Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection
Patient Care Issues in Mental Health
William Jennings Bryan Dorn
VA Medical Center
Columbia, South Carolina

Report No. 05-01838-41

December 8, 2005

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
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DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Director, VA Southeast Network (10N7)

SUBJECT: Healthcare Inspection – Patient Care Issues in Mental Health, William Jennings Bryan (WJB) Dorn VA Medical Center, Columbia, South Carolina, Project Number 2005-01838-HI-0200

Purpose

The Department of Veterans Affairs (VA) Office of Inspector General's (OIG) Office of Healthcare Inspections (OHI) conducted an inspection to determine the validity of allegations made by an anonymous complainant regarding the care of mental health (MH) patients at the WJB Dorn VA Medical Center (the medical center) in Columbia, South Carolina.

Background

The medical center is a 216-bed facility providing acute medical, surgical, psychiatric, and long-term-care services. The complainant alleged that:

- An inaccurate diagnosis was maintained on a patient's problem list.
- A patient was inappropriately committed on an involuntary status.
- A social worker failed to report an allegation of sexual abuse.
- A delay in scheduling a neurology appointment may have contributed to a patient's death.
- Clinics were terminated arbitrarily, without warning, and without planning for provision of care.
- MH employees were not treated equitably when disciplinary actions were taken.

Scope and Methodology

We visited the medical center in May 2005. We reviewed personnel records of MH staff, selected patients' medical records, MH policies and procedures, patient incident reports, and patient advocate reports. We interviewed facility managers who had knowledge of

the issues, listened to an audio taped interview with the complainant, and reviewed evidence provided by the complainant to better understand the allegations.

We conducted the inspection in accordance with the Quality Standards for Inspections published by the President's Council on Integrity and Efficiency.

Inspection Results

Issue 1: Accuracy of Problem List Diagnosis

We substantiated the allegation that an inaccurate diagnosis was maintained on a patient's problem list. The patient had a history of alcohol and drug abuse, and was enrolled in the Healthcare for Homeless Veterans (HCHV) program. The HCHV program operates on an alcohol and drug free basis and requires participants to abstain from these substances. On November 17, 2004, a social worker (SW) entered two diagnoses in the patient's problem list indicating that he was continuously abusing drugs and alcohol, even though his medical record reflected that he was recovering from his substance abuse disorder and was clean and sober at the time. All of the patient's progress notes and laboratory results indicated he was compliant with HCHV requirements to maintain sobriety. The patient requested his medical records, learned of this error, and feared these diagnoses might prevent him from gaining employment. The Chief of the MH Service Line (MHSL) reviewed the record and told us the patient did not meet Diagnostic and Statistical Manual of Mental Health Disorders IV (DSM-IV) criteria for these diagnoses. The Chief of the MHSL corrected the record and stated the medical center would notify the patient of the error and provide him with a corrected copy of his medical records.

We reviewed 16 additional medical records of veterans enrolled in the HCHV program to determine if this condition existed in other cases. We found that 5 of the 16 (31 percent) veterans had incorrect active diagnoses of substance or alcohol abuse (continuous use) in their problem lists, even though progress notes and laboratory results did not reflect these problems. Two of the five veterans were current Compensated Work Therapy employees of the medical center, and others were in the process of job placement through the HCHV program. The Chief of the MHSL provided us with an action plan to correct these records and provide staff training on appropriate documentation and revision of problem list diagnoses.

Issue 2: Appropriateness of an Involuntary Commitment

We did not substantiate the allegation that a patient's involuntary commitment was inappropriate. While the emergent need to commit the patient was unclear (the patient threatened to harm an individual in another city he'd seen on the news), the physician complied with medical center policy in doing so. The physician consulted with another provider more familiar with the patient, who confirmed that the patient was capable of the violent action he was threatening. We reviewed the records of six additional patients

who had been involuntarily committed between October 1, 2004, and March 23, 2005, and found all of these cases met the guidelines for involuntary commitment.

Issue 3: Reporting of Sexual Abuse

We did not substantiate the allegation that a SW failed to report an allegation of sexual abuse. In May 1999, the wife of a MH patient reported to a SW that another patient had brushed against her daughter in the hall at his home and kissed her on the neck. The SW could not confirm the incident but documented the allegation in a progress note and advised the mother to report the incident to authorities. The mother did not follow the SW's advice, but later (January 2000) reported the incident again to another MH provider. This provider also told her to report the incident to authorities and had her call from the medical center to ensure that she made the report. The daughter later refused counseling offered by the VA.

In general, privacy and confidentiality guidelines limit a healthcare provider's ability to disclose personal information. In this case, the SW provided adequate instructions to the mother to report the incident. As procedures to report incidents that occur off-site were not specifically addressed in MHSL procedures or policies, the Chief, MHSL told us he would develop a Standard Operating Procedure to report allegations of sexual abuse to outside authorities.

Issue 4: Wait Times for Neurology Clinic

We did not substantiate the allegation that a patient's excessive wait to be seen in Neurology Clinic may have contributed to his death. On March 17, 2004, the patient's MH provider referred him for a routine neurological consultation, noting that he had a history of headaches, with a current complaint of tingling in his head and times when "things get dark for a minute." While the Neurology consultation was pending, the patient underwent a computerized tomography scan of the head and an ambulatory cardiac monitoring test. Both exam results were within normal limits. The neurologist conducted a thorough evaluation of the patient on June 28, 2004, and documented that his near syncope (temporary loss of consciousness) was most likely related to variations in his blood pressure. She further noted that this condition had been ongoing for about one year, his "blood pressure medications were better," and he was not experiencing as many syncopal episodes. She recommended follow-up cardiac, neurological, and laboratory studies, and indicated that she would evaluate the patient again after completion of the recommended tests. The patient fell off his tractor the next day and died. No further information as to the cause of death was available.

Although the time between referral and appointment (103 days) exceeded the Veterans Health Administration's 30-day standard for completion of specialty consultations, we did not find any evidence that the delay in the patient's neurological evaluation contributed to his death. It did not appear that the patient was in acute neurological

distress, and the neurologist's evaluation and treatment plan reflected a systematic, non-urgent approach to rule out possible causes of the patient's symptoms.

Issue 5: Clinic Terminations and Impact on Patient Care

We did not substantiate the allegation that managers did not consider patient care when terminating clinics. The Chief of the MHSL told us that patients who had been enrolled in terminated clinics were scheduled for individual and group therapy sessions with other MH providers. We reviewed selected records of these patients and confirmed that this procedure was followed. In addition, we reviewed the patient advocate log from October 1, 2003, until May 6, 2005, and did not find any reports of patient concerns with clinic terminations. The Chief of the MHSL also told us that he was actively recruiting to replace the providers of the terminated clinics.

Issue 6: Equity of Disciplinary Actions

We could neither confirm nor refute the allegation that MH employees were not treated equitably regarding disciplinary actions. The complainant alleged that some MH employees were disciplined for infractions, while others who committed infractions were never disciplined. We reviewed the official personnel files (OPFs) of several MH providers, but found insufficient information to appropriately investigate this allegation. The OPFs of providers alleged to have committed infractions did not contain information related to the allegations. To protect the anonymity of the complainant, we could not fully evaluate this issue.

Issue 7: Other Issues

While not one of the complainant's allegations, we learned that the MHSL held a Post Traumatic Stress Disorder (PTSD) group every week that was attended by as many as 155 patients. This clinic met in the medical center's auditorium, and we were told that members often had a cookout in lieu of a meeting. The Chief of the MHSL explained that the group was "peer-led" by one of the veteran patients, and that the therapy that took place during the session was peer-to-peer. We reviewed clinical and administrative aspects of the April 29, 2005, PTSD group and identified the following conditions:

Clinic Designation. The Decision Support System (DSS) Identifiers for the PTSD Group are 516 (PTSD Group) and 558 (Psychology Group). An encounter, defined as the professional contact between a patient and a practitioner vested with primary responsibility for diagnosing, evaluating and/or rating the patient's condition, is created for each patient attending the clinic. This designation implies a qualified MH professional is providing services, yet the Chief of the MHSL told us that this is a peer-led group.

Workload and Documentation. To receive workload credit for the session, providers must complete a progress note. The progress note template indicated that the provider

assessed the stability of every patient's mood during each session. The same progress note was entered for every patient and signed by a psychologist or a recreation therapist. The Chief of the MHSL acknowledged that a provider could not assess the mood of 150 PTSD patients in an hour and also acknowledged the liability issues inherent in implying that they had. Before we left site, the Chief of the MHSL provided us with a revised progress note template that more accurately described the nature of the group, and did not reference mood assessments.

Billing. Although the Chief of the MHSL told us that this was a non-billable clinic, we found that two patients in attendance on April 29, 2005, had insurance that, if service was covered, would have potentially been billed. Both of these patients had attended this group during fiscal year 2004 and paid a co-payment each time they attended.

While we appreciate the therapeutic value of this group, its current designation does not reflect its true nature or intent. Although the Medical Center Director told us that they had reviewed some of these issues in the past, facility managers were unable to provide us a copy of this report.

Conclusion

We substantiated the allegation that a MH provider documented inaccurate diagnoses in a patient's medical record but did not substantiate the complainant's other allegations. Medical center managers were responsive to our concerns and provided acceptable action plans to address issues identified in the allegations. We also determined that a large, peer-led PTSD group designated as a Psychology Clinic did not meet criteria for this designation.

Recommended Improvement Action 1. The VISN Director needs to ensure that the Medical Center Director reviews the PTSD group DSS designation, workload capture, and billing practices.

VISN and Medical Center Directors' Comments

The VISN and Medical Center Directors agreed with our findings and recommendations and provided acceptable improvement plans. A review of the PTSD group DSS stop code designation resulted in assignment of a new stop code representing PTSD group Recreational Therapy. The facility reviewed workload capture and found it to be appropriate. The review of billing activities identified four instances of co-payments billed to, and paid by veterans. These co-payments were refunded and the group is now designated as a non-billable clinic to prevent any future billing of co-payments to veterans who attend.

Inspector General Comments

The VISN and Medical Center Directors agreed with our findings and recommendation and provided acceptable improvement plans. We will follow up on the planned actions until they are complete.

(original signed by:)
JOHN D. DAIGH, JR., MD
Assistant Inspector General
For Healthcare Inspections

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: September 7, 2005

From: Director, VA Southeast Network (10N7)

Subject: **Healthcare Inspection Patient Care Issues in Mental Health William Jennings Bryon Dorn VA Medical Center Columbia, South Carolina**

To: Assistant Inspector General for Healthcare Inspections

Thru: Director, Management Review Service (10B5)

Upon review of the Draft Report by the Department of Veterans Affairs (VA) Office of Inspector General's (OIG) Office of Healthcare Inspections (OHI), I concur with the findings and actions of the Medical Center Director, Mr. Brian Heckert, as outlined on subsequent pages.

(original signed by:)
Linda F. Watson

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 31, 2005

From: Medical Center Director (544/00)

Subject: **Healthcare Inspection Patient Care Issues in Mental Health William Jennings Bryan Dorn VA Medical Center Columbia, South Carolina**

To: Director, VA Southeast Network (10N7)

Upon review of the Draft Report by the Department of Veterans Affairs (VA) Office of Inspector General's (OIG) Office of Healthcare Inspections (OHI), I concur with their findings, recommendations, and suggestions.

(original signed by:)
Brian Heckert

Director's Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendation(s) in the Office of Inspector General's Report:

OIG Recommendation(s)

Recommended Improvement Action 1. The VISN Director needs to ensure that the Medical Center Director reviews the PTSD group DSS designation, workload capture, and billing practices.

Concur Target Completion Date: 8/24/2005

As recommended by the OIG, the PTSD group DSS designation, workload capture, and billing practices have been thoroughly reviewed.

A review of the DSS Stop Code designation by the MCCR/Revenue Section and DSS staff resulted in a changed designation for the clinic. The stop code assigned previously for the PTSD group has been changed to 516-202 (516 represents PTSD group and 202 represents Recreational Therapy). This reflects the consultation to peer-leaders by either a Recreational Therapist or a Ph.D. Psychologist present at each group meeting.

Based on the goals of the group and the staff involvement, it is appropriate to complete encounters and capture workload. In addition to consultation, Mental Health staff monitors group functions and interventions, provides direct education to the group, and assists any veteran in a psychological crisis.

The Columbia VAMC MCCR/Revenue Section staff also reviewed the billing activities related the services provided in the PTSD group. They found that no third party bills had been generated for these services. There were four instances of co-payments billed to, and paid by, veterans. These co-payments have been refunded. The MCCR/Revenue Section

program has also taken action to clearly designate the clinic/ group as a non-billable clinic to prevent any future billing of co-payments to veterans who attend the group meetings.

The Columbia VAMC met the target completion date for concluding the review and making the necessary administrative changes (completed by August 24, 2005).

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Hotline Call Center (800) 488-8244
Acknowledgments	Christa Sisterhen, Associate Director, Atlanta Office of Healthcare Inspections Toni Woodard

Appendix D

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