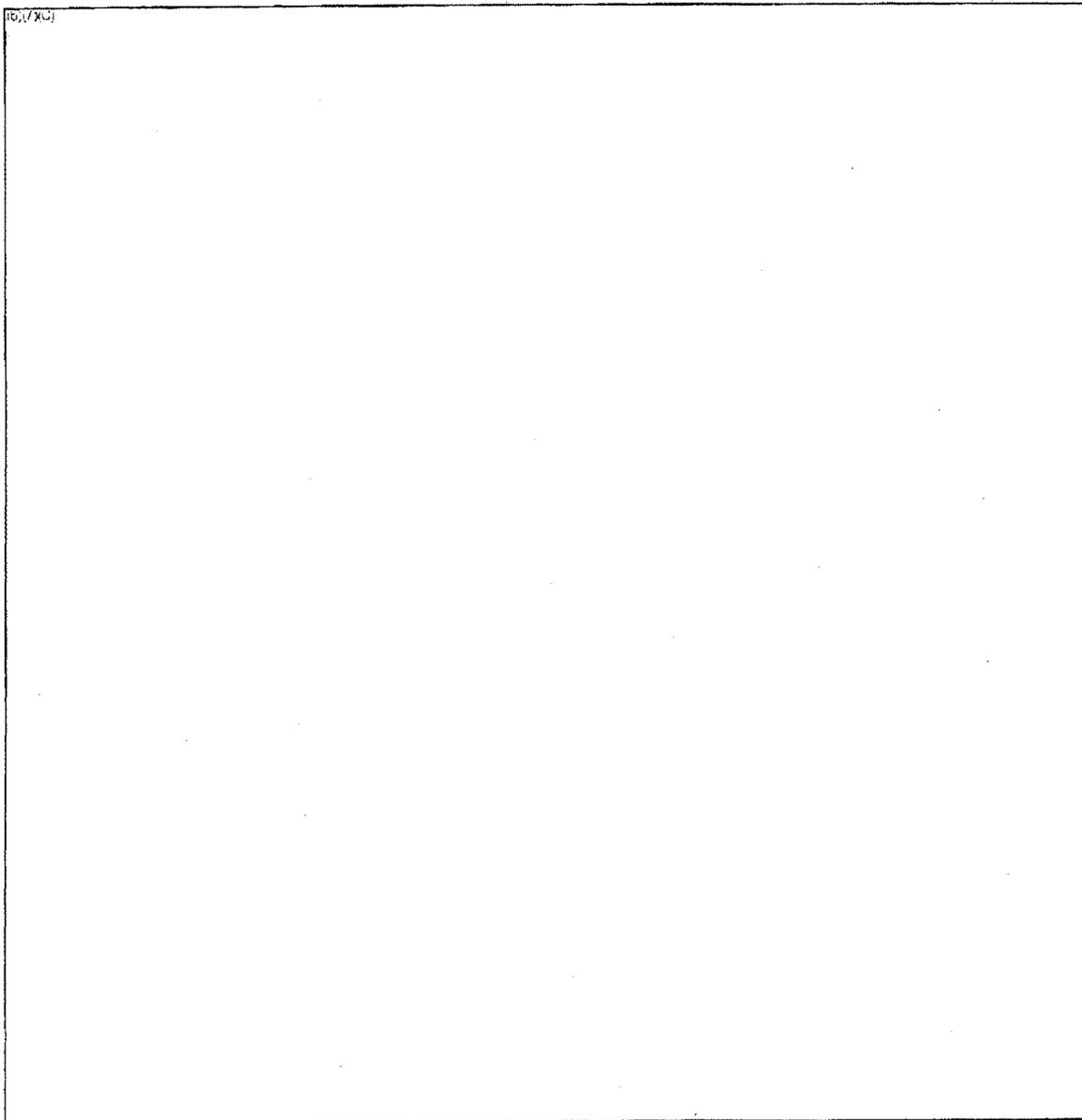
Interviewee: [REDACTED] Shreveport, Louisiana  
Interviewed By: [REDACTED] Special Agent, VA OIG  
[REDACTED] Special Agent, VA OIG

On June 19, 2014, Special Agent (SA) [REDACTED] and I interviewed [REDACTED] at the above-identified location in the presence of his attorney [REDACTED]. Prior to the interview, we both clearly identified ourselves as Special Agents from the Department of Veterans Affairs (VA), Office of Inspector General (OIG) and presented our respective credentials. The purpose of the interview was to obtain information about a list that had been developed in the Mental Health Department at the VA Medical Center (VAMC), Shreveport, Louisiana. Prior to the interview, [REDACTED] was given [REDACTED] Garrity Rights which were subsequently waived. The interview was audio recorded with [REDACTED]'s knowledge. [REDACTED] stated substantially as follows:

[REDACTED]

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File Number: 2014-02890-DD-0356  
Case Name: Alleged Secret Wait List – Shreveport Louisiana



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Department of Veterans Affairs  
 Office of Inspector General  
 Criminal Investigations Division  
 New Orleans Resident Agency  
 1515 Poydras Street #738  
 New Orleans, LA 70112

MEMORANDUM OF INTERVIEW

Date: September 8, 2014  
 Appr: RAC [redacted]

Case File: 2014-02890-DD-0356  
 Date of Interview: June 19, 2014  
 Time: 11:37 a.m.  
 Place of Interview: VA Medical Center  
 Shreveport, Louisiana

Interviewee: [redacted]  
 Interviewed By: [redacted], Special Agent, VA OIG  
 [redacted], Special Agent, VA OIG

On June 19, 2014, Special Agent (SA) [redacted] and I interviewed [redacted] at the above-identified location. Prior to the interview, SA [redacted] and I clearly identified ourselves as Special Agents from the Department of Veterans Affairs (VA), Office of Inspector General (OIG) and presented our respective credentials. The purpose of the interview was to obtain information about a list that had been developed in the Mental Health Department at the VA Medical Center (VAMC), Shreveport, Louisiana. Prior to the interview, [redacted] was given [redacted] Garrity Rights which were subsequently waived. The interview was audio recorded with [redacted]'s knowledge. [redacted] stated substantially as follows:

[redacted]

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File Number: 2014-02890-DD-0356  
Case Name: Alleged Secret Wait List – Shreveport Louisiana



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(Public Availability to be Determined Under 5 USC 552 and 552a)

File Number: 2014-02890-DD-0356  
Case Name: Alleged Secret Wait List – Shreveport Louisiana



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Department of Veterans Affairs  
Office of Inspector General  
Criminal Investigations Division  
New Orleans Resident Office  
1515 Poydras St, Rm 738  
New Orleans, LA 70112

### MEMORANDUM OF INTERVIEW

Date: August 8, 2014  
Appr: RAC [REDACTED]

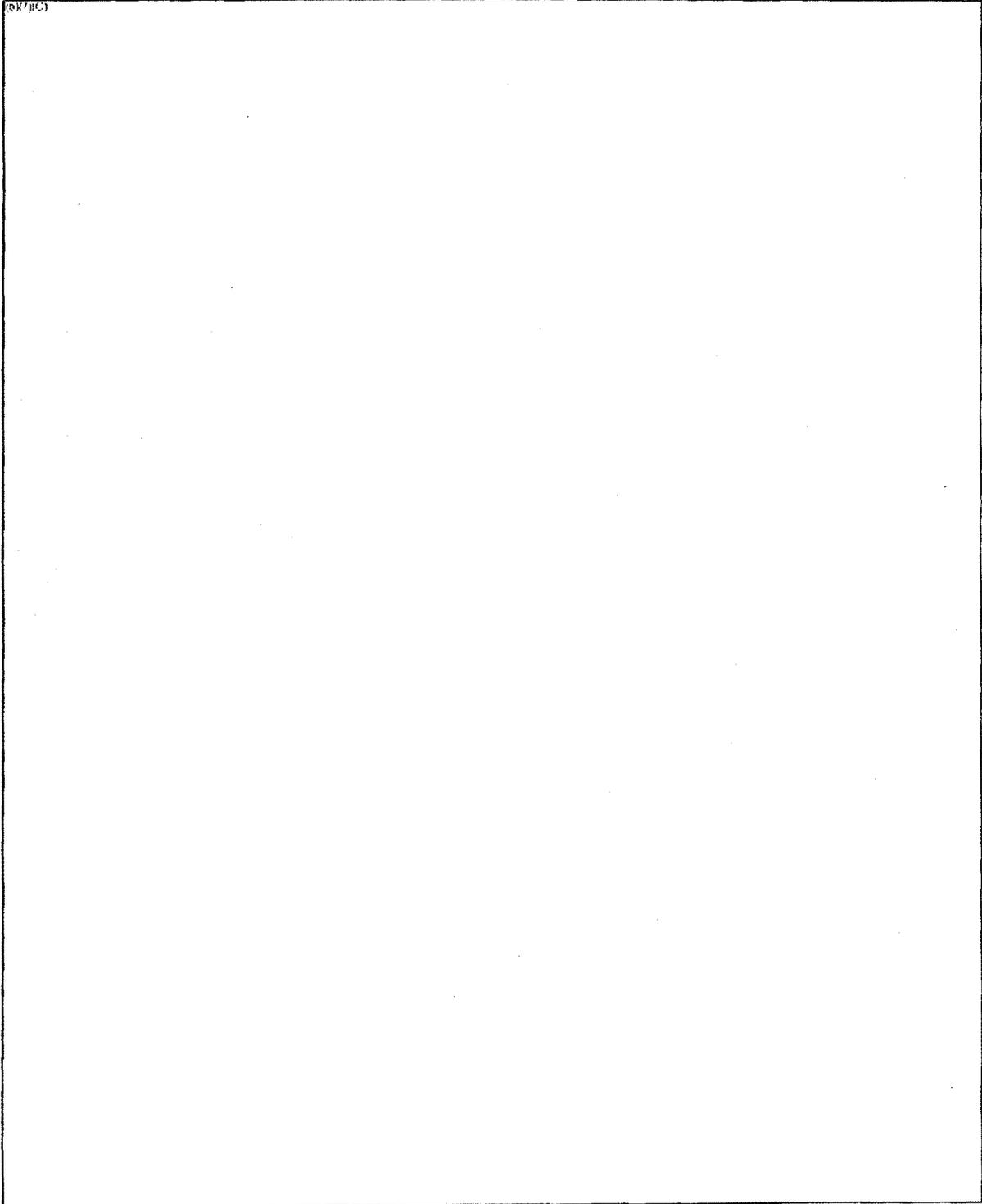
Case File: 2014-2890-DD-357  
Date of Interview: June 19, 2014  
Time: Approximately 9:45 a.m.  
Place of Interview: VAMC Shreveport, LA  
Interviewee: [REDACTED]  
Interviewed By: SA [REDACTED] and SA [REDACTED]

On the above date, Special Agent [REDACTED] and I, Department of Veterans Affairs (VA), Office of Inspector General (OIG), conducted an interview of [REDACTED] at the VAMC Shreveport, LA. Once we identified ourselves using our credentials, [REDACTED] was informed of [REDACTED] Garrity Rights and that [REDACTED] statements were voluntary. [REDACTED] agreed to answer questions and that the interview could be recorded. The interview was recorded and the recording was placed onto a compact disc, which is maintained in the case file. [REDACTED] provided the following information:

[REDACTED]

(Public Availability to be Determined Under 5 USC 552 and 552a)

File Number: 2014-2890-DD-357  
Case Name: Data Breach – Shreveport VAMC



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Department of Veterans Affairs  
Office of Inspector General  
Criminal Investigations Division  
New Orleans Resident Office  
1515 Poydras St, Rm 738  
New Orleans, LA 70112

**MEMORANDUM OF INTERVIEW**

Date: August 5, 2014  
Appr: RAC [REDACTED]

Case File: 2014-2890-DD-357  
Date of Interview: June 19, 2014  
Time: Approximately 11:10 a.m.  
Place of Interview: VAMC Shreveport, LA  
Interviewee: Christopher Shea WILKES  
Interviewed By: SA [REDACTED] and SA [REDACTED]

On the above date, Special Agent [REDACTED] and I, Department of Veterans Affairs (VA), Office of Inspector General (OIG), conducted an interview of Christopher WILKES at the VAMC Shreveport, LA. WILKES was reminded of his Garrity Rights and that his statements were voluntary. WILKES agreed to answer questions and that the interview could be recorded. The interview was recorded and placed onto a compact disc, which is maintained in the case file. WILKES provided the following information:

WILKES reiterated that he provided [REDACTED] [REDACTED] VAMC Shreveport, with comp time information within Mental Health Services and she told him the list was on the share drive and asked him if he still had access to the share drive. He told her he did, she pulled up the excel spreadsheet on her computer, and she told him "my password is [REDACTED] lower case."

WILKES stated he was willing to submit to a polygraph examination.

**Special Agent's Note:** WILKES subsequently obtained legal counsel and declined to take a polygraph examination.

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DEPARTMENT OF VETERANS AFFAIRS  
OFFICE OF INSPECTOR GENERAL

----- x  
: Case No.  
INTERVIEW OF : 2014-02980-DD-0357  
CHRISTOPHER WILKES :  
: June 19, 2014  
Mental Health :  
Social Worker : 00:08:07  
: **ORIGINAL**  
----- x

Thursday, June 19, 2014

VA Medical Center  
Shreveport, Louisiana

The above-entitled matter came on for interview,  
pursuant to notice at 11:10 a.m.

BEFORE:

MR. (b)(7)(C)  
MR. (b)(7)(C),

Special Agents  
Office of Inspector General  
Department of Veterans Affairs

This transcript produced from a sound file  
provided by Department of Veterans Affairs Office of  
Inspector General.

Diversified Reporting Services, Inc.  
(202) 467-9200

1 PROCEEDINGS  
 2 11:10 a.m.  
 3 SPECIAL AGENT [REDACTED] This is Special Agent  
 4 [REDACTED] and special Agent [REDACTED]. We're  
 5 at the VA Medical Center in Shreveport, Louisiana. It  
 6 is June 19th, 2014, and the time is 11:10.  
 7 We are speaking with Christopher Shea Wilkes  
 8 again.  
 9 All right. So the only thing we really wanted  
 10 to discuss the second time was the list and the  
 11 password.  
 12 MR. WILKES: Okay.  
 13 SPECIAL AGENT [REDACTED] Because we're getting  
 14 some conflicting information on that.  
 15 MR. WILKES: Right.  
 16 SPECIAL AGENT [REDACTED] When you -- tell us  
 17 again in your words how you acquired the access to that  
 18 list.  
 19 MR. WILKES: Well, her list and then like, you  
 20 know, it was a couple people mentioned list, and it was  
 21 like okay, and then [REDACTED] had said she was on there, and  
 22 I had asked before. I don't know if I mentioned this.

1 [REDACTED] had said there was a list, that she was [REDACTED]  
 2 (phonetic) [REDACTED] and then, you know, it finally  
 3 got to a thing and I had already spoke with the paper,  
 4 and I didn't have a list or anything at that time. I  
 5 said I know there's a list all over, and -- or they  
 6 talk about them and stuff, and I said, you know,  
 7 finally I came in on Monday, and [REDACTED] had actually  
 8 said something to me, I think, before, too.  
 9 But finally I said, you know, I was going to  
 10 Little Rock that morning, and I said, "You know what?  
 11 I'm going to need this list if there's a list, people  
 12 aren't scheduled." I decided I was going to see if I  
 13 could get it because we needed to get it to somebody.  
 14 That's just not right.  
 15 But so I went down and I had the comp time --  
 16 SPECIAL AGENT [REDACTED] Right.  
 17 MR. WILKES: -- [REDACTED] had got to --  
 18 SPECIAL AGENT [REDACTED]: Information, right.  
 19 MR. WILKES: Right, because there was a whole  
 20 issue with [REDACTED] that we had got in a big argument about  
 21 it. They wasn't going --  
 22 SPECIAL AGENT [REDACTED]: So you be sure you

1 brought the comp time.  
 2 MR. WILKES: Right, and I went to [REDACTED]  
 3 and I went in the office. I said, "Hey." I said, "I  
 4 know you" -- I can't remember. I said there's a list.  
 5 I know there's a list or whatever I need. I said -- I  
 6 said I'm going to whistleblow this.  
 7 And she was like, "Well, you know, they took  
 8 it from me," or something.  
 9 And I said, "Really? You don't have the  
 10 list?"  
 11 She said, "Well" -- I said, "Here." I said,  
 12 "I know there's a thing with comp time out here, and I  
 13 have this comp time that I go through this that this  
 14 person is getting a ton of comp time," and I said, "I  
 15 know that there's an issue that everybody's not." I  
 16 said, "I'll give you this," I said, "but I need that  
 17 list in that thing."  
 18 And she said, "Well, there's not -- it's on  
 19 the share drive. Do you still have access to the share  
 20 drive?"  
 21 And I said, "Yeah, I still do."  
 22 And then she said, "Well," -- she actually

1 pulled it up and showed me, and she said, "My password  
 2 is [REDACTED] lower case."  
 3 SPECIAL AGENT [REDACTED] She told you that  
 4 MR. WILKES: Yes.  
 5 SPECIAL AGENT [REDACTED] Is it common  
 6 knowledge --  
 7 SPECIAL AGENT [REDACTED] Exact words? What  
 8 were the words?  
 9 MR. WILKES: Oh, yes, I mean, that's how I got  
 10 it.  
 11 SPECIAL AGENT [REDACTED] She said, "It's my last  
 12 name?" What did she say?  
 13 MR. WILKES: Lower case last name, yeah.  
 14 SPECIAL AGENT [REDACTED] She told you -- you  
 15 asked for the password first or did she just offer it  
 16 to you?  
 17 MR. WILKES (Pause) Man, I can't -- I don't  
 18 know. I'm trying to -- because she said, "Well, it's  
 19 on the share drive." I thought it was just a list, and  
 20 she kind of showed me, and I can't -- I can't. Man, I  
 21 wouldn't know either way, if she did or I asked her  
 22 that. I remember just -- because if -- I mean, I

1 00:03:31  
 2 really - I remember her saying, "Well, the password,  
 3 it's my last name lower case," or something like that.  
 4 SPECIAL AGENT [REDACTED] Okay. She said,  
 5 "Well, the password is my last name lower case."  
 6 MR. WILKES: Right.  
 7 SPECIAL AGENT [REDACTED] And then this was on  
 8 Monday. Do you remember the date? Was it the Monday  
 9 after the news article came out?  
 10 MR. WILKES: It was before.  
 11 SPECIAL AGENT [REDACTED] Before?  
 12 SPECIAL AGENT [REDACTED] The Monday before?  
 13 SPECIAL AGENT [REDACTED] The Monday before or  
 14 just before? You know it was a Monday?  
 15 MR. WILKES: The news article came out. I was  
 16 in LDI. It came out that Sunday.  
 17 SPECIAL AGENT [REDACTED] So it would have been  
 18 before?  
 19 MR. WILKES: It would have been before, and  
 20 then the news article was Sunday, and I had told them  
 21 because I didn't want to do this to the media, and I  
 22 told them, I said, "I'm not talking to anybody but you

1 all."  
 2 And then I had reached out to a few more. I  
 3 said, "I'm not talking to anybody but - but you, and  
 4 this would be your exclusive."  
 5 And then it was Monday she gave it because I  
 6 was gone to Little Rock.  
 7 SPECIAL AGENT [REDACTED] And you came back that  
 8 Friday.  
 9 MR. WILKES: Right, and I talked to [REDACTED]  
 10 I said, "I'm worried that they'll get rid of this list.  
 11 Can you go in the share drive and see if it's there  
 12 and that way you could eyeball it or whatever?"  
 13 SPECIAL AGENT [REDACTED] So Monday when she gave  
 14 you the password, you went and looked at it, opened  
 15 it -  
 16 MR. WILKES: Right.  
 17 SPECIAL AGENT [REDACTED] -- with the password.  
 18 MR. WILKES: Right. Yes, I did.  
 19 SPECIAL AGENT [REDACTED] You knew the password on  
 20 Monday.  
 21 MR. WILKES: Yes, I did, and that's when I -  
 22 SPECIAL AGENT [REDACTED] And couldn't print it or

1 save it.  
 2 MR. WILKES: You remember on the hard drive I  
 3 said there was three?  
 4 SPECIAL AGENT [REDACTED] Yes.  
 5 MR. WILKES: When I went back in there  
 6 yesterday I said, look. This is the one that I saved  
 7 Friday at five-something when I came back.  
 8 SPECIAL AGENT [REDACTED] Un-huh.  
 9 MR. WILKES: That's the one that wouldn't  
 10 save. Now, there was one of them there that was three  
 11 lists, one, two, three. There was one under there from  
 12 like April. It had an April date on it. It would save  
 13 on there, but that one from 5/6, it had a pass -- I  
 14 couldn't save it. I couldn't print it. I couldn't do  
 15 anything. So when I came back, [REDACTED] told me. I  
 16 said, "[REDACTED] I just want you to eyeball this because  
 17 I don't -- I don't want people to think I am lying, and  
 18 they may get rid of it." And I said, "Can you go in  
 19 and just go here and look at it, go here and look at  
 20 it?"  
 21 And she went in there, and she said yeah. She  
 22 said, "Oh, my God, Shea," and --

1 SPECIAL AGENT [REDACTED] What are the two places  
 2 you told her to look? At the --  
 3 MR. WILKES: In the share drive.  
 4 SPECIAL AGENT [REDACTED] In the share drive?  
 5 MR. WILKES: Yes.  
 6 SPECIAL AGENT [REDACTED] And this was when they  
 7 had a password on it still or this was --  
 8 MR. WILKES: When she went in there she told  
 9 me there wasn't one.  
 10 SPECIAL AGENT [REDACTED] Okay.  
 11 MR. WILKES: That's why I came back Friday.  
 12 When I got here --  
 13 SPECIAL AGENT [REDACTED] Who said there wasn't  
 14 one?  
 15 MR. WILKES: [REDACTED]  
 16 SPECIAL AGENT [REDACTED] Did you give her the  
 17 password to look at it?  
 18 MR. WILKES: No.  
 19 SPECIAL AGENT [REDACTED] But you asked her to go  
 20 look at it, but the only --  
 21 MR. WILKES: Right.  
 22 SPECIAL AGENT [REDACTED] -- way you could look at

1 00:06:14  
 2 it was with the password  
 3 MR. WILKES: I don't think I gave her the  
 4 password because she says -- I said, "It's passworded."  
 5 And then when she got there she said, "Well,  
 6 it's not passworded."  
 7 I may have -- I can't remember. I don't think  
 8 I gave her that password because, I mean, I can't be a  
 9 -- I may -- I mean, I can't tell you, but I know she  
 10 looked at it and she told me it's not passworded.  
 11 And I was like, "What? So you can save it or  
 12 do whatever?"  
 13 And she said, "Yeah."  
 14 And I'm like, "Huh. Okay."  
 15 So then --  
 16 SPECIAL AGENT [REDACTED] And this is the Friday  
 17 before the paper article came out on Sunday.  
 18 MR. WILKES: Right. So I came back on Friday,  
 19 and I came up here, and I looked at that one, and I was  
 20 like, "Whoa." I was like, "Yeah." and it -- that's  
 21 when it would, and that's when I saved it to the --  
 22 SPECIAL AGENT [REDACTED] The hard drive?

1 MR. WILKES: Yeah, M -- I'll take whatever,  
 2 man.  
 3 SPECIAL AGENT [REDACTED] All right. That's all  
 4 we needed you to clear up.  
 5 That's it.  
 6 MR. WILKES: And I'll tell you. She is scared  
 7 and a --  
 8 SPECIAL AGENT [REDACTED] (Inaudible.)  
 9 SPECIAL AGENT [REDACTED] Ending the interview at  
 10 11:18.  
 11 (Whereupon, the interview was concluded at  
 12 approximately 11:18 a.m.)  
 13 \* \* \* \* \*  
 14  
 15  
 16  
 17  
 18  
 19  
 20  
 21  
 22

1 MR. WILKES: Yeah, where it said -- remember  
 2 it had the date on there, that Friday at five-  
 3 something? Yeah, I came up here that Friday after I  
 4 got back from Little Rock, and I saved it on there.  
 5 SPECIAL AGENT [REDACTED] I'm going to ask you  
 6 one more time. Be careful how you answer this because  
 7 this is critical. Did [REDACTED] give you the password?  
 8 Did she verbally give you the password as you stated?  
 9 Did she give you the password?  
 10 MR. WILKES: Yeah.  
 11 SPECIAL AGENT [REDACTED] She intentionally  
 12 said it, and she said, "Well, the pass word is my last  
 13 name lower case?"  
 14 MR. WILKES: Un-huh.  
 15 SPECIAL AGENT [REDACTED] Okay.  
 16 MR. WILKES: That's what I --  
 17 SPECIAL AGENT [REDACTED] Are you willing to  
 18 take a polygraph on that?  
 19 MR. WILKES: Yeah.  
 20 SPECIAL AGENT [REDACTED] Okay. I've got  
 21 nothing.  
 22 SPECIAL AGENT [REDACTED] Okay.

## C E R T I F I C A T E

MATTER: Interview of CHRISTOPHER WILKES

DATE: Thursday, June 19, 2014

I hereby certify that the attached transcription of pages \_\_\_1\_\_\_ to \_\_\_12\_\_\_ inclusive is, to the best of my belief and ability a true, accurate, and complete record of the above-referenced proceedings as contained in the provided audio recording.

Signature: \_\_\_\_\_

FOIA/AGC

FOIA/AGC

Date: 12/2/14



Department of Veterans Affairs  
Office of Inspector General  
Criminal Investigations Division  
New Orleans Resident Agency  
1515 Poydras Street #738  
New Orleans, LA 70112

MEMORANDUM OF INTERVIEW

Date: 11/12/2014

Appr: RAC [REDACTED]

Case File: 2014-02890-DD-0356  
Date of Interview: September 19, 2014  
Time: 9:08 a.m.  
Place of Interview: VA Medical Center  
Shreveport, Louisiana

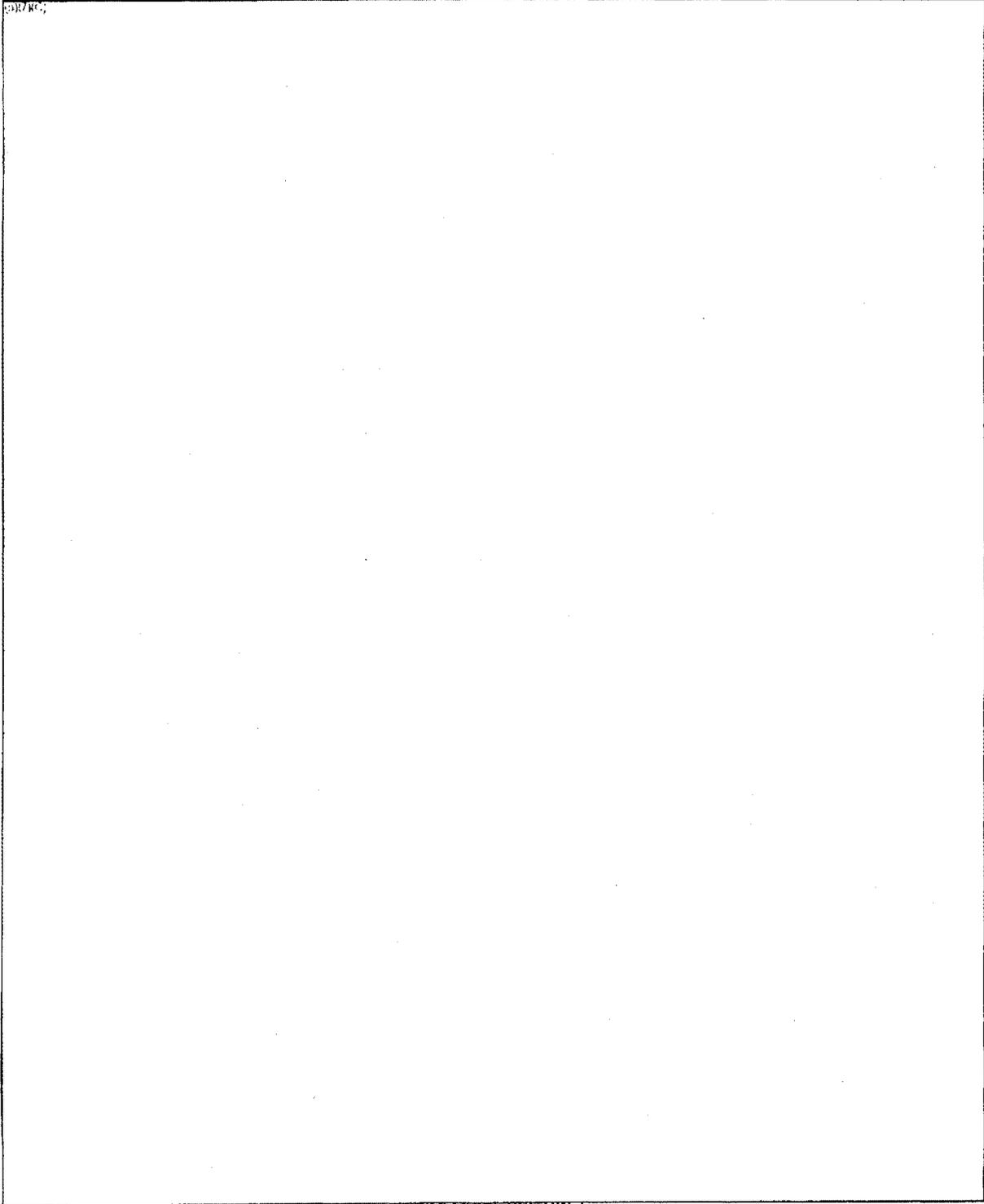
Interviewee: [REDACTED]  
Interviewed By: [REDACTED] Special Agent, VA OIG  
[REDACTED] Special Agent, VA OIG

On September 19, 2014, Special Agent (SA) [REDACTED] and I interviewed [REDACTED] at the above-identified location. Prior to the interview, SA [REDACTED] and I clearly identified ourselves as Special Agents from the Department of Veterans Affairs (VA), Office of Inspector General (OIG). We met with [REDACTED] previously on several occasions so he was familiar with us prior to the interview. The purpose of the interview was to 1) obtain information about a list that had been developed in the Mental Health Department at the VA Medical Center (VAMC), Shreveport, Louisiana; 2) obtain information about manipulating wait times when scheduling patients for appointments at the Shreveport VAMC; 3) obtain information about how Shea Wilkes got access to the list in question. Prior to the interview [REDACTED] was given his Garrity Rights which were subsequently waived. The interview was audio recorded with [REDACTED]'s knowledge. [REDACTED] stated substantially as follows:

[REDACTED]

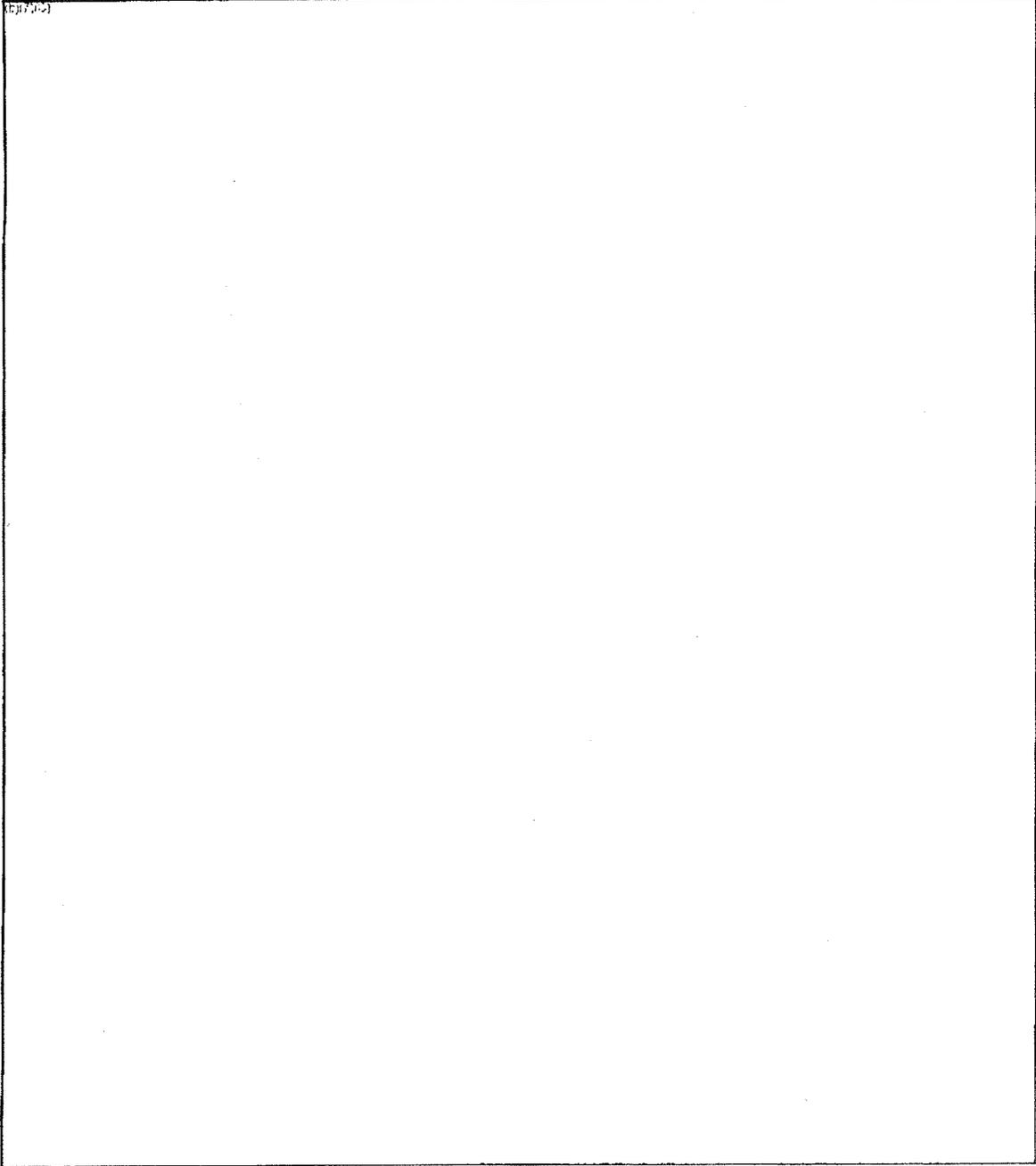
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(Public Availability to be Determined Under 5 USC 552 and 552a)

File Number: 2014-02890-DD-0356  
Case Name: Alleged Secret Wait List - Shreveport Louisiana



(Public Availability to be Determined Under 5 USC 552 and 552a)

File Number: 2014-02890-DD-0356  
Case Name: Alleged Secret Wait List – Shreveport Louisiana



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Department of Veterans Affairs  
Office of Inspector General

ADVISEMENT OF RIGHTS  
(FEDERAL EMPLOYEES - GARRITY)

You are being contacted to solicit your cooperation in an official investigation regarding misconduct or improper performance of official duties. In accordance with the Privacy Act, you are advised that the authority to conduct this investigation is contained in the Inspector General Act of 1978, 5 U.S.C. App. 3.

The matter under investigation could constitute a violation of law that could result in the criminal prosecution of the responsible individuals.

This inquiry concerns Improper <sup>in VA</sup> patient list

You have the right to remain silent if your answers may tend to incriminate you. If you do decide to answer questions or make a statement, you may stop answering at any time.

Anything you say may be used as evidence both in an administrative proceeding or any future criminal proceeding involving you.

If you refuse to answer the questions posed to you on the grounds that the answers may tend to incriminate you, you cannot be removed (fired) for remaining silent.

ACKNOWLEDGEMENT

I understand the warnings and assurances stated above and I am willing to make a statement and answer questions voluntarily. No promises or threats have been made to me and no pressure or coercion of any kind has been used against me.

SR/RC  
[Signature of Witness box]

Signature of Witness

SR/RC  
[Printed Name of Witness box]

Printed Name of Witness

6/18/14  
Date

Signature of Employee

Christopher Shea Wilkes  
Printed Name of Employee

6/18/2014  
Date

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(Public Availability to be Determined Under 5 USC 552)



Department of Veterans Affairs  
Office of Inspector General

ADVISEMENT OF RIGHTS  
(FEDERAL EMPLOYEES - GARRITY)

You are being contacted to solicit your cooperation in an official investigation regarding misconduct or improper performance of official duties. In accordance with the Privacy Act, you are advised that the authority to conduct this investigation is contained in the Inspector General Act of 1978, 5 U.S.C. App. 3.

The matter under investigation could constitute a violation of law that could result in the criminal prosecution of the responsible individuals.

This inquiry concerns unauthorized use of patient list & unauthorized access to patient information

You have the right to remain silent if your answers may tend to incriminate you. If you do decide to answer questions or make a statement, you may stop answering at any time.

Anything you say may be used as evidence both in an administrative proceeding or any future criminal proceeding involving you.

If you refuse to answer the questions posed to you on the grounds that the answers may tend to incriminate you, you cannot be removed (fired) for remaining silent.

ACKNOWLEDGEMENT

I understand the warnings and assurances stated above and I am willing to make a statement and answer questions voluntarily. No promises or threats have been made to me and no pressure or coercion of any kind has been used against me.

(B)(7)(C)  
[Signature of Witness]

Signature of Witness

(B)(7)(C)  
[Printed Name of Witness]

Printed Name of Witness

Date

06/19/2014

(B)(7)(C)  
[Signature of Employee]

Signature of Employee

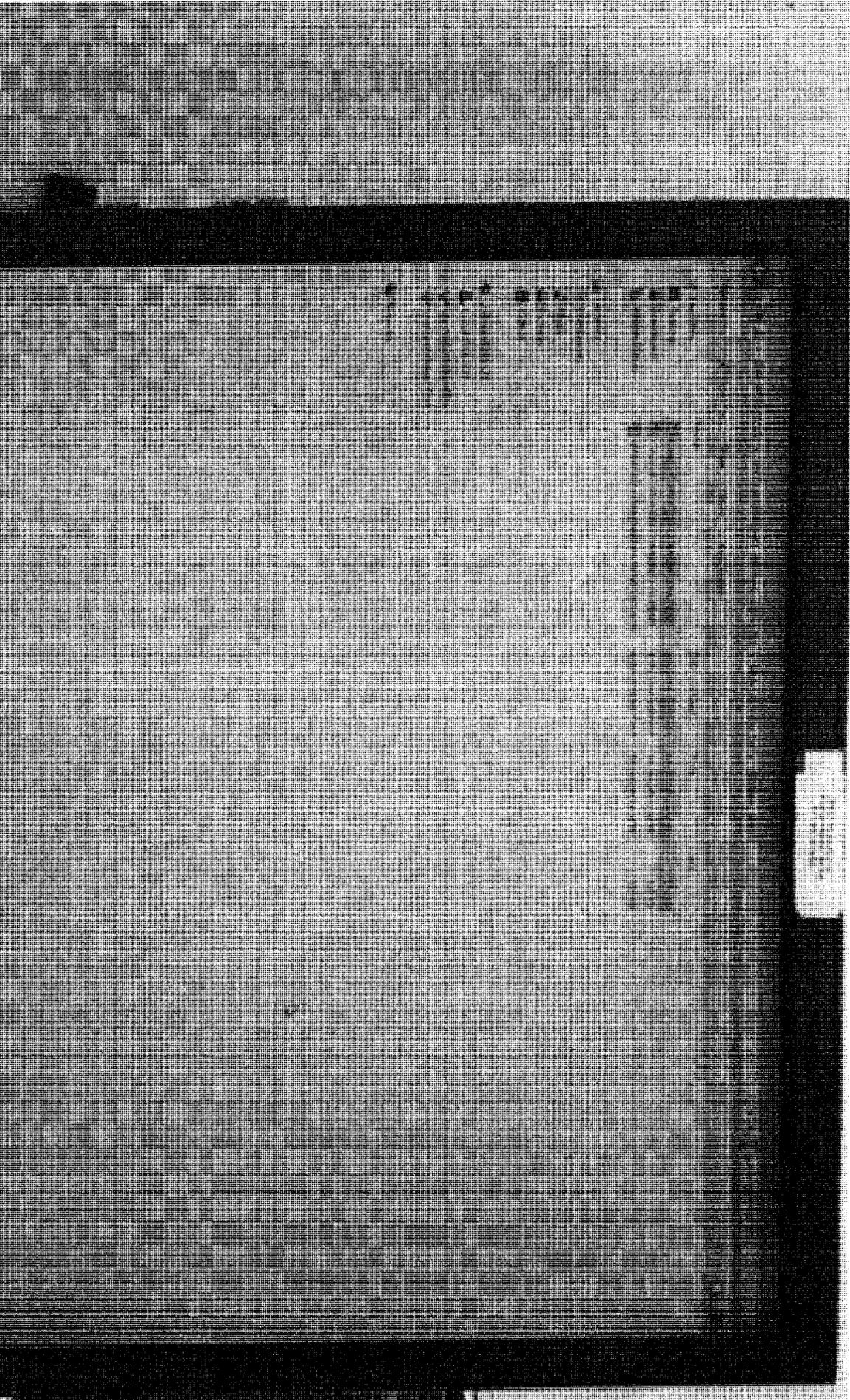
(B)(7)(C)  
[Printed Name of Employee]

Printed Name of Employee

Date

6/19/2014

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(Public Availability to be Determined Under 5 USC 552)



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EXHIBIT  
7



Ricky John

**Re: OSC File No. DI-14-3657**

1 message

Ricky John

Tue, Jul 22, 2014 at 1:13 PM

Reply-To:

To: "Oliver, Johanna" <joh@vergovsc.gov>

Ms. Oliver,

Thank you for your time in reviewing Mr. Wilke's complaint with him today. I believe that the package I previously emailed to your office has all of the pertinent emails with the exception of the attached email from Dr. Magee. If I find any others I will forward them to you.

Additionally, Mr. Wilke suggest that any investigator may want to interview the following employees:

Stephanie Alexander - Nurse in Mental Health. As shown in the emails Ms. Alexander was tasked with compiling the list from excel spreadsheets and paper lists in an effort to get appointments to all vets who had been on the list. Ms. Alexander is represented by Mr. Marty Stroud, an attorney, who can be contacted at [redacted]. Ms. Alexander is reluctant to speak because she was informed that she is a possible target in the IG's investigation concerning the list.

Ricky Ladimore - scheduler Primary Care. Can discuss practice of schedulers going into the system to get dates and backing out

Adam Sanchez - scheduler in Mental Health. He is now employed by the Veterans Benefits Administration in Omaha, Nebraska

Lynn Harris - scheduler Mental Health

Angela Murphy - Scheduler Mental Health

Marie Cordova - scheduler Mental Health

Julianne Forte - Psychiatrist in Mental Health

John Maggee - Psychologist Mental Health

Sharon Moore - Nurse Manager Mental Health

V/r,

Ricky John



Richard M. John  
Smith & John  
Attorneys at Law  
3646 Youree Drive



Ricky John

**OSC File No. DI-14-3657**

1 message

**Ricky John**

Mon, Aug 4, 2014 at 5:27 PM

Reply-To:

To: "Oliver, Johanna" &lt;joliver@osc.gov&gt;

Mr. Wilkes asked that I forward the following information to you regarding the above captioned file. Thank you.

Mr. Wilkes was informed that Letitia Henderson, is the Homeless Social Worker has state that sometime back she learned that one of her Veterans was placed on a wait list and that she noted it in the Veterans Chart at the time.

Also the following email was forwarded to Mr. Wilkes from Dr. Magee, who was a source of some of the information concerning meetings at the VA regarding the list. Dr. Magee was placed on administrative leave this week for some reason unknown to Mr. Wilkes.

**From:** Magee, John**Sent:** Friday, August 01, 2014 12:21 PM**To:** Wilkes, Christopher S.**Subject:** Information

Shea,

I attended a "Training" on Monday 7/28/14 regarding coding, scheduling, appointments, EWL, etc. There were six of us attending at 1 p.m. in 1W50. I believe there were six of us in attendance, all providers, including Vicki Laborde and some individuals from Buckner Square.

The presenter noted the following information:

**MAKING APPOINTMENTS.**

"I'm going to show you how some clerks here manipulated an appointment" (she made the statement twice, and then demonstrated).

She presented an example of a Veteran seen on 8/28/14 and the provider putting a Text Order in for RTC.

The soonest available was 9/15/14, which made the waiting time to be "18 days."

However, she then showed how clerks were able to go in with the same data and "make the wait days

0"

(i.e. made the appointment for 9/15/14, but the procedures "changed wait time to be 0 days")

**000002**

**ELECTRONIC WAIT LIST (EWL).**

"The Electronic Wait List is the official wait list"

"Back in the day, Managers said we could not put anyone on the EWL."

**EXCELL LISTS, PAPER LISTS, ETC.**

"The only official waiting list is the EWL"

"The EWL is the only wait list authorized for use."

"No other wait list formats, paper, electronic spread sheets, are to be used for tracking requests for outpatient appointments."

"Do we have a list of patients on an Excel sheet? We can't have that."

I haven't seen this information in the paper, or on Channel 3 (unless I missed it).

How do you think I should handle this?

My recommendation is to send it to the individuals who interviewed me for the fact finding last week.

What do you think?

John

Richard M. John  
Smith & John  
Attorneys at Law  
3646 Youree Drive  
Shreveport, Louisiana 71105

**000003**



Ricky John

---

**Re: OSC File No. DI-14-3657 - Consent Form**

1 message

---

**Ricky John**

Fri, Sep 12, 2014 at 4:52 PM

Reply-To:

To: "Oliver, Johanna" <joliver@osc.gov>

Please find attached a memo outlining information given to Mr. Wilkes concerning how appointment scheduling continues to be manipulated at Overton Brooks VAMC. It looks like there may be a flaw with the programming that allows a patient to have an appointment scheduled but not show up on the wait list. Thank you.

V/r,

Ricky John

Richard M. John  
Smith & John  
Attorneys at Law  
3646 Youree Drive  
Shreveport, Louisiana 71105

On Thu, Jul 24, 2014 at 3:05 PM, Oliver, Johanna <joliver@osc.gov> wrote:

Attached is the Consent Form for Mr. Wilkes' signature. Please let me know if you have any questions or concerns.

Thanks,

Johanna

Johanna L. Oliver

Attorney, Disclosure Unit

U.S. Office of Special Counsel

1730 M Street, NW, Ste. 218

Washington, DC 20036

000004

It was reported to me by 2 separate persons that the Overton Brooks VAMC continues to manipulate appointment scheduling thus producing false data related to Veteran wait times. Both persons explained to me basically the same process being used to manipulate data here at Overton Brooks. I verified the process through an individual with scheduling capability at Overton Brooks. The process explained to me by the 2 person's looks to be very legitimate. I will try to explain the process to the best of my ability below.

**Step 1 :** The scheduler goes into the Vista System to schedule a appointment. Upon entering the system the scheduler finds the first available appointment is 35 days from that present day.

**Step 2:** The scheduler does make the appointment for the Veteran 35 days from that present day. After the appointment is scheduled Vista displays this:

**WAIT TIME1 30 days** (all appt. are expected to be scheduled in 30 days)

**WAIT TIME2 5 days** (days over the expected 30 wait time)

**Step 3:** The scheduler at this point should place the Veteran on the Electronic Wait List.

**THE SCHEDULER HOWEVER DOES NOT PUT THE VETERAN ON THE ELECTRONIC WAIT LIST.**

**Step 4:** The scheduler continues by backing out of Vista and then returns into Vista. The scheduler then cancels the Veterans' appointment which was 35 days from that present day.

**Step 5:** After canceling the appointment the scheduler then reschedules the Veterans' appointment. This appointment is scheduled "let's say" 36 days from that present day. Once the scheduler sets the appointment for 36 days, Vista now displays:

**WAIT TIME1 30 days** (all appt. are expected to be scheduled in 30 days)

**WAIT TIME2 0 days** (days over the expected 30 wait time)

The "**WAIT TIME2 0 days**" now means that the Veteran is scheduled to supposedly see a provider within 30 days. Therefore not showing up on the numbers as being over the 30 day expected scheduling time.

**Conclusion:**

By conducting the steps mentioned above VA Hospitals are able to manipulate wait time data by:

1. The Veteran is never placed on the electronic wait List.
2. The Veteran appears in Vista as having been scheduled within the expected 30 day wait period.

**000005**

SUMMARY OF NONCOMPLIANCE WITH OSC EVALUATION CRITERIA IN  
DEPARTMENT OF VETERANS AFFAIRS REPORT ON SHEA WILKES REFERRAL

In addition to being unreasonable, the VA report on Mr. Wilkes disclosures, OSC File No. DI-14-3657, failed the following OSC criteria for a complete response.

3. *Did the agency report include a summary of the information with respect to which the investigation was initiated? 5 USC § 1213(d)(1)* No, while there was some overlap the report did not recognize the existence of evidence in Mr. Wilkes' OSC disclosure that was referred for investigation.

a) *Did the report set forth allegations submitted by the Special Counsel for investigation?* No, although the issues were reiterated in the cover letter, the report itself investigated different allegations about one individual, Ms. Ruthie McDaniel, contained in a separate Hotline disclosure. It did not recognize the existence of Mr. Wilkes' concerns for public health and safety.

b) *Did the report summarize the material evidence relating to each of the allegations?* No, this was not possible since the report was not in response to Mr. Wilkes' OSC allegations.

4. *Did the agency report include a description of the conduct of the investigation? 5 USC § 1213 (d)(2)*

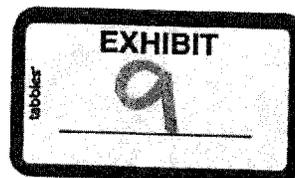
a) *Was the whistleblower interviewed at the outset of the investigation?* No, despite his repeated requests and offers, Mr. Wilkes was not interviewed at all in response to the OSC referral.

b) *Did the report identify the personnel who investigated the whistleblower's charges?* No.

d) *Did the report list witnesses interviewed, including the subjects of the investigation and witnesses suggested by the whistleblower?* No, the report kept all identities confidential, listed responses without disclosure of the predicate questions, and could not interview Mr. Wilkes' witnesses because it did not communicate with Mr. Wilkes.

g) *Did the report state whether notice was provided for on-site investigations?*

No.



*h) Did the report reveal the areas of inquiry covered with each witness? No, only their answers.*

*i) Did the agency rely on any other investigative report as a substitute for investigation in direct response to the referral under 5 USC § 1213(c)? Yes. If so, did the agency answer Question 4, (a) through (h) above in that report? No.*

*5. Did the report include a summary of any evidence obtained from the investigation? 5 USC § 1213(d)(3) No.*

*a) Did the report summarize all relevant and material evidence that the agency considered in making its conclusions on each of the allegations? No.*

*6. Did the agency report include a listing of any violation or apparent violation of any law, rule, or regulation? 5 USC § 1213(d)(4) No.*

*a) Did the report cite any law, rule, or regulation relevant to the whistleblower's allegations, whether or not the report concludes that the disclosure and evidence substantiates a violation? No, the report did not reference any legal authority.*