THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

October 27, 2017

The Honorable Joni K. Ernst
United States Senate
Washington, DC 20510

Dear Senator Ernst:

Thank you for your October 19, 2017, co-signed letter to the Department of Veterans Affairs (VA) regarding a recent internal audit of the VA Nebraska-Western Iowa Health Care System (NWIHCS) which revealed that employees there kept an unauthorized waiting list of patients from Nebraska and Iowa, obscuring actual wait times for Veterans. The NWIHCS Director ordered the investigation by the organization's compliance officer after concerns from employees were brought to leadership's attention that a waiting list not authorized by the Veterans Health Administration's (VHA) Scheduling Directive 1230, Outpatient Scheduling Processes and Procedures, was being used for Veterans requiring psychotherapy consults.

Throughout the period in question, VA NWIHCS staff used the approved Electronic Waiting List (EWL) tool for tracking psychotherapy consults. The staff also used a tracking spreadsheet of EWL Veterans to track patient priority and contact efforts; the spreadsheet was not authorized by VHA's Scheduling Directive 1230. As part of its internal investigation, VA NWIHCS identified training deficiencies in Mental Health staff that led to improper use of the EWL; a copy of the internal audit is enclosed. As a result of those training deficiencies, 87 Veterans encountered delays from employees improperly managing the EWL and tracking spreadsheet in spring 2017. These Veterans were referred for psychotherapy by their psychiatric providers, who continued to follow them during this time period. They also engaged in a variety of other Mental Health services during this time period, including substance abuse treatment, post-traumatic stress disorder treatment, inpatient treatment (if necessary), and counseling through our primary care or Veteran's Center resources. Additionally, the VA NWIHCS has long maintained same-day walk-in services for Mental Health urgencies or emergencies that were available, as needed, to Veterans. Nevertheless, the management of these psychotherapy referrals during the spring 2017 timeframe was handled poorly and did not meet the standards of the VA Health Care System.

VA employees not following VHA's Scheduling Directive 1230 is an issue we take very seriously. One employee who was involved retired and one resigned. An investigation is ongoing into the culpability of additional subordinate employees. The investigation is scheduled to be completed by the end of the month. Appropriate disciplinary action will be taken if warranted.

VA has also taken additional steps to ensure that this does not happen again. For example, new leadership was brought in to the NWIHCS Mental Health Service Line to ensure that employees follow VHA Scheduling Directive1230, and ensure all of our Veterans continue to receive timely, high-quality health care. Moreover, facility leaders held a town hall meeting with Mental Health Clinic staff on August 2, 2017, outlining the plan to become compliant with the scheduling directive. Also, remedial scheduling directive training was provided electronically to NWIHCS Mental Health medical support assistants (MSAs) and weekly audits are being conducted for each MSA.

We want our Veterans to have full confidence that they are receiving the highest-quality health care at VA. Our highest priority in VA has been to ensure we meet the health care needs of the Veterans whom we service in a timely manner. VA has been clear about the importance of transparency, accountability, and rapidly fixing all problems brought to our attention. Leadership at VA NWIHCS is applying these principles to this situation

Thank you for your continued support of our mission. Should you have further questions, please have a member of your staff contact Mr. Bailey Jackson, Congressional Relations Officer, at (202) 461-7128 or by email at James.Jackson25@va.gov. A similar letter has been sent to Senator Grassley.

Sincerely,

David J. Shulkin, M.D.

Enclosure

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The Honorable Charles E. Grassley
United States Senate
Washington, DC 20510

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Sincerely,

David J. Shulkin, M.D.

Enclosure

Department of Veterans Affairs

Memorandum

Date: August 11, 2017

From: (b) (6) [redacted] NWIHCS

Subj: Mental Health EWL Audit

To: Don Burman, Director, NWIHCS

1. As part of the external review of the scheduling process within NWIHCS Mental Health Psychotherapy clinic, a request was made by (b) (6) [redacted] (b) (6) [redacted] to pull a report to include all patients that were in the stop code 502 electronic wait list (EWL) between August 2016 and August 2017.

2. In a joint effort between Compliance, Quality Management and the Data Management team, it was decided to pull the information from the VSSC EWL data cube. The report resulted in 301 unique Veterans pulled by the EWL Originating Date between August 2016 and August 2017.

3. The data was divided between the (b) (6) [redacted] and six Quality Management staff members. 100% of the 301 Veterans were reviewed.

4. Results:

   a. 12 EWL entries from August 2016 – December 2016.
   b. 289 EWL entries from January 2017 – August 2016.
   c. 19 EWL entries did not have an O/Psychotherapy consult
   d. 44 EWL entries do not have a disposition date
   e. 160 EWL entries were dispositioned in less than 30 days
   f. 92 EWL entries were dispositioned in less than 10 days
   g. 5 Veterans were entered on the EWL three times for same consult
   h. 68 Veterans were entered on the EWL two times for same consult

5. Observations:

   a. There is a delay from the consult create date to first contact with the Veteran recorded on the consult. It may indicate another document source was being used for tracking.
   b. If the Veteran opts in to the Veteran's Choice Program and a Choice consult is created, the internal consult is discontinued prior to knowledge of Veteran receiving an appointment in the community.
   c. There appears to be very few EWL entries from August 2016 – December 2016.
   d. There are no comments by a clinician on the consult prior to MSA discontinuing a consult.

e. It appears that all Veterans are currently being added to EWL prior to scheduling attempt instead of following VHA Scheduling Directive 1230.

6. In addition to the EWL report, a review of the two excel spreadsheets from Mental Health were reconciled against the EWL report.

   a. January 13, 2017 excel list included 67 names
      i. 47 names had been added to the EWL
      ii. 20 names had not been added to the EWL due to being appointed timely, declined care or no response to scheduling attempts.
   b. June 27, 2017 excel list included 87 names
      i. 87 names had been added to the EWL

7. Currently, a more thorough review of the audit comments is being conducted to ensure that outliers are identified for immediate action.

8. Please contact me if you have any further questions. I can be reached at 402-995-(b) (6)

(b) (6)

cc (b) (6)
Dr. David Williams, Chief of Staff

Attachments: EWL MH-502 20160801-20170808 Review