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.

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 PRACTICESIN 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 Antoineo, 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 Antoineo 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 Antoineo, 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.