DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON DC 20420
February 29, 2016

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-15-5392

Dear Ms. Lerner:

I am responding to your November 3, 2015, letter regarding allegations made by a whistleblower at the Southeast Community-Based Outpatient Clinic's Mental Health Clinic (SE CBOC-MH) in Gilbert, Arizona, operated by the Phoenix Department of Veterans Affairs (VA) Health Care System, in Phoenix, Arizona (the Medical Center). The whistleblower alleges that Medical Support Assistants (MSA) engaged in scheduling improprieties, that a psychiatrist failed to examine an admitted patient in a timely manner, and that employees are engaging in professional conduct that may constitute a violation of law, rule, or regulation; gross mismanagement; abuse of authority; and a substantial and specific danger to public health. The Secretary has delegated to me the authority to sign the enclosed report and take any actions deemed necessary as referenced in 5 United States Code § 1213(d)(5).

The Under Secretary for Health directed the Office of the Medical Inspector to assemble and lead a VA team to conduct an investigation. The VA team substantiates the first allegation that some MSAs improperly scheduled patients. They did not substantiate the second allegation that patients were improperly triaged at the SE CBOC-MH and found that all unscheduled patients who presented at the SE CBOC-MH without an appointment during August 25, 2014, and January 2, 2015, were screened and seen by a mental health provider and/or registered nurse. The VA team substantiates the additional allegation that a psychiatrist failed to examine an admitted patient in a timely manner and concludes that this posed a possible danger to public health and safety. The report makes ten recommendations to the Medical Center. I have directed the Veterans Health Administration and the Medical Center Director to carry out the recommended actions.

Thank you for the opportunity to respond.

Sincerely,

Robert D. Snyder
Interim Chief of Staff

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
Washington, DC

Report to the
Office of Special Counsel
OSC File Number DI-15-5392

Department of Veterans Affairs
Phoenix VA Health Care System
Southeast Community-Based Outpatient Clinic
Gilbert, Arizona

Report Date: February 19, 2016

TRIM 2015-D-6639

Executive Summary

The Under Secretary for Health (USH) directed the Office of the Medical Inspector (OMI) to assemble and lead a Department of Veterans Affairs (VA) team to investigate allegations lodged with the Office of Special Counsel (OSC) concerning the Phoenix VA Health Care System's (hereafter, the Medical Center) Southeast Community-Based Outpatient Clinic (SE CBOC), specifically within the Mental Health clinic (hereafter, the SE CBOC-MH) located in Gilbert, Arizona. Elaine Ramos, M.D. (hereafter, the whistleblower), a former psychiatrist at the SE CBOC, who consented to the release of her name, alleges that the SE CBOC-MH Medical Support Assistants (MSA) engaged in misconduct in patient scheduling procedures. She also made additional allegations that a psychiatrist failed to examine an admitted patient in a timely manner, and that employees are engaging in professional conduct that may constitute a violation of law, rule, or regulation; gross mismanagement; abuse of authority; and a substantial and specific danger to public health. The VA team conducted a site visit to the Medical Center and the SE CBOC on
November 17–19, 2015.

Specific Allegations of the Whistleblower

1. Schedulers in the SE CBOC have rescheduled and cancelled patients' appointments without their knowledge, and failed to reschedule cancelled appointments; and

2. Patients presenting at the SE CBOC in times of mental health crisis are not triaged appropriately and are scheduled for evaluations weeks after they present.

Additional Allegations

A psychiatrist failed to examine an admitted patient in a timely manner, and employees were engaging in professional conduct that may constitute a violation of law, rule, or regulation; gross mismanagement; abuse of authority; and a substantial and specific danger to public health.

The whistleblower reports that a patient was admitted to the inpatient psychiatry unit from the Emergency Department (ED) on a Friday and was not evaluated by the on-call psychiatrist until the following Monday.

VA **substantiated** allegations when the facts and findings supported that the alleged events or actions took place, **did not substantiate** allegations when the facts and findings showed the allegations were unfounded, or **was not able to substantiate** allegations when no facts or findings supported that the alleged event or action took place.

After careful review of its investigative findings, VA makes the following conclusions and recommendations:

- VA **substantiated** the allegation that some schedulers in the SE CBOC-MH have rescheduled and cancelled some patients' appointments without their knowledge through a prohibited practice known as blind scheduling.

- The Medical Center's scheduling policy did not incorporate the most recent policy guidance on scheduling processes, VHA Memorandum, Acting Deputy Under Secretary for Health for Operations and Management, June 8, 2015, CORRECTION: *Clarification of Veterans Health Administration (VHA) Outpatient Scheduling Policy and Procedures and Interim Guidance,* and *Attachment A, Outpatient Scheduling Operating Procedures* (hereinafter "June 8, 2015, *Clarification*").

- The SE CBOC-MH MSAs, mental health providers, and registered nurses (RN) have not been trained on the scheduling practice updates contained in the June 8, 2015, *Clarification.*

- There is a staffing shortage and high turnover of MSAs at the Medical Center and the SE CBOC-MH, which may negatively impact scheduling practices and the safe provision of patient care.

Recommendations to the Medical Center:

1. Immediately provide updated education and training for all SE CBOC-MH MSAs on the scheduling policy updates contained in the June 8, 2015, *Clarification,* and make sure all mental health providers and RNs receive updated education and training, as well.

2. Fill all MSA vacancies throughout the Medical Center and SE CBOC-MH.

3. Continue to conduct MSA scheduling audits to ensure they are appropriately executing scheduling policy and practice and include follow-up or corrective actions when the requirements are not met. Utilize the Scheduling Trainer to maintain an aggressive and robust program to ensure that new and current schedulers are aware of VHA scheduling processes.

4. Conduct a focused review of scheduling practices and remediation of Medical Center and all CBOC MSAs, specifically on rescheduling missed appointments.

5. Determine the accountability of the Acting Chief, Health Administration Service (HAS), with regard to failing to ensure all MSAs are trained in updated scheduling processes.

Conclusions for Allegation 2

- VA **did not substantiate** that patients presenting at the SE CBOC-MH in times of mental health crises are not triaged appropriately and are scheduled for evaluations weeks after they present.

- The SE CBOC-MH did not have a Standard Operating Procedure (SOP) for triaging and managing unscheduled patients, and there were no written guidelines, policies, or procedures to guide staff members in this process.

Recommendations to the Medical Center:

6. In accordance with the VHA Memorandum, Acting Assistant Deputy Under Secretary for Health for Operations and Management for Clinical Operations, July 3, 2012, *CBOC Mental Health Operations*, develop a local policy with corresponding SOPs for triaging and managing unscheduled patients in the SE CBOC-MH.

7. Fill the SE CBOC-MH Medical Assistant vacancy or assign clinical responsibility for directly observing Veterans with suicidal or homicidal thoughts to other clinical staff members to ensure patient safety.

Conclusion for Additional Allegations

- VA **substantiated** that a psychiatrist failed to examine an admitted patient or implement an initial treatment plan within 24 hours of admission, which violates Medical Center Bylaws. These Bylaws govern professional medical practice. Any violation of the Bylaws requires the initiation of a Focused Professional Practice Evaluation (FPPE).

Recommendations to the Medical Center

8. Initiate an FPPE on the psychiatrist who was assigned to admit patients from the ED to inpatient psychiatry on July 10 and 11, 2015.

9. Review Medical Center Bylaws pertaining to the duties of admitting psychiatrists with the psychiatrist assigned to the case reviewed and ensure that all psychiatrists with admitting privileges are aware of the admission requirements.

10. Conduct an audit of medical records for Friday and Saturday admissions to inpatient psychiatry during fiscal year 2015 by all psychiatrists to ensure that this is not a systemic issue, and that they are in compliance with the bylaws.

Summary Statement

VA has developed this report in consultation with other VHA and VA offices to address OSC's concerns about the Medical Center's possible violation of law, rule, or regulation; gross mismanagement; abuse of authority; and a substantial and specific danger to public health. In particular, VA's Office of General Counsel (OGC) has provided a legal review; VHA Human Resources (HR) has examined personnel issues to establish accountability; and the Office of Accountability Review (OAR) has reviewed the report and has or will address potential senior leadership accountability. VA's investigation and review of its findings revealed violations of VHA policy, and these violations pose a potential danger to public health.

Table of Contents

I. Introduction

The Under Secretary for Health (USH) directed the Office of the Medical Inspector (OMI) to assemble and lead a Department of Veterans Affairs (VA) team to investigate allegations lodged with the Office of Special Counsel (OSC) concerning the Phoenix VA Health Care System's (hereafter, the Medical Center) Southeast Community-Based Outpatient Clinic (SE CBOC), specifically the Mental Health clinic (hereafter, the SE CBOC-MH) located in Gilbert, Arizona. Elaine Ramos, M.D. (hereafter, the whistleblower), a former psychiatrist at the SE CBOC, who consented to the release of her name, alleges that the SE CBOC-MH Medical Support Assistants (MSA) have engaged in misconduct in patient scheduling procedures. She also made additional allegations that a psychiatrist failed to examine an admitted patient in a timely manner, and that employees are engaging in professional conduct that may constitute a violation of law, rule, or regulation; gross mismanagement; abuse of authority; and a substantial and specific danger to public health. The VA team conducted a site visit to the Medical Center and the SE CBOC on November 17–19, 2015.

II. Facility Profile

The Medical Center, part of Veterans Integrated Service Network (VISN) 18, is a complexity level 1c tertiary care facility with six CBOCs in Phoenix, Southeast, Payson, Show Low, Globe, and Surprise, Arizona.[1] It is a teaching hospital, providing a full range of patient care services, with state-of-the-art technology and research. The Medical Center provides comprehensive health care through primary care, long-term care, and tertiary care in the areas of medicine, surgery, psychiatry, physical medicine and rehabilitation, neurology, oncology, dentistry, nutrition, geriatrics, and extended care. It has 177 inpatient and 104 Community Living Center beds and maintained an average daily census of 99.2 in fiscal year (FY) 2015. The CBOCs had a total of 957,019 patient visits and 82,390 unique patients for FY 2015, out of which, the SE CBOC, a very large CBOC, and the largest of this health care system's clinics, had 98,500 visits and 20,150 unique patients in FY 2015.[2] The SE CBOC does not provide urgent or emergency care, and other arrangements are made for patients seeking this type of care.[3] The Medical Center has 464 affiliation agreements with more than 145 institutions and supports and funds over 80 resident positions annually.

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[1] Complexity level 1c: complexity levels are determined by patient population (volume and complexity of care), complexity of clinical services offered, and education and research (number of residents, affiliated teaching programs, and research dollars). Complexity level 1 is the most complex and level 3 is the least complex; complexity for level 2 facilities is considered moderate. (Veterans Health Administration Executive Decision Memo (EDM), *2011 Facility Complexity Level Model).*

[2] Very large CBOC: The services that must be provided in CBOCs differ according to the size of the clinics. Very large CBOCs are those that serve more than 10,000 unique Veterans each year; large CBOCs are those that serve 5000-10,000 Veterans; mid-sized CBOCs are those that serve 1,500-5,000 Veterans; and small CBOCs are those that serve fewer than 1,500 Veterans. VHA Handbook 1160.01, 3a. *Scope, Uniform Mental Health Services In VA Medical Centers and Clinics.* http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=1762

[3] Emergency and Urgent Care: Urgent Care is care for an acute medical or psychiatric illness or for minor injuries for which there is a pressing need for treatment to manage pain or to prevent deterioration of a condition where delay might impair recovery. For example, urgent care includes the follow-up appointment for a patient discharged from the medical facility if the discharging physician directs the patient to return on a specified day for the appointment.

III. Specific Allegations of the Whistleblower

1. Schedulers in the SE CBOC have rescheduled and cancelled patients' appointments without their knowledge, and failed to reschedule cancelled appointments; and

2. Patients presenting at the SE CBOC in times of mental health crisis are not triaged appropriately and are scheduled for evaluations weeks after they present.

Additional Allegations

A psychiatrist failed to examine an admitted patient in a timely manner and employees are engaging in professional conduct that may constitute a violation of law, rule, or regulation; gross mismanagement; abuse of authority; and a substantial and specific danger to public health.

The whistleblower reports that a patient was admitted to the inpatient psychiatry unit from the Emergency Department (ED) on a Friday and was not evaluated by the on-call psychiatrist until the following Monday.

IV. Conduct of Investigation

The VA team conducting the investigation included (B6), Senior Medical Investigator (an internist), and (B6) Clinical Program Manager, both from OMI; (B6) Health Systems Specialist, VHA Access and Clinic Administration Program (ACAP); and (B6) Deputy HR Officer, VISN 20.

On November 9, 2015, the team interviewed the whistleblower by phone, and on November 16, 2015, conducted a subsequent face-to-face interview with her in Gilbert, Arizona. The team reviewed policies, additional reports, memoranda, and other relevant documents listed in Attachment A.

On November 17, 2015, VA held an entrance briefing and discussed the Department's whistleblower protection policy with Medical Center and VISN leadership:

Participated by teleconference:

- (B6) Interim Medical Center Director
- (B6) Chief of Staff (CoS)
- (B6) Associate Director for Patient Care Services (ADPCS)
- (B6) Acting Associate Director (AD)
- (B6) Deputy Nurse Executive
- (B6)., Deputy CoS

Emergency care is the resuscitative or stabilizing treatment needed for any acute medical or psychiatric illness or condition that poses a threat of serious jeopardy to life, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part.

- (B6) Acting Assistant Director
- (B6) Chief, Quality Safety & Improvement (QSI)
- (B6) Acting Chief, Health Administration Service (HAS)
- (B6) Deputy Quality Management Officer (QMO), VISN 18
- (B6) QMO, VISN 18

Participated face-to-face at the SE CBOC:

- (B6) Chief, Primary Care (PC)
- (B6) , SE CBOC Clinic Director, PC
- (B6) , SE CBOC Clinic Director PC
- (B6) HAS Chief, Outpatient Patient Aligned Care Team (PACT)
- (B6) Supervisor, Medical Administrative Specialist
- (B6) RN, SE CBOC Nurse Manager, PC

VA interviewed the following staff telephonically or in person:

- (B6) Interim Medical Center Director
- (B6) D.O., CoS
- (B6) , Acting Chief, Human Resources Officer (HRO)
- (B6) Acting Chief, HAS
- (B6) ., Chief, PC
- (B6) , SE CBOC, Nurse Manager, PC
- (B6) Acting Chief, Psychiatry
- (B6) , CBOCs Section Chief, Psychiatry
- (B6) SE CBOC-MH, Psychiatrist
- (B6) , SE CBOC-MH, Psychiatrist
- (B6) SE CBOC-MH, Psychiatrist
- , SE CBOC-MH, Psychiatrist
- (B6) SE CBOC-MH, Psychiatrist
- (B6) , SE CBOC-MH, Psychiatrist
- (B6) SE CBOC-MH, Psychologist
- (B6) SE CBOC, Clinical Director, PC
- (B6) , SE CBOC, Clinical Director, PC
- (B6) Nurse Manager, Outpatient MH
- SE CBOC-MH
- (B6) , SE CBOC-MH
- (B6) SE CBOC-MH
- SE CBOC
- (B6) , MSA, Supervisor, PACT
- (B6) Chief of Specialty Care Clinics
- (B6) Lead MSA Supervisor
- (B6) , MSA, SE CBOC-MH
- (B6) , MSA, SE CBOC-MH

On November 19, 2015, VA held an exit briefing with the Medical Center and VISN Leadership:

Participated by teleconference:

- (B6) Interim Medical Center Director
- (B6) CoS
- (B6) ADPCS
- (B6) Acting Associate Director
- (B6) Health System Specialist for AD
- (B6) Chief QS&I
- (B6) Chief Outpatient Psychiatry
- (B6) Mental Health Quality Manager
- (B6) Administrative Officer, Psychiatry
- (B6) Deputy QMO, VISN 18
- (B6) QMO, VISN 18
- (B6) (attended in person at the SE CBOC)

V. Findings, Conclusions, and Recommendations

Allegation 1

Schedulers in the SE CBOC-MH have rescheduled and cancelled patients' appointments without their knowledge and failed to reschedule cancelled appointments.

Background

VHA Directive 2010-027, (June 9, 2010) *VHA Outpatient Scheduling Processes and Procedures,* and a subsequent memorandum update, VHA Memorandum, Acting Deputy Under Secretary for Health for Operations and Management, June 8, 2015, CORRECTION: *Clarification of Veterans Health Administration (VHA) Outpatient Scheduling Policy and Procedures and Interim Guidance,* and *Attachment A, Outpatient Scheduling Operating Procedures* (hereinafter "June 8, 2015, *Clarification*") provide policy direction related to VHA scheduling practices. The scheduling practices pertaining to allegation 1 are outlined below.

Schedulers, also known as MSAs, play an important role in the appointment process and in a patient's access to outpatient care. MSAs must consider patient input and preference when making all appointments, including when rescheduling patients who do not report for their appointments, known as "no-shows." The MSA is not allowed to "blind schedule" an appointment, which means to make it without the input of the patient. VHA has an established process for contacting and rescheduling patients who are no-shows. When the patient fails to keep a scheduled appointment, the MSAs make three attempts to reach him or her to reschedule it. They make two telephone

calls and send one letter, all on separate days, and then wait 14 days for the patient to respond.

As part of the process for cancelling appointments, MSAs are required to indicate whether the cancellation was at the request of the patient (cancelled by patient) or clinic staff (cancelled by clinic).

VHA measures wait times based on the patient's preferred date or the clinically-indicated date (CID) as the first reference point and the pending or completed appointment date as the second reference point. It is important that the scheduler accurately document the reason for cancellation in the electronic health record (EHR) to reflect the true patient wait time. When the patient cancels an appointment, the first and second reference points change to reflect the patient's desired appointment date and the new pending appointment date, allowing for the accurate calculation of the true wait time. When cancelled by the clinic, the second reference point is unchanged resulting in a longer wait time.

Findings

Scheduling Review

The whistleblower referenced in her letter to OSC, and during her interviews, that in March 2015, patient no-shows began to occur in approximately 50 percent of her daily scheduled appointments. She estimated that this represented 80 to 100 patients per month, and that this continued until November 2015.

VA reviewed the whistleblower's appointments in her two assigned clinics from March 2 through October 2, 2015, totaling 1,468 scheduled appointments. During this time, 164 (11 percent) of these appointments were considered no-shows. VA found a high number of multiple (three or more) no-shows and/or appointment cancellation groupings, suggesting inconsistent scheduling practice. To further provide an indication of scheduling practice, we reviewed the appointment history surrounding the no-show appointments that occurred during the referenced time period. Fifty-four (40 percent) of the no-show appointments were either preceded or followed by two or more appointment cancellations or no-shows. There were several instances where the patient was scheduled for two appointments in the same clinic on the same day. These dual appointments were either documented as two no-shows or as a cancellation by patient and a no-show. While VA found these irregularities, we also found that many appointments were scheduled during the patient's prior visit and appropriately included documentation of a face-to-face conversation where the patient's appointment preferences were incorporated. Of the 164 no-show appointments, 16 (10 percent) appointments were neither rescheduled nor completed within 3 months.

In an attempt to discover the cause of the no-shows, the whistleblower stated that she spoke with her patients, and some reported that SE CBOC-MH MSAs told them that the whistleblower would no longer be assigned as their provider, and that they should not

request any additional appointments with her. At the time of her interview, the whistleblower did not identify a specific person; however, one MSA interviewed informed us that 1 month prior to the whistleblower leaving the facility, his supervisor instructed him to reassign her patients to another provider because, according to the Section Chief, Psychiatry, and the Chief, Outpatient Psychiatry, she would be leaving. The Section Chief and Chief did not want to leave her patients without an assigned provider.

During her interview, the whistleblower also stated that when providers took scheduled leave, MSAs cancelled their patient appointments but documented them as cancellations by patient. In addition, the whistleblower reported that in April 2015, when returning to work after 1 week of leave, she determined that rather than indicating in the EHR that her appointments were cancelled by clinic, her records noted that many of the appointments were cancelled by patient.

VA reviewed 151 clinic appointment cancellations that occurred during the whistleblower's approved leave between February and September 2015. One hundred thirty six (90 percent) of her appointments were cancelled by the clinic and 15 (10 percent) by the patient. VA also found that the MSAs had correctly documented and recorded the reasons for the appointment cancellations. In addition, during interviews, all SE CBOC-MH MSAs and their supervisor correctly outlined the appointment cancellation process.

The whistleblower requested the team to review appointment clinic cancellations of providers whose clinics were cancelled when they did not work December 26, 2014, to determine whether the appointment cancellations were correctly recorded. She provided the names of two clinics. Upon review, we found that the clinics were previously blocked because the providers had requested and received approval for annual leave before the clinic schedule was populated. The two clinics were appropriately managed, and no patient appointments were cancelled.

The whistleblower also provided VA with a list of 23 specific appointments that she stated were inaccurately documented as cancellations by patient based on her review of the EHR. VA reviewed these appointments and did not find any conclusive evidence of appointments that were inaccurately documented as cancellations by patient. A breakdown of reasons for cancellation for these 23 appointments includes 10 (43 percent) cancellations by patient, 3 (13 percent) cancellations by clinic, and 9 (39 percent) no-shows. VA found that the MSAs properly recorded the reasons for patient cancellations, as required per VHA policy.

The whistleblower reported that she repeatedly reached out to the SE CBOC-MH MSAs and their supervisor to address their scheduling process, but she asserts that she was ignored. She stated that she complained about the MSAs multiple times to their previous supervisor, who no longer works at the facility but had not taken it to Medical Center leadership.

Staffing

All staff members interviewed during our site visit reported concerns about MSA staffing shortages and chronic turnover, which negatively impacts the scheduling processes. VA found that the SE CBOC-MH, and the Medical Center throughout, has a chronic shortage of MSA staff. According to HAS, there are a total of 71 MSA vacancies throughout the Medical Center including inpatient units, Patient Aligned Care Teams (PACT), Specialty Clinics, Call Center, and Health Benefits and Processing (HB&P), including 13 SE CBOC vacancies (PACT and Specialty), of which there are 5 MSA vacancies for the SE CBOC-MH. The Chief HAS and Acting HRO spoke of the problem with hiring quality MSAs and reported a turnover rate of 6.8 percent for MSAs throughout the Medical Center. In addition, VA found that the Medical Center did not have a current approved organizational chart that showed the authorized number of MSA full time employee equivalents (FTEE). One MSA stated that "blind scheduling happens from time to time," due to understaffing, and therefore, they have to take shortcuts. A second MSA voiced concerns over the number of electronic alerts she received daily and stated that it is not always possible to get them all done.

Training

Another issue impacting the scheduling process is the training of the MSAs. At the time of our site visit, there were three MSAs assigned to the SE CBOC-MH. All of these MSAs reported having completed the initial training required of all VHA schedulers; however, two of the three reported very little or no training of the updated scheduling processes included in the June 8, 2015, *Clarification*. VA reviewed the training records of these SE CBOC-MH MSAs and found evidence of training in the Talent Management System (TMS), but when asked about VHA Directive 2010-027, and its June 8, 2015, *Clarification*, they were unaware of the changes and how these impacted their duties. VA also found that these MSAs were not scheduling correctly regarding the entry of the CID for new and established patients. The updated policy mandated that staff involved in scheduling appointments should receive training on the scheduling changes by August 1, 2015, and that these changes be implemented into the scheduling process within 90 days of June 8, 2015. We found that the SE CBOC-MH providers were not using CID dates or specific Return to Clinic (RTC) orders per policy, and that some mental health providers and RNs were unaware of the scheduling changes.

To ensure that all schedulers at the Medical Center and its CBOCs are trained in current processes, the SE CBOC had been scheduled to receive updated refresher training on June 8, 2015, but that training did not occur. As of November 17, 2015, the SE CBOC-MH MSAs were not trained in these scheduling changes. The responsibility for ensuring that all SE CBOC-MH MSAs receive appropriate training rests upon the Acting Chief, HAS.

Conclusions for Allegation 1

- VA **substantiated** the allegation that some schedulers in the SE CBOC-MH have rescheduled and cancelled some patients' appointments without their knowledge through a prohibited practice known as blind scheduling.

- The Medical Center's scheduling policy did not incorporate the most recent *Clarification* in scheduling processes established by VHA on June 8, 2015.

- The SE CBOC-MH MSAs, mental health providers, and RNs have not been trained on the scheduling practice updates in the June 8, 2015, *Clarification.*

- There is a staffing shortage and high turnover of MSAs at the Medical Center and the SE CBOC-MH that may negatively impact scheduling practices and the safe provision of patient care.

Recommendations to the Medical Center:

1. Immediately provide updated education and training for all SE CBOC-MH MSAs on the scheduling policy updates contained in the June 8, 2015, *Clarification*, and make sure all mental health providers and RNs receive updated education and training, as well.

2. Fill all MSA vacancies throughout the Medical Center and SE CBOC-MH.

3. Continue to conduct MSA scheduling audits to ensure they are appropriately executing scheduling policy and practice and include follow-up or corrective actions when the requirements are not met. Utilize the Scheduling Trainer to maintain an aggressive and robust program to ensure that new and current schedulers are aware of VHA scheduling processes.

4. Conduct a focused review of scheduling practices and remediation of Medical Center and all CBOC MSAs, specifically on rescheduling missed appointments.

5. Determine the accountability of the Acting Chief, HAS, with regard to failing to ensure all MSAs are trained in updated scheduling processes.

Allegation 2

Patients presenting at the SE CBOC-MH in times of mental health crisis are not triaged appropriately and are scheduled for evaluations weeks after they present.

The whistleblower specifically asserted that many no-shows were patients who were self-referred and walked into the SE CBOC-MH during a mental health crisis. Her review of records found that rather than performing appropriate triage on these individuals and scheduling them for an evaluation as soon as practicable, MSAs

scheduled them 2 to 3 weeks after they presented at the clinic. These individuals did not appear at the time of their scheduled evaluation, and there were no subsequent clinical interactions with them. She asserted that individuals experiencing self-perceived mental health crises accounted for 60 to 80 percent of the total no-shows she observed.

Findings

VA reviewed the process for patient entry into the SE CBOC-MH. Upon entering the facility, scheduled patients make initial contact with an MSA assigned to the check-in desk. If the Veteran is an established patient with a scheduled appointment, the MSA alerts the mental health provider or RN by instant messaging, verifies the patient's identification, and electronically retrieves his or her appointment information. The MSA prints an encounter form for the patient to take to the provider. After the appointment, the mental health provider writes a follow-up appointment order for the patient to return to clinic at a CID, and the MSA schedules the follow-up appointment.

MSAs interviewed described the process for unscheduled patient visits. When unscheduled patients come to the SE CBOC-MH, the MSA discretely asks the patient about suicidal or homicidal thoughts, and immediately notifies an RN or mental health provider if the Veteran replies in the affirmative. If necessary, the MSA sits with the patient until an RN or mental health provider is available. In the past, a Medical Assistant (MA) was assigned to sit with any patients requiring one-to-one observation for suicidal or homicidal thoughts until an RN or mental health provider was available; however, the MA position is currently vacant.

Unscheduled patients who are not suicidal or homicidal are asked to complete a "Walk-In Screening" form that includes the patient's personally-identifiable information, updated contact information, and the reason for the unscheduled visit. If they have previously been seen at the SE CBOC-MH, the name of their mental health provider is also requested, along with the date of their last visit. If the Veteran is an established patient, the MSAs will contact an RN to further screen and triage the Veteran, or they contact the assigned mental health provider who makes arrangements for the patient to be seen. If the Veteran is not an established patient, the MSA assigns him or her to the mental health provider next in line for a walk-in patient.

VA found that the SE CBOC-MH does not have written guidelines, policies, or an SOP addressing unscheduled patients. The SE CBOC Primary Care (PC) clinic has clearly written policies and SOPs describing its process for managing these visits; however, the September 21, 2015, Medical Center Memorandum *SOP for Triaging Walk-In/Unscheduled Patients* does not take patients presenting to mental health into consideration. The SOP addresses the PC setting only. In addition, the Medical Center's March 2014 Scheduling Policy is out of date and does not include the June 8, 2015, *Clarification*. In accordance with the VHA Memorandum, Acting Assistant Deputy Under Secretary for Health for Operations and Management for Clinical Operations, July 3, 2012, *CBOC Mental Health Operations*, all VA-operated and

contract CBOCs must have a plan that defines how mental health emergencies that require a higher level of care are addressed.

VA interviewed the RN Nurse Manager and three RNs assigned to the SE CBOC-MH. All stated that RNs assigned to the SE CBOC-MH do not routinely triage unscheduled patients, since they are usually busy with their own scheduled patients; however, they all said that they would immediately respond if a patient presented to the clinic in mental health crisis. All SE CBOC-MH staff interviewed, including the psychiatrists, psychologist, RNs, and MSAs said that unscheduled patients, especially patients in mental health crisis, are never sent away without being appropriately triaged and treated.

VA reviewed the EHRs for all unscheduled patients who presented at the SE CBOC-MH between August 25, 2014, and January 2, 2015. All 350 were screened and seen by a mental health provider and/or an RN. The whistleblower saw 11 (3 percent) of the total walk-ins.

Conclusions for Allegation 2

- VA **did not substantiate** that patients presenting at the SE CBOC-MH in times of mental health crises are not triaged appropriately or are scheduled for evaluations weeks after they present.

- The SE CBOC-MH did not have an SOP for triaging and managing unscheduled patients, and there were no written guidelines, policies, or procedures to guide staff members in this process.

Recommendations to the Medical Center:

6. In accordance with the VHA Memorandum, Acting Assistant Deputy Under Secretary for Health for Operations and Management for Clinical Operations, July 3, 2012, *CBOC Mental Health Operations*, develop a local policy with corresponding SOPs for triaging and managing unscheduled patients in the SE CBOC-MH.

7. Fill the SE CBOC-MH Medical Assistant vacancy or assign clinical responsibility for directly observing Veterans with suicidal or homicidal thoughts to other clinical staff members to ensure patient safety.

Additional Allegations

A psychiatrist failed to examine an admitted patient in a timely manner and employees were engaging in professional conduct that may constitute a violation of law, rule, or regulation; gross mismanagement; abuse of authority; and a substantial and specific danger to public health.

The whistleblower reported that a patient was admitted from the ED to the inpatient psychiatry unit on a Friday and was not evaluated by the in-house psychiatrist until Monday.

Findings

Medical Center Policy #11-70, Article XIII of the Medical Center Bylaws, *History and Physical (H&P)*, mandates that a complete inpatient admission examination must be available within 24 hours of admission. In addition, Article XXIV of the Medical Center Bylaws, *Treatment Planning*, states that an initial treatment plan, documented by the clinician, must be established on all patients within 24 hours of admission for acute care.

The whistleblower stated that on July 10, 2015, a patient who was seen in the Medical Center ED was admitted, by verbal order of the psychiatrist on-call, to the inpatient psychiatry unit. She further said that the patient was not evaluated face-to-face by the in-house psychiatrist until July 13, 2015, instead of within 24 hours of admission, as required by VA policy for completion of the patient's mental health history, assessment, and plan of treatment.

VA conducted a comprehensive review of this admission in the Veteran's EHR and found evidence that the patient was not seen and examined by a staff psychiatrist within 24 hours of admission, which violates Medical Center Bylaws. VA found no evidence of harm to the patient due to this delay in evaluation and treatment; however, there was a potential for patient harm.

Conclusion for Additional Allegation

- VA **substantiated** that a psychiatrist failed to examine an admitted patient or implement an initial treatment plan within 24-hours of admission, which violates Medical Center Bylaws. These Bylaws govern professional medical practice. Any violation of the Bylaws requires the initiation of an FPPE.

Recommendations to the Medical Center

8. Initiate an FPPE on the psychiatrist who was assigned to admit patients from the ED to inpatient psychiatry on July 10 and 11, 2015.

9. Review Medical Center Bylaws pertaining to the duties of admitting psychiatrists with the psychiatrist assigned to the case reviewed and ensure that all psychiatrists with admitting privileges are aware of the admission requirements.

10. Conduct an audit of medical records for Friday and Saturday admissions to inpatient psychiatry during FY 2015 by all psychiatrists to ensure that this is not a systemic issue, and that they are in compliance with the bylaws.

Summary Statement

VA has developed this report in consultation with other VHA and VA offices to address OSC's concerns about the Medical Center's possible violation of law, rule, or regulation; gross mismanagement; abuse of authority; and a substantial and specific danger to public health. In particular, OGC has provided a legal review, VHA HR has examined personnel issues to establish accountability, and OAR has reviewed the report and has or will address potential senior leadership accountability. VA's investigation and review of its findings revealed violations of VHA policy, and these violations pose a potential danger to public health.

Attachment A

Documents Reviewed by VA:

1. VHA Handbook 1907.01, March 19, 2015, *Health Information Management and Health Records.*

2. VHA Handbook 1160.01, September 11, 2008, Amended November 16, 2015, *Uniform Mental Health Services in VA Medical Centers and Clinics.*

3. VHA Memorandum, Acting Deputy Under Secretary for Health for Operations and Management, June 8, 2015, CORRECTION: *Clarification of Veterans Health Administration (VHA) Outpatient Scheduling Policy and Procedures and Interim Guidance,* and *Attachment A, Outpatient Scheduling Operating Procedures.*

4. VHA Memorandum, Acting Deputy Under Secretary for Health for Operations and Management, May 18, 2015, *Clarification of Veterans Health Administration (VHA) Outpatient Scheduling Policy and Procedures and Interim Guidance.*

5. VHA Memorandum, Acting Assistant Deputy Under Secretary for Health for Operations and Management for Clinical Operations, July 3, 2012, *CBOC Mental Health Operations.*

6. Medical Center Policy #11-70, May 23, 2014, *Rules & Regulations of the Medical Staff, Article XXIV.* Treatment Planning, page 27.

7. Medical Center Policy #11-70, May 23, 2014, *Rules & Regulations of the Medical Staff, Article XIII.* History & Physical (H&P), page 18.

8. Medical Center Policy Memorandum No. 116A-03, October 16, 2013, *Management of Mental Health Patients Who Do Not Appear for Scheduled Appointments.*

9. Medical Center Policy Memorandum No. HAS 136-83, March 6, 2014, *Scheduling Policy.*

10. Medical Center Policy Memorandum No. HRMS/05-17, July 1, 2011, *Leave Policies.*

11. Medical Center Policy Memorandum No 11-07, June 5, 2012, *Clinic Cancellations.*

12. SE CBOC Primary Care Services, SOP, October 8, 2014, *Unscheduled Triage.*

13. SE CBOC Primary Care Services, SOP, September 21, 2015, *Triaging Walk-Ins.*

14. Psychology SOP, November 15, 2013, *Mental Health Scheduling.*

15. Medical Center HAS Organizational Chart, December 8, 2014.

16. Mental Health & Behavioral Science Service (MH&BSS), February 18, 2015, current Organizational Chart.

17. MH&BSS, November 5, 2015, Proposed Organizational Chart.

18. Medical Center Nursing Service, May 4, 2015, Organizational Chart.

19. Medical Center Clinic, June 15-October 2, 2015, Appointment Availability Report.

20. Medical Center VSSC Outpatient Visits and Uniques FY2015.

21. Summary Count of All Appointments with Mental Health stop codes 502 and 509 completed during January 1-December 31, 2014, and Appointments completed as Unscheduled/Walk-in from April 2014-September 2015.

22. Medical Center Cancelled & Future Appointments by Clinic Report.

23. E-mail documents of November 10, 11, 12, and December 1, 2015, from the whistleblower.

24. Medical Center Trip Pack. October 2015.

25. Mental Health MSA's Competency and Education folders.

26. Appointment Audit Detail Report (Scheduling Audit), June 1–November 18, 2015, on MSAs.

27. MSA recruitment information, November 19, 2015.

28. Patient Advocate Tracking System Complaints for Mental Health Service at the SE CBOC, January 2014–September 2015.

29. SE CBOC Unscheduled Visit Roster, July 7–November 16, 2015.

30. Medical Center's Functional Statement for General Psychiatry Physician.

31. Veterans' Electronic Health Records.