Whisleblower Comments

Elaine Ramos, DO, DABPN, FAPA

OSC File No. DI-15-5392

Introduction

I write to provide comments in response to the written report of the VA investigation. I believe the investigation remains incomplete and provide the following information to aid in that determination.

Allegation 1 – Response to Findings

- The findings cite "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 . . . 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 (Dr. Elizabeth Munshi), and the Chief, Outpatient Psychiatry (Dr. Amanda Cattelino), she would be leaving. The Section Chief and Chief did not want to leave her patients without an assigned provider."

There is no discussion here that the whistleblower had not resigned and did not have any plans of leaving her position with the Phoenix VA HCS. It also does not mention that the whistleblower was working full-time, and reporting to work daily to see her existing panel of patients, that patients were asking to be seen by the whistleblower, complaining that they did not want another provider, and requesting that their follow-up appointment not be changed or rescheduled with another provider, that patients were informing the whistleblower that they were being informed that she would no longer be working for the Phoenix VA HCS and being seen by the whistleblower after demanding that their appointment with her not be changed, that patients were upset that they were being informed that she would not be their provider and making it to their appointment after many efforts only to find that they were misinformed and able to see their existing and preferred provider the whistleblower, and that patients would be reassigned as arranged by management upon the departure of a provider and not prior as it would be a gross waste of funds to have more than one provider on staff to provide care to the same panel of patients leaving one provider with nothing to do while employed full-time with the agency.

- The findings cite "during interviews, all SE CBOC-MH MSAs and their supervisor correctly outlined the appointment cancellation process".

This is not particularly relevant since correctly outlining the appointment cancellation process is not consistent with their <u>actual</u> practice of cancelling appointments as whistleblower has alleged.

- The findings cite "December 26, 2014 . . . she provided the names of two clinics".

The whistleblower provided the names of two providers whose clinics should be reviewed and provided the names of two or three clinics for each provider. Each of these providers has an intake clinic (scheduled 7-14 days in advance), a follow-up clinic (scheduled days to months in advance), and an urgent clinic (scheduled 1-2 days in advance). It is unclear to the whistleblower which two clinics were

looked at, but given the fact that this date was declared a federal holiday late in the year it is highly likely that the clinics that were examined were those that are scheduled close to appointment dates and not those that are booked months in advance. Additionally, the Section Chief, Psychiatry (Dr. Elizabeth Munshi) has noted that the policy is that no more than two providers be approved for leave at the same time. It is highly unlikely that she would have knowingly approved leave for two providers in addition to a third provider who was not scheduled to work on Fridays during the holiday season, which is a timeframe known to have a high volume of patients seeking to be seen for mental health services. This would have left only two of five providers in the clinic to provide scheduled and walk-in coverage for the clinic in times of high-demand.

- The findings cite "23 specific appointments . . . did not find any conclusive evidence of appointments that were inaccurately documented as cancellations by patient . . . VA found that the MSAs properly recorded the reasons for patient cancellations."

These findings do not indicate whether these patients were actually contacted by the VA to confirm that they had indeed cancelled their appointments.

- The findings cite "reported that she repeatedly reached out to the SE CBOC-MH MSAs and their supervisor to address their scheduling process . . . to their previous supervisor, who no longer works at the facility but had not taken it to the Medical Center Leadership".

The MSAs and their supervisor, who were previously cited in the report to have "correctly" outlined the appointment cancellation process, were not actually following the scheduling process, the supervisor was not holding them accountable for this, and management apparently had no oversight of their activities. The report does not address this issue.

Allegation 1 – Response to Staffing

- The staffing section cites "MSA staffing shortages and chronic turnover, which negatively impacts the scheduling processes . . . there are 5 MSA vacancies for the SE CBOC-MH . . . 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".

The SE CBOC-MH clinic was fully staffed with MSAs during whistleblower's tenure there when from August 2014 to October 2015 there were at least two MSAs and from August 2014 to April 2015 there were at least three MSAs who were seasoned MSAs - a total of three to five MSAs at any given time. As a matter of fact, the three seasoned MSAs were all hired April 2014 and underwent training at the same time per their report and a fourth seasoned MSA had been serving in that capacity for years. Two of the three worked in MH from the get-go and the third requested a transfer to MH and was the MSA team lead upon her transfer from the main facility MH clinic to the SE CBOC-MH clinic. The main facility has three to four MSAs for at least twice as many providers than the number of providers at the SE CBOC-MH clinic, as well as a walk-in clinic that alone sees about 40 patients daily in addition to all scheduled patients. While whistleblower was at the main facility MH clinic, it never seemed to have the scheduling problems that are evident at the SE CBOC-MH. From the whistleblower's standpoint, there was no shortage of MSAs at the SE CBOC-MH. However, there was a lack of accountability on the part of the

MSAs, a lack of following policy, and a lack of oversight on the part of management. There was not a "shortage" to justify taking "shortcuts" that are clearly prohibited scheduling practices – especially when everyone knows the correct process.

Allegation 1 – Response to Training

- The training section cites "another issue impacting the scheduling process is the training of the MSAs".

The whistleblower notes that Section Chief, Psychiatry (Dr. Elizabeth Munshi) stated and Team Lead SE CBOC-MH, Psychiatry (Dr. Himanshu Patel) reiterated that management cited that they would not implement the new scheduling/cancellation policy despite their awareness of it. The reason for not implementing the new policy was not clear, but all providers were directed by management to not follow it and MSAs expressed appreciation since this would only add to their electronic alerts received daily that they were not getting to, even without the implementation of this new policy. Whistleblower verbalized during bimonthly SE CBOC-MH team meetings that this new policy placed a burden on everyone, but that every precaution needed to be taken to always do that which is beneficial to the Veterans served. The expression of this sentiment was not well-received. It is whistleblower's opinion that bypassing the new policy makes it easy to limit the ability to track scheduling practices and management was in favor of this. This was not a lack of training, but a lack of management of staff from management officials who were ignoring the new policy.

Allegation 2 – Response to Findings

- The findings cite "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".

The SE CBOC opened its doors in April 2014 and to the knowledge of whistleblower there was never an MA on-site from its opening to her departure. Additionally, management stated on several occasions at the bimonthly SE CBOC-MH team meetings that there were plans to hire an MA but there wasn't a place in the clinic to assign the MA to for the practical purpose of having the MA work out of (an office) and so there wasn't any push to hire one despite the dire need for one for patient safety.

- The findings cite "if the Veteran is an established patient, the MSAs will contact the 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 . . . 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."

Whistleblower notes that these statements appear contradictory and it is not clear if the RNs are or are not triaging patients. Additionally, management stated that RNs were to triage all patients asking to be seen and that that was why they had every hour set up as follows: one 30-minute slot for scheduled appointments and one 30-minute slot for unscheduled walk-ins to be seen (every hour included a 30-

minute window set aside exclusively for the purpose of seeing walk-ins). However, RNs working 4 days per week including Saturdays were seeing an average of 5 patients per day on weekdays and usually 0 on weekends in their clinics, and, to the knowledge of whistleblower, these RNs were on compressed schedules.

- The findings cite "all SE CBOC-MH staff interviewed . . . said that unscheduled patients, especially patients in mental health crisis, are never sent away without being appropriately triaged and treated."

This statement is self-serving and completely unsupported. Whistleblower would like to know how the report is defining "mental health crisis" in this context and who is deciding what is or is not a "mental health crisis". A "mental health crisis" is not limited to being suicidal or homicidal. At the main facility, every patient who presents to the MH clinic is seen by a provider after checking in with an MSA. This is not true at the SE CBOC-MH clinic. Who gets checked in and is seen at the SE CBOC-MH clinic by a provider is at the complete discretion of the MSAs. At the SE CBOC-MH clinic, patients asking to be seen by a provider for a same-day evaluation who are unassigned are turned away, given an intake appointment within 7-14 days, and then often not making it to their future appointment. Whistleblower suggests that patients scheduled into her clinic, who were then listed as "no-shows" for intakes, be contacted in order to substantiate allegation 2.

- The findings cite "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."

It is unclear to whistleblower how many of these 350 unscheduled patients or walk-ins were assigned vs. unassigned – a key distinction. The fact that whistleblower saw 11 of 350 or 3% of total walk-ins is likely a reflection of a low number of walk-ins for her assigned patients. The lower the number of assigned walk-ins a provider has the better, because this means the provider's assigned patients are being managed appropriately on an outpatient basis. The number of unassigned walk-ins are supposed to be shared equally among psychiatrists according to a roster with each psychiatrist's name in a particular order that is filled in one at a time. There are five psychiatrists on the roster and an average of one unassigned walk-in patient a month per provider noted on the roster. Whistleblower saw her full fair share of unassigned walk-ins – which were often simply added to her list of patients without even being rotated through the various providers according to the roster. If unassigned walk-in patients were to all be added to the walk-in roster upon presentation to the SE-CBOC MH clinic and distributed equally among the five psychiatrists, then there would be a far greater number of walk-ins listed on the roster and lesser number of no-shows for follow-up appointments in the whistleblower's clinics than actually appear there. This signifies that whistleblower was scheduled to see a far larger share of unassigned walk-in patients, and this share is not being accounted for in the percentage of walk-in patients cited to have been seen by whistleblower in this report. These patients also contributed to a significant number of no-shows in the whistleblower's clinics.

In contrast, the reason for the many assigned walk-ins was often due to the inappropriate cancelling and/or blocking of clinics, where patients had their appointments canceled and had to subsequently

"walk in" to see their usual provider. As noted previously, there so many unscheduled walk-ins that they were scheduled for 30 minutes of every hour.

Whistleblower is aware of a "Walk-In Screening" form for all walk-in patients at the main facility MH clinic, but not at the SE CBOC-MH clinic. It is impossible to "discretely" ask about suicidal or homicidal thoughts at a check-in window in the small patient waiting area at the SE CBOC-MH clinic. Whistleblower also notes the term "provider" seems to be used here as a substitute for "psychiatrist;" however, it should be noted that in mental health a provider can be a nurse, psychologist, pharmacist, psychiatrist, etc., and the usage is not clear in this report. Unscheduled assigned and unassigned walk-in patients should be triaged the same way because a "mental health crisis" does not distinguish one from the other.

Additional Allegations – Response to Recommendations to the Medical Center

It may be useful to obtain copies of the disciplinary action involving the staff member/s (Dr. Amanda Cattelino, others) mentioned in the report.