

**STATEMENT OF JOSE MATHEWS, M.D., CHIEF OF PSYCHIATRY, ST.
LOUIS, VA
BEFORE THE UNITED STATES HOUSE OF REPRESENTATIVES
COMMITTEE ON VETERANS' AFFAIRS**

**OVERSIGHT HEARING ON VA WHISTLEBLOWERS: EXPOSING
INADEQUATE SERVICE PROVIDED TO VETERANS AND ENSURING
APPROPRIATE ACCOUNTABILITY**

Tuesday, July 8, 2014

Time: 7:30 pm

Place: Room 334, Cannon House Office Building

Executive Summary

Since the tragic events of September 11, 2001 and our country's involvement in Afghanistan and Iraq, millions of troops have deployed overseas in the interest of protecting our nation and advancing others. Although the VA was charged with the responsibility of providing services to generations of veterans, it has only been in the most recent years that mental health care treatments for conditions like PTSD have been better understood with modalities of treatment reaching heightened rates of efficacy. We know now that with proper treatment of mental health concerns, joblessness, homelessness, and suicide risk can be mitigated and in some instances eliminated. And it is from this perspective that the VA's role in treating veterans should be evaluated.

It is the responsibility and duty of the federal government to provide these esteemed service members with the best health care possible.

I can only speak from my personal experiences and observations as the Chief of Psychiatry at the St. Louis VA. There, the healthcare system as currently exists, has proven only to be a maze of bureaucracy and red tape for veterans to weave through upon their return home. Instead of being provided with the immediate medical treatment and VA related benefits they are entitled to, the St. Louis, VA has failed the same vulnerable population it was designed to serve.

The men and women who have so bravely served our country deserve a system that will be responsive and efficient; and more importantly, will not fail them. The only way to ensure effective and timely access to health care is to provide transparency and to create objective metrics that evaluate the care that is provided on a regular. Perhaps more poignantly, the existing resources to provide this care is simply not being managed effectively.

There are several initiatives I would like to propose that will improve access and quality of health care afforded to veterans. These initiatives include: (i) objective metrics to increase transparency; and, (ii) ensuring accountability by amending the Whistleblower Protection Enhancement Act, which has proven inadequate for whistleblowers who make allegations regarding risks to veteran health and safety.

These recommendations will provide a paradigm to ensure that the quality of care is not only maintained but exceeded. The Department of Veterans Affairs should be a world leader in the treatment of combat related medical conditions; not an institution where mismanagement and indifference breaches a community's prevailing standard of care.

STATEMENT OF JOSE MATHEWS

Mr. Chairman and distinguished members of the committee: I am honored to appear before you today to speak about my experiences while serving in the capacity as the Chief of Psychiatry with Department of Veterans Affairs in St. Louis, Missouri.

In order for you to better understand my connection and interest in veteran related health care matters; I would like to provide you with some brief information about myself. I am a first generation immigrant from India and my father is a combat veteran of the Indian Army. I am well acquainted with the aftermath of a war and the toll it takes on the warrior and their family. I have had a longstanding interest in understanding mental illness, particularly mood disorders and trauma related illnesses. I was fortunate to have had the opportunity to study psychiatry and complete my residency training at Washington University in St. Louis, a top-notch psychiatry program in the country. I subsequently completed my fellowship training in forensic psychiatry at Yale University.

I accepted the position of the Chief of Psychiatry at the St. Louis VA in November 2012. I considered my job as a mission to improve the mental health care of our veterans. I worked hard to understand the VA system of care and I diligently followed-up on veteran complaints about their mental health care. I was very concerned about some of the complaints I reviewed that were about poor access to care. I studied the official VA productivity data and this data showed that the psychiatrists at the St. Louis VA were amongst the most productive in the nation. Based on this, I concluded that I needed more psychiatrists to provide good, timely and safe mental health care to our veterans. During the course of my employment, and as I identified deficiencies I took actions to correct these deficiencies. Notwithstanding, the management structure of the VA not only precluded me from correcting the deficiencies, but treated me adversely as a result of my initiatives to makes changes. This represented a dramatic departure from my experience working in private and academic settings.

A. Defining the Problem

I requested an extra full time psychiatrist position and this was approved by the VA administration. However, some of the veteran complaints still persisted. Including the complaint of a veteran who came to the clinic with a deterioration of his illness and who instead of being evaluated by a provider, was turned away with an appointment scheduled for months later. Another case that I found alarming involved a disabled veteran without independent transportation, who was experiencing worsening of his serious mental illness and who had traveled a long distance to the VA clinic to get help. Again, he was not seen by his provider or any other provider, or *any* provider for that matter. His medications were not refilled; instead, he was sent away with an appointment that was no fewer than 48 days later. I found it difficult to believe that no one could spare 15 minutes to address this veteran's urgent medical needs. I wanted to find the answer to a simple question: *"How busy are the providers at the outpatient clinic?"*

The St. Louis VA, to my surprise, could not identify the average number of veterans seen by a provider/day or the time a provider spends on direct patient care/day. I asked other psychiatry Chiefs to estimate similar data at their facilities by contacting them through a national e-mail group that encompassed other VA facilities and I received answers that ranged from 8 to 16 veterans/day/psychiatrist. I also worked with a VA database administrator and my outpatient psychiatry director to find out how many veterans were actually being seen/day/psychiatrist at the St. Louis VA. I was interested in estimating time spent on direct patient care. I wanted to know the amount of **available** physician time for direct patient care and the amount of **actual** time spent in direct patient care in order to estimate utilization of expertise (available time/ actual time).

I was shocked to find that outpatient psychiatrists at the St. Louis VA were only seeing on average, 6 veterans/8 hours for 30-minute appointments with rare 60-minute appointments (3/week). I could only account for 3.5 hours of work during an 8-hour workday. In essence, we were utilizing less than 50% of the available physician time for direct veteran care. I checked my data multiple times and once I was confident that my data was accurate, I investigated why there was such low utilization of psychiatrist time, what the wait time for care was for the veterans and whether we were able to engage and retain our patients in ongoing mental health care and what the veteran experience of care was at the VA. The answers I got were alarming:

1. Low utilization of expertise:
 - a. I discovered that veterans were not being scheduled in all the available appointment slots. Three slots out of the possible 12 (1.5 hours) were inexplicably blocked from scheduling each day.
 - b. There was a very high no-show rate (~35%).
2. Wait times:
 - a. I found that the wait time for a new appointment was 25 days and for a follow-up appointment was 30 days after the desired follow-up date.
3. Retention in care:
 - a. I was most troubled by my finding that 60% of the veterans were dropping out of mental health care after one or two visits with their psychiatrist.
4. Veteran Experience:
 - a. There was a lack of meaningful veteran satisfaction measure. The surveys administered by the VA that I saw were not done with safeguards to preserve anonymity and confidentiality e.g., the treating provider would hand out the surveys to the veterans and would also collect the completed surveys: From the veteran's perspective, it would be extremely difficult to make any negative assessment/comments under these circumstances as one cannot feel confident about confidentiality and will have concerns about their opinion impacting the care they receive.

B. Disclosing the Inadequate Care to Veterans

I discussed my data with the Chief of Staff, Chief of Mental Health and my staff. The staff psychiatrists contested my data and offered various unconvincing reasons for not seeing more veterans/day (usually this involved pointing fingers at the scheduler/person tasked with reminder calls /other specialties). To address this, I collected prospective data (going forward) for 1 month for all the specialties (Psychiatry, Psychology, Social Work, Nurse Practitioners) and 22 weeks (5 months) of data for the psychiatrists (other specialties opted out).

I could *only* account for less than 4 hours of work during an 8-hour workday for any of the staff in Mental Health (psychiatry, psychology etc...) It was as if there was an agreement amongst all the clinic employees to only work for less than half the time they are paid to work. An agreement amongst administration and staff that on paper everyone would be “productive” and that everyone would qualify for “performance” bonuses.

I argued that this situation was unethical and unsafe for our veterans and that this needed to change urgently. I ran my intervention strategies by the Chief of Staff and I instituted three changes:

1. I increased the scheduling grid to accommodate 19 veterans/day in the hopes of seeing, on average, 12 veterans/day/psychiatrist and when this milestone was accomplished, to reduce the scheduling grid to 16 veterans/day to maintain access to care.
2. Instituted a strict policy of not turning away a veteran who had presented for care. I instructed the clinic to arrange for the veteran to be evaluated by other providers if a provider calls in sick. I put myself in this pool and I saw veterans on three occasions to underscore my commitment to this policy.
3. I instructed outpatient psychiatrists to stratify their patients into two groups: high intensity care and usual intensity care. I wanted more intense monitoring and follow-up for those in high intensity care group.

I was also able to secure philanthropic support for a pilot program to collect real time, meaningful veteran satisfaction survey with questions such as: Did your provider address your concerns today? Do you know when your next appointment is? Using ipads and real time data integration.

There was a significant amount of resistance from many psychiatrists and other specialties. I was yelled at on many occasions, I was told repeatedly, “this is the VA” to explain away the poor access to care. I persevered and I had partial success in increasing the number of veterans seen/day/psychiatrist; in reducing the wait times and in implementing a real-time veteran satisfaction survey.

I wanted to focus on four core meaningful metrics:

1. Time to care.
2. Utilization of resource (available/actual)
3. Veteran retention in care.
4. Veteran satisfaction with care.

I had argued that if the above metrics were headed in the right direction, we would be advancing towards our goal of creating a care environment where we could honestly refer a loved one, and if these metrics were not improving, other metrics (e.g., productivity measures) were meaningless.

I observed several unethical practices at the VA and I would bring this to the attention of the administration or address these if they were my staff.

1. Some of the psychiatrists were not respecting their tour of duty time commitments. I called them on it that resulted in improved behavior.
2. I was part of a search committee for a senior position at the VA and I was concerned about a particular candidate not being accorded proper consideration. I wrote a frank e-mail to all the members including the Chief of Staff where I argued that this was both unethical and possibly illegal.
3. I had a transgender veteran complaint about the quality of psychological evaluation report that had resulted in the denial of hormonal treatment. I found this psychological report grossly inadequate and I strongly argued for a second opinion for this veteran. This resulted in the then Chief of Psychology falsely vouching for the “expertise” of the evaluating psychologist. Subsequently I found out that the evaluating psychologist was placed on probation, that her clinical privileges were restricted, that she had many veteran complaints and that she was hired despite concerns about her competence, I requested a meeting with the Chief of Staff and the Chief of Psychology where I voiced my concern about this incident and I suggested that this psychologist’s work be reviewed by a psychologist from outside the St. Louis VA. The Chief of Staff did not seem concerned and the next veteran complaint against this psychologist for a similar issue was deliberately hidden from me.
4. I had concerns about two avoidable deaths:
 - a. One involved a young OIF/OEF veteran who was not assessed properly at the VA, whose medication management was sub-standard and who was discharged the very next day after his inpatient admission. My request for a Root Cause Analysis was not honored.
 - b. An elderly veteran was not assessed properly in the ER and he died shortly after he was admitted to the psychiatry inpatient unit.

5. A suicide attempt by a veteran in the inpatient unit while the Joint Commission was reviewing the VA was covered up and this incident was not reported to the Joint Commission. A safety barrier was breached during this attempt and this vulnerability was not addressed promptly as this event was not reported to the Joint Commission, hence, corrective actions were deliberately delayed at real risk of harm to the veteran.
6. The Acting Chief of Mental Health had opened up a backchannel communication with the psychiatrists who were opposed to my increasing access to care and with my demanding accountability from all. I had met with the Chief of Staff and the Acting Chief of Mental Health regarding this. The Acting Chief of Mental Health had apologized to me for his behavior, I accepted his apology and his assurances that he would fully support my efforts to improve access to care.
7. However, shortly thereafter, while I was on paternity leave, the Acting Chief of Mental Health was the person who determined that an Administrative Investigation was warranted based on the complaints he got from the very disgruntled psychiatrist who were opposed to my initiatives.

C. Retaliation for Whistleblower Disclosure and Subsequent Disclosures

On the heels of disclosing the deficiencies and barriers to care, the Chief of Staff called me into a meeting on August 26, 2013 to inform me that there was a “mutiny” and that to “protect” me “and the VA” he was authorizing an Administrative Investigation to investigate the allegation that I had created a hostile work environment for the staff psychiatrists. I reminded him that the staff psychiatrists had nominated me for an award before I had discovered the extremely poor work ethic and I had started to demand accountability. He told me that this would give people time to “cool off.” He assured me that I did not need an attorney and that he did not anticipate this process to take more than a few months and that I would be immediately detailed to Compensation and Pension and was not to access any of my patient files or information pertaining to the provider/patient care ratio.

Although provided with very little information about the exact nature of the investigation against me, my understanding is that the Chief of Staff and the Chief of Mental Health met with all the staff psychiatrists after my meeting with the Chief of Staff. The three of the psychiatry directors were excluded from this meeting. This meeting was described to me by some of the psychiatrists I had recruited as “embarrassing, bad-mouthing” and I got a phone call from a concerned psychiatrist who wanted to know if I was fired.

I continued doing Compensation and Pension evaluations throughout the pendency of the “investigation.” I independently filed a complaint with the Office of Special

Counsel and although I disclosed all of this information, because of the way I phrased the information, the Office of Special Counsel declined to find that I had establish that I was subject to a prohibited personnel practice. I was forced to retain counsel and only with the assistance of an attorney was able to craft a complaint that has engendered the interest of the Office of Special Counsel; which only recently notified me last week that they were referring my complaint for investigation.

In broad brush stroke terms, since the time of my disclosures last year, the VA has retaliated against me in the following manner:

1. I was completely removed from my position as Chief of Psychiatry;
2. I was forbidden from contacting other psychiatrists and my access to the database I set up to monitor the number of veterans seen by provider each day was terminated;
3. The independent funding for the veteran satisfaction survey project I secured as put on hold because of my removal from the Chief position;
4. Two excellent psychiatrists I had worked hard to recruit, who had interviewed at the VA, were from excellent training programs (Hopkins and Harvard) decided not to join the VA;
5. A hostile work environment was created in so much as, some of the staff psychiatrists outwardly mocked me;
6. I had an earlier performance review completed by Dr. Steve Gaioni who was the ACOS for Mental Health until July 2013 that was a reasonable assessment however I did not agree with his assessment of my management as Dr. Gaioni would counsel me to “go slow” where I saw an urgent need to improve access to care. I was re-evaluated by Dr. Metzger and he used a “performance” metric that I could not understand but it covered 5 weeks of my work from October 1 2013 until November 4 2013 and he determined that I had only met 50% of the goals he had set for me that was unbeknownst to me and was set after I was put on the administrative investigation. I refused to sign this document, however Dr. Welling, the Chief of Staff determined that this was an accurate representation of my work for the entire fiscal year and as represented by their approval. This is why almost every psychiatrist got the full performance pay they were eligible for based on bogus “productivity” data.
7. I was overlooked for promotion opportunities. More specifically, The Chief of Staff, on at least two occasions, pre-selected individuals for the Associate Chief of Staff position (a position for which he was aware I intended to apply), before the position was even advertised. Although, as the Agency was also aware, the fact that I was under investigation, impacted my ability to compete for positions.

8. Approximately one year after my initial disclosures, and although, no one at the VA had ever disagreed with my calculations concerning the number of veterans seen on a daily basis, the St. Louis, VA defamed my professional reputation and issued a press release suggesting that the VA's own careful investigation showed that the actual number was more than double of what I had found (14). This was blatantly false.
9. After my disclosures to the Offices of Senators Blunt and McCaskill I was contacted by the VA Privacy officer, who suggested he was investigating violations of PHI; which I did not. They filed complaints with the Federal Prosecutors office and the OIG. I had to have my attorney intervene again on my behalf.
10. Shortly after Senators Blunt and McCaskill made an inquiry into the caliber of patient care at the St. Louis, VA, the Chief of Staff called me into his office and demanded to know what my "end game was? Where is all this going?" I told him that I did not know and that I had no control over how everything was going to play out. This meeting ended abruptly.
11. I discovered that false data was entered into the medical records of veterans in June of 2014. After disclosing this to Acting Secretary Gibson, I was immediately reprimanded. More specifically, both myself and a colleague were subsequently instructed to report to a meeting with the Chief of Staff, who stated in pertinent part that it was Acting Secretary Gibson's expectation that the "chain of command is followed." The Chief of Staff went on to state that "I am telling you what the chain of command is, this is what it is, you work for me." I was offended by this and I told him that I thought I was working for the US government and not for him. He reiterated that it was Secretary Gibson's expectation that we first discuss any issues first with Dr. Metzger, if there is no resolution, to "go up the chain of command." I clearly felt that I was being reprimanded for writing to Secretary Gibson and that I should resolve the issue "locally first." He commented that this was the best way to manage any organization and that this was the "safe" thing to do. The way he said safe and the manner he lingered on it made it clear to me that he was conveying a gag order and a threat. I called him on it and I asked him if this was a gag order. He said no but that this was the expectation of Secretary Gibson.

He also stated that he wanted to tell us that even discussing de-identified information with outside agencies and looking for information in patient chart may constitute privacy violation and he wanted us to be aware of this. I asked for clarification if he was telling me that I could not contact OIG, OSC or Senators, he said that this is not what he meant but for us to be mindful of the fact that the VA takes veteran privacy very seriously. The spirit and tenor of this meeting was in direct contradiction to the memo Secretary Gibson had sent that called for Whistleblower protection.

12. Shortly after I disclosed the false data entry in June of 2014, my official protected time for research was revoked.

D. Crafting an Effective Solution

Any effective mechanism for improving Veteran care will necessarily incorporate transparency and accountability; neither of which is mutually exclusive of the other.

I have had the opportunity to think deeply about some tangible and concrete measures that the Congress and White House could take immediately to restore trust and faith in the St. Louis, VA by focusing on two elements. The First component of which applies to patient care and transparency:

Safe Guarding Patient Care

1. **Data Integrity:** VA data must be managed by an independent entity. Transparently tracking just four simple metrics can yield huge benefits:
 - a. **Wait times for each specialty/ procedure:** This could be available on a real-time basis.
 - b. **Reasonable time veteran satisfaction measure:** We have the technology to implement a concise, well validated measure of veteran satisfaction on a reasonable time basis (compiled weekly), at the point of contact to get a more complete set of veteran experiences.
 - c. **Utilization of expertise:** Available time/actual time spent by providers.
 - d. **Retention in care** or the attrition rate of the veterans.
2. **Employee Discipline:** Those individuals in direct patient care role must not have life-time tenured positions. I think that this “job security” is a big factor in veteran interest not being central which then ironically threatens the very existence of VA as a health care system.

Protecting and Fostering Transparency

As currently drafted, the Whistleblower Protection Enhancement Act (WPEA) as enacted, has done little to shield the professional rebuke that has occurred following my disclosures. Moreover, some of the events that have happened, although impacting my professional career, fall beyond the ambit of the definition of Prohibited Personnel Practice (PPP). For this reason alone, the WPEA should be amended to require the VA to maintain the *status quo* for all whistleblowers who allege breaches to the standard of patient care. This will ensure timely investigation and resolution of the allegations and will preclude the VA from conducting “administrative investigations” that, while harmful and professionally detrimental, may not fall neatly with the confines of the PPP.

Perhaps more importantly however, is the personal and financial sacrifice associated with the disclosures. Although I have a medical degree and am a Yale trained psychiatrist, I could not navigate the OSC process without the benefit of counsel. Not every whistleblower will be able to afford to retain an attorney to provide the legal advice that is absolutely necessary when an Agency begins making professional and potentially criminal allegations; all of which are grossly unfounded. Even now that OSC is involved, an investigation has not been completed and I am required to commence an action before the Merit Systems Protection Board if the OSC declines to prosecute or if the OSC is not successful in negotiating an agreeable resolution to my complaint. To that end, the WPEA should be amended to make optional the need to exhaust administrative remedies by first filing whistleblower appeals with the OSC and to provide for the mandatory payment of treble attorney fees for prevailing parties in order to provide VA employees with greater access to private legal representation at all stages of the whistleblowing process.

I would, and will continue to, blow the whistle a thousand times over again to protect the patients I treat; but some of the barriers I have identified may for example prove too onerous a burden for others to sustain. For this reason alone, the laws must change to afford actual and timely protection for whistleblowers.

The recommended solutions identified will result in the following:

Veterans: With readily available wait times and satisfaction measure, a veteran will have the choice to obtain care at a facility that optimizes acceptable wait time with satisfactory care. This will lead to a more even utilization of specialty care that in-turn will improve efficiency by distributing care. The cost savings from early intervention and reductions in secondary complications could justify travel assistance or other incentives to distribute care.

Policy Makers: A more accurate and meaningful measure of resource utilization and hospitals/ specialties needing closer scrutiny will be available to guide sounder policy. VA will not be saddled with poorly performing employees who may be toxic to veterans health.

Veteran Service Organizations: More effective monitoring of the VA with transparent reasonable time data.

Taxpayers: Determine if we are getting value.

Whistleblowers: Will be encouraged. This will create transparency in their individual VA institutions without the fear of professional rebuke and potentially, financial devastation.

I would like to deeply thank the Committee for the privilege of appearing before you today on, what I view, to be a defining moment in how our Government responds to the mental health needs of veterans. Thank you.