



**Department of Veterans Affairs
Office of Inspector General**

Office of Healthcare Inspections

Report No. 12-03869-187

Healthcare Inspection

Follow-Up of Mental Health Inpatient Unit and Contract Outpatient Programs Atlanta VA Medical Center Decatur, Georgia

June 19, 2014

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection at the request of Senator Johnny Isakson to follow up on two prior reports at the Atlanta VA Medical Center (facility), Decatur, GA. We evaluated management of care on the facility's mental health (MH) inpatient unit and published *Mismanagement of Inpatient Mental Health Care, Atlanta VA Medical Center, Decatur, Georgia*, Report No. 12-03869-179, April 17, 2013. We assessed administration, management, and coordination of the facility's contract MH program through which patients receive outpatient MH services at community service boards (CSBs) and published *Patient Care Issues and Contract Mental Health Program Mismanagement, Atlanta VA Medical Center, Decatur, Georgia*, Report No. 12-02955-178, April 17, 2013. The contracted MH care report also addressed related patient care issues including the coordination, monitoring, and oversight of care for patients referred to CSBs.

We noted overall improvements in oversight of the inpatient MH unit and contract MH care program. These improvements were the result of a joint effort by the VA Central Office for MH Operations, Veterans Integrated Service Network 7, the facility, and the CSBs. Importantly, we found that the facility made changes in leadership that enhanced interdisciplinary collaboration and added supervisory processes previously absent from the inpatient MH unit and contract MH program.

In response to recommendations from the inpatient MH unit report, we found that the Office of the Under Secretary for Health had issued a memorandum to the field and published a Veterans Health Administration (VHA) Handbook to provide guidelines and requirements for inpatient MH units. Aligned with our recommendations, we also found that the facility had developed and implemented policies and procedures to address potential patient safety issues including hazardous items on the unit, patient off-unit escorts, urine drug screenings, and patient visitation. The facility also established processes to strengthen documentation of patient monitoring and on-unit observation, interdisciplinary communication, leadership oversight, and rigor of the root cause analysis process.

On follow-up to the contracted MH care report, we also found improvements to the facility's administration and coordination of contracted MH care with CSBs, billing, and oversight. However, business process challenges persist due to VA's privacy and security regulations that limit the transfer of information electronically between the facility and the CSBs. Clinical contract liaisons tracked patients' initial CSB appointments and census using various tools, such as spreadsheets and photocopied lists, because the facility did not have a centralized repository for CSB patient data.

Clinical contract liaisons did not consistently document patients' CSB attendance after initial appointments, in part because current contract agreements did not require that CSBs notify the facility when patients missed appointments or discontinued care. To address this gap, the facility pursued informal agreements with the CSBs and added guidelines to proposed contracts. In addition, communication from the facility to the CSB was required only at the time of the initial referral. However, facility to CSB

communication at the time of reauthorization or significant medical or mental health changes would improve the CSB's ability to coordinate and integrate care for patients.

The facility acknowledged the need for continued progress in these areas. As such, the facility's challenge is to continue further along the path of improvement while sustaining positive changes to date.

We recommended:

1. The Facility Director ensure that a standardized and facility-wide repository be developed and implemented to monitor patients referred to community service boards.
2. The Facility Director strengthen processes to ensure that patients are tracked for follow-up beyond the first contracted mental health care appointment.
3. The Facility Director strengthen communication between the facility and the community service boards to better integrate and coordinate medical and mental health aspects of patient care.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with our recommendations and provided an acceptable action plan. (See Appendixes A and B, pages 17–20 for the Directors' comments.) We will follow up on the planned actions until they are completed.



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Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection at the request of Senator Johnny Isakson to follow up on two prior reports at the Atlanta VA Medical Center (facility), Decatur, GA. We evaluated management of care on the facility's mental health (MH) inpatient unit and published *Mismanagement of Inpatient Mental Health Care, Atlanta VA Medical Center, Decatur, Georgia*, Report No. 12-03869-179, April 17, 2013. We assessed administration, management, and coordination of the facility's contract MH program through which patients receive outpatient MH services at community service boards (CSBs) and published *Patient Care Issues and Contract Mental Health Program Mismanagement, Atlanta VA Medical Center, Decatur, Georgia*, Report no. 12-02955-178, April 17, 2013. The contracted MH care report also addressed related patient care issues including the coordination, monitoring, and oversight of care for patients referred to CSBs. Specifically, we evaluated the implementation and progress of the action plans developed in response to OHI recommendations, including the:

- Under Secretary for Health's (USH's) development of national policies that address contraband (hazardous items),¹ visitation, urine drug screening (UDS), and patient off-unit escort for inpatient MH units.
- Facility's strengthening of inpatient MH unit policies and practices related to hazardous items, visitation, UDS, off-unit escort, patient observation, program oversight, and root cause analysis (RCA).
- USH's actions to address deficiencies in provision and management of quality contracted MH care.
- Facility's improvement of the management, delivery, and continuity of care for patients referred to contracted MH programs.

Background

Facility

The facility is a 311-bed teaching hospital that provides a broad range of emergency, medical, surgical, long-term care, and MH services. The facility also provides outpatient services at 10 community based outpatient clinics located in Austell/Cobb County, Blairsville, Carrollton, Decatur, Fort McPherson/East Point, Lawrenceville, Newnan, Northeast Georgia/Oakwood, Rome, and Stockbridge, GA. As part of Veterans Integrated Service Network (VISN) 7, the facility has experienced rapid growth with the

¹ Hazardous items are any items that are illegal, interpreted as being a weapon, flammable, explosive, or otherwise potentially dangerous, unsuitable, or non-therapeutic to the inpatient hospital setting. "Protocol for the Control of Hazardous Items for Mental Health Patients," Atlanta VA Medical Center, October 21, 2013.

number of unique veterans served increasing from 62,729 in fiscal year (FY) 2007 to 90,732 in FY 2013.

The MH Service Line (MHSL) provides general outpatient and specialized outpatient programs, including trauma and substance abuse (SA) treatment, through in-house and contracted MH services. Overall, unique MH outpatients increased by an estimated 11 percent from FY 2012 to FY 2013. The number of MH unique patient visits to the facility's General MH Clinic continues to increase significantly. Therefore, the facility projects the need to continue utilization of contracted MH services in addition to expanding in-house capability.

Following our initial inspections, new leaders assumed critical positions, including the directorships of the facility and VISN 7. The facility appointed a Deputy Chief of Staff, an Acting Chief of MHSL, an Acting MH Associate Nurse Executive, and an Acting MHSL Administrative Officer in addition to hiring a new inpatient MH unit Nurse Manager. To improve coordination of facility and contracted MH care services, the facility increased the number of clinical contract liaisons (CCLs).² The inpatient MH unit Social Work Service supervisor assumed responsibility for supervising the CCLs, and the inpatient MH unit social work position was backfilled.

Inpatient MH Unit

The facility has one 40-bed acute locked inpatient MH unit and admits only voluntary patients. During FY 2013, the unit's average daily census was 30 with an occupancy rate of 76 percent and a 9-day average length of stay.

In the inpatient MH unit report, we investigated the unexpected death of a patient on the facility's inpatient MH unit. The autopsy report indicated that the patient died of opiate³ or alprazolam⁴ poisoning, neither of which the facility had prescribed for this patient. Facility reviews determined that the patient had obtained alprazolam from another MH inpatient whose visitors had brought the medication onto the unit. Although not definitively confirmed, reviews suggested that the patient might have obtained opiates from outside of the hospital during his absence from the eye clinic while waiting unsupervised for a scheduled appointment. Upon return to the inpatient unit, the patient provided an unobserved UDS specimen, which came back negative. Another patient subsequently admitted to having provided the patient with a clean urine sample. Following the patient's death, the facility conducted a mandatory RCA.

The inpatient MH unit report described facility and inpatient MH unit policies that did not sufficiently address patient care safety. Specifically, we found:

² CCLs are social workers who do not have direct patient care responsibilities but are tasked to improve tracking, patient care coordination, communication, and resource connection.

³ An opiate is a drug (such as morphine or codeine) containing or derived from opium and intended to medically induce sleep, alleviate pain, and treat certain gastrointestinal disorders.

⁴ Alprazolam is a benzodiazepine sedative that causes dose-related depression of the central nervous system and is useful in treating anxiety, panic attacks, insomnia, and muscle spasms.

- Inadequate policies and practices for hazardous items, visitation, UDS, and off-unit escort.
- Inadequate procedures for staff members' monitoring of patients and documentation.
- Gaps in program oversight, including leadership's follow-up to patient incidents.
- Insufficient communication between leadership and staff members regarding debriefings and planned actions to address identified deficiencies.
- Compromised document review and timeliness of follow-up actions in the RCA related to the subject inpatient's death.

Contracted MH

In 2008, VISN 7 established a contract with Select Systems LLC (SELECT), an affiliate of the Georgia Association of CSBs. CSBs are non-VA public and non-profit providers of community based MH and SA disorder treatment services. The SELECT contract provided general outpatient MH services, crisis stabilization, and psychosocial rehabilitation/day treatment to patients referred by any of the eight VA Medical Centers in VISN 7. Under the contract with SELECT, 26 CSBs provided MH care as subcontractors. The SELECT contract expired in January 2013, and the facility awarded interim contracts to five CSBs until long term contracts could be negotiated.

In a 2011 OIG report, OIG substantiated that several MH clinics had significantly high numbers of patients on their electronic wait lists⁵ and that facility managers were slow to respond to the problem. (For more information, refer to *Electronic Waiting List Management for Mental Health Clinics, Atlanta VA Medical Center, Atlanta, Georgia*, Report No. 10-02986-215, July 12, 2011.) To reduce the number of patients waiting for MH treatment, the facility planned to increase utilization of CSBs. Subsequent allegations of mismanagement in the facility's administration of the contracted MH program were substantiated in our contracted MH care report, which also found inadequate coordination, monitoring, and staffing for oversight of contracted MH patient care.

Scope and Methodology

We visited the facility and the two most utilized CSBs during the week of October 28–31, 2013, and we toured the inpatient MH unit. We interviewed facility managers, CCLs, inpatient MH unit administrative and clinical staff members, and other key personnel knowledgeable of the pertinent issues. We also conducted interviews with leaders from VA Central Office MH Operations on December 12. We reviewed

⁵The electronic wait list "... is used to list patients waiting to be scheduled, or waiting for a panel assignment." VHA Directive 2009-070, *VHA Outpatient Scheduling Processes and Procedures*, December 17, 2009.

relevant Veterans Health Administration (VHA) publications and Deputy USH for Operations and Management (DUSHOM) memoranda.

We reviewed incident reports relevant to inpatient MH treatment submitted from August 2012 through September 2013. To assess whether staff members complied with new guidance, we reviewed the electronic health records (EHRs) of all 26 patients admitted to the inpatient MH unit from October 1 through October 24, 2013. To assess the status of contracted MH care patient referrals, we reviewed the EHRs of all 69 patients who had initial CSB referrals and all 51 patients with reauthorization referrals during the week of September 9, 2013.

We reviewed current contracts, procedures, and documentation provided by CSBs. Additionally, we reviewed selected facility documents, including facility policies, issue briefs, and data related to patient safety and advocacy, staffing, and quality management (QM).

We conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Inspection Results

A. Management of Inpatient MH Care

Issue 1: National Guidance

In 2012, at the time of the initial OIG inspection, VHA had not established national guidance for VHA inpatient MH units regarding hazardous items, visitation, UDS, and patient off-unit escort. Notably, this was in contrast to the requirements published 2 years earlier for VHA's MH residential rehabilitation programs, which were designed for stable (non-acute) patients.

In the inpatient MH unit report, we recommended that the USH ensure the development of national inpatient MH policies that address hazardous items, visitation, UDS, and patient escort for inpatients requiring supervision for off-unit activities. Consistent with this recommendation, the DUSHOM issued an August 1, 2013, "*Safety and Security on Inpatient Mental Health Units*" memorandum that provides national guidance regarding expectations for policies, practice, and follow-up in these four areas. VHA also published Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013, that outlines inpatient MH unit governing principles, reporting requirements, and other critical patient safety components such as environment of care, seclusion and restraint, and evidence-based care.

In addition, consultants from the VA Central Office of MH Operations conducted a site visit, developed a strategic action plan, and provided ongoing monitoring of the facility's progress. Office of MH Operations consultants recommended some changes to the

monitoring processes, physical environment, and treatment program. The facility has made progress in pursuing these recommended action plans.

Issue 2: Facility Policies and Procedures

The inpatient MH unit report recommended that the facility develop adequate policies and procedures to address hazardous items, visitation, UDS, and escort service. As of October 2013, the facility established comprehensive policies, provided staff training, and implemented new procedures. The new policies were consistent with the DUSHOM memorandum.

Inpatient MH unit leadership provided training for all staff members with ongoing review of policies and relevant issues in regularly scheduled meetings. An assigned registered nurse trains and assesses procedural competencies for each new nursing employee. The new employee must demonstrate all competencies to complete new employee orientation successfully. In addition, leadership conducts an annual "Skills Day" that includes review and discussion of policies and procedures, as well as training in areas identified through a training needs assessment.

Leadership established monthly compliance monitors for hazardous items, visitation, and UDS procedures, as well as for completion of staff education regarding the new policies. Data indicated 100 percent compliance by October 2013. A patient handbook provided to patients upon admission to the unit, and updated October 2013, describes the new policies and procedures.

Thirteen staff members interviewed during the initial inspection, and again for this follow-up inspection, described significant improvements and positive responses towards the changes. Staff echoed the sentiment captured in one nurse's statement, "I think it is a safer unit. That is probably the biggest change."

Hazardous Items

In the inpatient MH unit report we found national and facility protocols related to hazardous items and facility staff training and follow-up to patient incidents to be inadequate.

Following our report, the DUSHOM's memorandum specified that, "Family and visitors should be educated regarding safety on the unit for the Veteran and others and the need to ensure that hazardous items are not given to the Veteran or brought on to the unit." To comply with the DUSHOM's memorandum, the facility included this information in the patient handbook that staff members provide during each patient's orientation.

The facility also specified MH unit and MH emergency department procedures for confiscation and handling of hazardous items, documentation, and oversight of the process, in the new "*Protocol for the Control of Hazardous Items for Mental Health Patients.*" The facility provided staff training and, during our interviews, staff articulated procedures consistent with the policy.

To assess whether staff complied with the new guidance, we reviewed the EHRs of 26 patients admitted to the inpatient MH unit from October 1 through October 24, 2013. Staff documented in all EHRs that they searched and secured patients' belongings prior to admission to the unit. All patients received orientation to the unit (individually or in a group setting), and 11 EHRs included specific notation of the provision of hazardous items education.

Visitation

The inpatient MH unit report found inadequate facility and national protocols related to visitation to the inpatient MH unit and inconsistencies among facility staff members when signing in visitors, limiting the number of visitors, restricting items brought onto the unit, and observing visitation. Following the publication of the inpatient report, the facility established the "*Acute Inpatient MH Unit Visitation Policy*" that limited the number of visitors per patient, visitation hours, and visitation areas and restricted the belongings visitors could bring onto the unit. Under the new policy, a staff member accompanies visitors to lockers for storage of personal belongings and then escorts them to the designated visiting area. Staff supervise the visiting area and escort the visitors back to the lockers and off the unit upon the visit's end. Visitors must sign in and out of a visitation log maintained at the nursing station.

During our recent site visit, staff were well versed in the new MH unit visitation policy and procedures and expressed positive responses to the increased structure and monitoring. We reviewed relevant incident reports submitted from August 2012 through September 2013. One report described an incident in which a visitor brought a bag onto the unit but remained unobserved for 30 minutes following the end of visiting hours. Although there was a lapse in procedure during this incident, unit staff and leadership responded timely. Staff communicated the incident through appropriate channels, discussed the situation with the patient, and obtained a UDS specimen. The psychiatric resident followed up with the patient and completed an EHR note within 2 hours of the incident.

UDS

At the time of the inpatient MH unit report, VHA guidance and local policy did not address UDS for patients admitted to an acute care setting.

The facility published the Medical Center Memorandum (MCM), "*Monitored Urine Drug Screen Collection*," March 12, 2013, with the Chief of Staff and Associate Director, Nursing and Patient Care Services responsible for ensuring compliance. This MCM stresses procedures to ensure specimen integrity, including general methods of collection and observation. As an MCM, it applies to all personnel who perform the procedure, including the inpatient MH unit and the MH emergency department. The MCM does not require that staff members specify in the EHR the identification of those responsible for UDS collection, confirmation of observation, or other aspects of the procedure.

The facility provided training on the MCM, and MH inpatient staff members correctly identified the steps outlined in the MCM during OIG interviews. To assess compliance with the MCM, we conducted an EHR review of 23⁶ patients admitted to the inpatient MH unit through the facility's emergency department from October 1 through October 24, 2013. Providers ordered admission UDSs for all the patients and additional UDSs for three patients later during their stay. According to compliance monitoring data for July through October 2013 collected by the facility, staff observed 10 of 10 UDS collections.

Off-Unit Escort

At the time of our inpatient MH unit report, the facility had no policy for escorting inpatient MH patients off the unit, and practices depended upon provider-assigned patient observation levels of 1 (low supervision) to 4 (high supervision).

Following the report, the facility disseminated and trained staff on a protocol that specified, "Off unit medical appointments, tests, or procedures will be limited only to those determined to be urgent or emergent and that cannot be completed on the unit. If the patient must leave the unit for a medical appointment, test, or procedure, he or she will be escorted by an inpatient MH unit staff member during the entire absence from the unit."

The new policy created a significant change for MH patients who were familiar with the rules of the past. Therefore, staff have been providing patient orientation and ongoing education to explain the new procedures and to address patient concerns about the changes.

Although we found one off-unit escort-related incident that indicated a lapse in protocol, the facility's response demonstrated that the oversight improvements in place were effective. In July 2013, a provider ordered the escort of a one-to-one⁷ patient to and from a dental clinic appointment. At the conclusion of the appointment, the patient left the clinic without a MH staff member escort and returned to the unit on his own. Nursing staff informed the psychiatric resident, obtained a UDS, searched the patient's belongings and room, and provided education to the patient. This incident did not result in adverse consequences, and the staff's follow-up was consistent with the new policy and procedure.

At our follow-up inspection, all staff who were interviewed verbalized the new procedures accurately. Additionally, we interviewed support staff in the eye and dental clinics who confirmed that an inpatient MH unit staff member escorted the patients and remained with them for the entire appointment. Outpatient clinic staff described

⁶ Three of 26 patients were excluded because they were transferred from private facilities and did not process through the facility's emergency department.

⁷ One-to-one supervision is a level of patient observation used when patients pose an imminent danger to themselves or others. http://www.uth.tmc.edu/uth_orgs/hcpc/procedures/alpha/nur/otos.htm. Accessed April 3, 2014.

appreciation of the changes, and one staff member stated, “It is much better on our end, really so much better.”

Issue 3: Patient Monitoring and Documentation of Observations

In our inpatient MH unit report, we found problems in the staff’s supervision of patients and documentation of monitoring. In response to OIG recommendations, the facility modified the patient observation level system to require that providers assign one-to-one or check every 15-minutes, based upon the patient’s needs. In addition, clear guidelines for documentation are now included in the *Acute Inpatient MH Unit Standard Operating Procedure*. The facility also completed a time study that resulted in the hiring of additional staff to monitor patients.

Inpatient MH unit staff members now attach photographs of each patient to their respective observation sheet to reduce errors when identifying patients. Nursing leadership appointed in August 2013 incorporated staff members’ ideas into the redesign of flow sheets and documentation.⁸ Additionally, inpatient MH unit leadership conducted mock missing patient drills to reinforce staff members’ understandings and implementation of procedures. Staff members we interviewed were able to verbalize understanding and compliance with the new procedures, including the levels of supervisory oversight.

Issue 4: Leadership Follow-Up Action

The inpatient MH unit report described leadership’s failure to follow up in response to patient incidents and staff members’ concerns and to communicate adequately with staff. During that inspection, we found that MHSL and inpatient MH unit meetings were routinely canceled, attendance was poor, minutes were not kept, and follow-up actions were not taken. In particular, staff members voiced frustration with leadership’s failure to implement changes or update them on progress made toward change following the inpatient’s death.

In this follow-up inspection, we found significant improvements in leadership’s communication with staff and staff morale. Since April 2013, the inpatient MH unit director facilitated two regularly scheduled meetings—a monthly Joint Staff Meeting for all staff and a bi-weekly Acute MH Services staff meeting that included psychiatrists, social workers, and nursing leadership. Standing agenda items for both meetings addressed policy reviews, environment of care concerns, programmatic education and discussion, and strategic plan overviews. Attendance rosters and minutes were completed and the inpatient MH unit director emailed the minutes to all staff. The minutes reflected action planning and opportunities for staff members to provide input and feedback.

⁸ Hourly rounding is a “systematic, proactive nurse-driven evidence-based intervention to anticipate and address needs in hospitalized patients.” Effective hourly rounding can promote patient safety, foster team communication, and improve staff ability to provide efficient patient care.

http://www.nursingcenter.com/Inc/journalarticle?Article_ID=1265838. Accessed February 4, 2014.

The inpatient MH unit director also established an interdisciplinary workgroup that included a VHA consultant and the facility's patient safety manager to initiate the action plan recommendations from the Office of MH Operations. Minutes reflected significant ongoing progress toward implementation of those action plans. Other inpatient MH unit initiatives included daily team rounding to speak with each patient and formalized "huddles."⁹ In addition, the Acting Chief of MH initiated twice-monthly meetings to include all MHSL staff.

Staff members described an open atmosphere in which questions are encouraged and they are involved and informed, commenting that "People are able to speak out and are heard," and "[It is] Easy to share concerns, they [MHSL leaders] are very open, immediately give us feedback. They come on to the unit."

After the patient death described in the inpatient MH unit report, the facility implemented an incident alert system that ensures inpatient MH leadership is informed of an incident as soon as it is entered in the Electronic Patient Event Reporting System. This supports improved awareness and tracking of leadership response to incidents and adverse events. Beginning in December 2012, Patient Safety staff members started to provide a quarterly aggregate events report to MHSL leadership for review.

At the time of the OIG follow-up site visit, the inpatient MH unit was piloting a direct link telephone system to enhance real time communication between clinical providers, nursing staff, and social workers. The system will eliminate the need for paging, allow text messaging through a secure system, and include panic alarm staff locating capability.

Issue 5: RCA

Our inpatient MH unit report identified the facility's failure to include all critical documentation in the mandatory RCA of the inpatient's death. In response, the facility has ensured that RCA teams have all relevant documentation available to support a thorough review.

Issue 6: Equipment

When reviewing the facility's response to the patient's death at the time of the inpatient MH unit report, we learned that certain life support equipment used in resuscitation attempts was not adequately stocked, readily available, or functional. As noted in the inpatient report, medical reviews concluded that these problems did not contribute to the unsuccessful resuscitation attempt. OIG recommended that the facility ensure that the inpatient MH unit be equipped with functional and well-maintained life support equipment. In response to these recommendations, the facility established quarterly mock resuscitation drills on the inpatient MH unit for all shifts. Documentation from the

⁹ A huddle is a brief interdisciplinary meeting to facilitate patient care coordination, http://journals.lww.com/academicmedicine/Fulltext/2014/02000/Huddle_Coaching___A_Dynamic_Intervention_for.18.aspx. Accessed February 5, 2014.

facility's FY 2013 mock resuscitation drill reports supported proactive identification of potential equipment issues and strengthened staff competencies.

Issue 7: Disclosure

In our inpatient MH unit report, we recommended that the facility and Regional Counsel evaluate the care of the deceased patient for possible disclosure(s)¹⁰ to the appropriate surviving family member(s) of the patient. The facility had provided a clinical disclosure at the time of the patient's death. In response to the OIG recommendation, facility leadership proceeded with an institutional disclosure to the family.

B. Management of Contract MH Care and Related Patient Care Issues

Issue 1: Contract MH Program Oversight, Administration, and Staffing

MH Contract Oversight

A leader from VA Central Office of MH Operations visited the facility in April 2013 to assess the contract MH program and meet with the contractors and facility staff. Subsequently, the VA Central Office of MH Operations consultants, the National Center for Organization Development representatives, a leader from a different medical center, and an MH contracting employee conducted a "...thorough review and look at the institutional culture." The facility incorporated this team's findings into its action plan.

The facility's new leadership also took an active role in closely monitoring contract MH care and providing needed staffing and other resources. The Facility Director held meetings with CSB leaders and CCL staff, and the facility leadership began daily huddles. A Deputy Chief of Staff who was hired in May 2013 became directly involved in overseeing contract MH care, along with the Acting CSB Business Manager, Acting Contracting Officer's Representative, and other staff members.

Administration

We found significant improvements to the administration and coordination of the contract MH care program. These improvements were the result of a joint effort by the VA Central Office for MH Operations, VISN 7, the facility, and the CSBs. The facility established new contracts with selected CSBs. The facility implemented several key leadership changes and hired additional staff. After comprehensively reviewing the contract MH program's clinical and business processes, the facility developed strategic action plans to improve care, address responsibilities, and enhance communication.

¹⁰ Clinical disclosure is an informal process to discuss harmful or potentially harmful adverse events with patients and/or their families. Institutional disclosure is a more formal process used in cases of serious injury, death, or potential legal liability and includes an apology, compensation information, and procedures available to request compensation. VHA Handbook 1004.08, *Disclosure of Adverse Events to Patients*, October 2, 2012.

Following publication of the contract MH care report, the facility began actively collaborating with the CSBs. Through this partnership, the facility identified problems and coordinated effective processes for paying invoices and for receiving the medical documentation contractually required for payment. The facility redesigned flow steps to receive, track, and process invoices with the goal of shortening the time to pay for contracted MH care. The facility stated these processes reduced the backlog of unpaid invoices and outstanding balances owed to CSBs. The facility trained six program support assistants in the improved processes and the current medical codes used to report clinician procedures and services. In addition, the facility implemented business process changes that improved and supported administrative and clinical management, such as scheduling, consultation, and reauthorization procedures.

Leadership led efforts to begin the transition from the SELECT contract with 26 CSBs to long-term MH contracts with 5 primary CSBs in FY 2014. The facility is currently using interim contracts. The new interim contracts established a direct liaison with the facility to resolve and manage administrative and billing processes. The facility anticipates that long-term contracts will have an improved performance-based statement of work that clarifies contractor and facility responsibilities, authorization, billing, contract pricing, and other administrative and documentation requirements. These contracts should consolidate and simplify the management of the patients enrolled in contracted MH care.

Progress has been made; however, the facility continues to face residual business process challenges such as not knowing the payment status and amounts owed without contacting the CSB administrative staff. These challenges are largely caused by VA's privacy and security regulations, which limit the transfer of information electronically between the facility and the CSBs¹¹ and pose a major barrier to efficiency and accuracy. The inability to communicate electronically is a source of frustration for the CSBs and facility staff. CSBs must print large data files, such as billing invoices, treatment records, and other information, and arrange courier delivery. Once received, facility employees unpack, sort, transcribe and/or scan, and further process the paper. The facility's business office employees have been unable to scan the documents sent by some CSB facilities.

Administrative Staffing

At the time of our initial review, the facility had assigned approximately 10 employees (some with collateral duties) to manage and provide oversight of an estimated 4,000 patients who had been referred to multiple CSB programs. Following publication of the contract MH care report, VHA leaders addressed contract MH program oversight and referral by appointing VISN employees in roles of Acting CSB Business Manager and Acting Contracting Officer's Representative, and reassigning other key staff

¹¹ The use of the removable, unencrypted storage devices to store sensitive VA data is prohibited per *VA Handbook 6500, Risk Management Framework for VA Information Systems – TIER 3: Information Security Program*, September 20, 2012.

members within the MHSL. The facility also embedded 11 CCLs at the CSBs and hired a CCL supervisor. As of October 2013, the facility had increased staffing to 21 employees who manage approximately 2,040 patients across the 5 CSBs, each with multiple locations.

Issue 2: Coordination of Care and Monitoring for Patients Referred to CSBs

CSB Patient Tracking

Following the contract MH care report, facility staff members began efforts for outreach and re-engagement of contract MH patients. The facility conducted a comprehensive review of consultations, CSB lists, and EHRs, and found 4,912 patients had been referred to contracted care. Of the referred patients, the facility ascertained the clinical disposition of 4,500, found 69 others to be deceased, and scheduled 154 others for reassessment. The remaining 189 patients did not respond to the facility's telephone calls and outreach letters. Additionally, from July through October, the facility reduced the electronic wait list from 240 to 4 patients and transitioned MH services for 350 patients back to the facility or to CSBs.

The facility's action plan included the goals of developing tracking systems for CCLs to monitor real-time census, new referrals, treatment start and end dates, missed appointments, and other patient-related data. Individual CCLs were assigned up to 450 unique CSB patients. The CCLs tracked patients' completion of initial CSB visits and, weekly, transcribed names and updated information from CSB-provided lists onto their own census reports. In the absence of electronic data exchange, some maintained manually populated databases. Some CCLs managed their CSB patient census reports using computerized spreadsheets or databases, while others utilized hand-edited photocopied lists.

The facility did not have in place a centralized or facility-wide repository for CSB patient tracking data or a standardized tracking tool to support efficient oversight, access, and backup of data. Facility staff members were continuing to seek more efficient solutions for tracking patients and exchanging paper-based data with the CSBs.

Referral for Initial Contract MH Appointment

The contract MH care report found that the process for scheduling initial CSB appointments was ambiguous, and referrals to the CSB were not effectively monitored by the facility, allowing some patients to "fall through the cracks."

Following the contract MH care report, the facility implemented business process changes that improved and supported administrative and clinical management of the contracted MH program. For example, new scheduling procedures allowed patients to receive their CSB appointments before leaving the referring provider's office. The facility also revised contract consultation requests initiated through the EHR to conform

to the non-VA medical care coordination model¹² and added EHR alerts for managing consultations.

The facility developed a standard operating procedure that outlines specific duties and expectations of the CSB-embedded CCLs. As of January 2014, the standard operating procedure remained in draft but described the CCL's role to:

- Serve as the facility's point of contact at the CSB to facilitate resolution of administrative issues.
- Document CSB patients' initial appointments, treatments and discharge plans, interventions, incidents, emergencies, complaints, reauthorization extensions, and other events.
- Provide outreach to patients waiting longer than 14 days for intake appointments and offer participation in a CSB orientation group.
- Establish office hours for interaction with patients and CSB staff members.
- Be available to attend patient case review (treatment team) meetings and treatment groups.

To assess the efficacy of the changes made to processes in improving patient hand-off to the CSBs, we reviewed the EHRs of all 69 patients who had initial CSB referrals made during the week of September 9, 2013. Generally, facility staff members acted timely upon consultations and communicated with every patient in-person, by telephone, and/or by letter.

Of the 69 initial referrals, 56 patients received initial appointment dates and 13 patients did not respond to multiple contact efforts, declined initial CSB appointment dates, or had other reasons for consultation discontinuation or cancellation. In several cases, patients rescheduled or missed the initial appointments; however, the CCLs followed up with these patients to arrange new appointment dates. By the end of January 2014, 55 patients had attended their first CSB appointment and one patient's appointment was pending for February. With one exception, all EHRs contained scanned copies of the CSB's initial appointment documentation. After confirming that patients attended the first CSB appointments, CCLs administratively completed the initial referral consultations within the EHRs.

Monitoring of Ongoing CSB Follow-up

To assess continued CSB follow-up care, we looked for evidence of scanned CSB and CCL documentation from September 9, 2013 through February 2, 2014, in the EHRs of the 55 initial and 51 reauthorized CSB-referred patients mentioned above. On average, these patients had been enrolled in contract MH care for approximately 24 months and CCLs most often reauthorized an additional 12 months of treatment.

¹² Non-VA care coordination refers to medical care provided outside of the VA to eligible veterans when VA medical facilities are not feasibly available. It was formerly known as fee basis, purchased care, or non-VA care. <http://www.boise.va.gov/docs/FeeGUIDEBOOK.pdf>. Accessed February 12, 2014.

We reviewed documentation in the facility EHRs and found that most reauthorized CSB-referred patients had evidence of CSB follow-up. However, several EHRs did not have scanned copies of CSB follow-up notes suggesting that patients may have missed or stopped attending CSB appointments. In a few cases, CCLs documented in the EHRs their steps to contact the patients, coordinate care, or address concerns.

We referred 21 EHRs to the facility that had issues and/or lacked evidence of expected documentation for review and inquired if the CCLs should have documented on these patients. The facility acknowledged that more complete documentation was needed and noted that, in part, the problem was that the interim contracts did not require the same level of coordination that was required in VHA care, such as notification by phone for missed appointments or life-changing events.

An example case:

A patient's EHR had no recent CCL notes and one scanned CSB note, dated September 30, 2013, that outlined a clinician's plan of once-monthly counseling for the patient. Following the OIG inquiry, the facility learned that the patient did not show for subsequent appointments and eventually declined CSB offers for continued care; therefore, the CSB discharged the patient.

In this and similar cases, the facility stated that current MH interim contracts did not require that the CSBs communicate with the facility or CCL when patients did not show for appointments or discontinued care. Having this information would improve the facility's ability to send reminder notices and provide outreach to patients. The facility has reportedly worked out informal agreements with some of the CSBs to receive this information and the long-term contracts under negotiation are expected to address these issues.

VHA requires "[...] that mental health services must be integrated or coordinated with other components of overall health care."¹³ Current contract MH care agreements require that the facility communicate with the CSBs at the time of patients' initial referrals, but do not identify other points of care, such as reauthorizations or significant changes in patients' MH or medical care. Having this information would improve the CSB's ability to coordinate and integrate care for patients.

Issue 3: QM

The integration of an effective QM program between the facility and the CSBs is an essential component to ensuring safe and high quality patient care. Previously, the facility did not fulfill QM requirements for monitoring CSB and facility administrative and clinical processes. However, the strategic action plan included development and implementation of contract program QM monitors to evaluate compliance with patient

¹³ VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008

safety, patient complaints and satisfaction, and other elements of contract requirements. At the time of our follow-up inspection, VISN 7 staff collaborated with the facility to develop a data collection tool for quality monitoring.

The facility has implemented a QM plan that reports CSB performance and quality monitoring results through partnership meetings between the facility's Executive Leadership Committee and CSB leadership. The facility tracks, trends, and reviews data for VA referred CSB patient complaints and incidents. The CCLs monitor CSB medical records for quality, including CSB clinical patient care treatment plans, documentation, and other QM elements. The facility staff also conduct site visits and reviewed CSBs' quality information. Fee clerks and the Acting Contracting Officer's Representative utilize a spreadsheet and quality procedure to ensure that invoices are accurate and have been paid in full and on time.

Issue 4: Disclosure

In our contract MH care report, we recommended that the facility and Regional Counsel evaluate the care of two deceased CSB-referred patients for possible disclosures to the appropriate surviving family members of the patients. In May 2013, the facility provided an institutional disclosure to the brother and sister of one of the patients. In addition, the facility attempted to provide an institutional disclosure but was unable to reach the next of kin for the other patient's surviving family member.

Conclusions

Inpatient MH

In response to the recommendations in the inpatient MH unit report, the USH and the facility have implemented enhanced policies and procedures to support patient safety on inpatient MH units. The USH published a memorandum and a VHA Handbook that provided national guidance to inpatient MH units. The new facility leadership developed and implemented comprehensive policies and procedures, ongoing monitoring processes, and improved interdisciplinary staff communication that enhanced patient monitoring and safety on the inpatient MH unit. The facility plans other changes including restructuring the physical environment to accommodate different populations more effectively.

Staff members endorsed significant improvements in processes that contribute to enhanced competencies and procedural standardization. In addition to improving procedures, processes, and operations, facility leadership had established a safe learning culture.

Contract MH

We found improvements had been made to the administration and coordination of the contract MH care program. These improvements were the result of a joint effort by the VA Central Office for MH Operations, VISN 7, the facility, and the CSBs.

Key leadership changes were made and additional staff were hired at the facility. After comprehensively reviewing the contract MH program's clinical and business processes, facility leaders developed strategic action plans to improve care, address responsibilities, enhance communication, and resolve other problems.

Although CCLs individually track initial appointments and census of patients assigned to them, as of the end of FY2013, the facility did not have a standardized method or facility-wide repository for CSB patient tracking data. A centralized repository will provide for ready access and back up of this data.

We found that the facility improved processes related to initial referral of patients receiving contract MH. However, opportunities exist to improve coordination of patient care between the facility and the CSBs beyond the first appointment. Specifically, processes could be strengthened to improve communication from the CSBs to the facility when patients miss several appointments or discontinue care. Further, to ensure that care is integrated and coordinated beyond the initial referral, the facility should strengthen expectations for ongoing communication with the CSBs at the time of reauthorization and with significant changes in a referred patient's medical or MH care.

Overall, we noted improvements in oversight of the inpatient MH unit and contract MH care programs. The facility acknowledged the need for continued progress in these areas. As such, the facility's challenge is to continue to make improvements while sustaining positive changes made to date.

Recommendations

1. We recommended that the Facility Director ensure that a standardized and facility-wide repository be developed and implemented to monitor patients referred to community service boards.
2. We recommended that the Facility Director strengthen processes to ensure that patients are tracked for follow-up beyond the first contracted mental health care appointment.
3. We recommended that the Facility Director strengthen communication between the facility and the community service boards to better integrate and coordinate medical and mental health aspects of patient care.

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: May 16, 2014

From: Director, VA Southeast Network (10N7)

Subject: Healthcare Inspection—Follow-Up of MH Inpatient Unit and Contract Outpatient Programs, Atlanta VA Medical Center, Decatur, Georgia

To: Director, Baltimore Regional Office of Healthcare Inspections (54BA)
Director, Management Review Service (VHA 10AR MRS OIG Hotline)

1. The VISN 7 Network Office and the Atlanta VA Medical Center (VAMC) concurs with the findings and recommendations from the Office of Inspector General draft report on Follow up of Mental Health Inpatient Unit and Contract Outpatient Programs at the Atlanta VA Medical Center, Decatur, GA.
2. Specific to this report, I have detailed our plan of completion for these recommendations.
3. If there are any questions, please contact Dr. Robin Hindsman, VISN 7 Quality Management Officer at robin.hindsman@va.gov or 678-924-5723.


Charles E. Sepich, FACHE

Facility Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: May 14, 2014

From: Director, Atlanta VA Medical Center (508/00)

Subject: **Draft Report** – Healthcare Inspection – Follow-up of MH Inpatient Unit and Contract Outpatient Programs, Atlanta VA Medical Center, Decatur, Georgia

To: Director, VA Southeast Network 7 (10N7)

1. I concur with the findings and recommendations from the Office of Inspector General draft report on Follow up of MH Inpatient Unit and Contract Outpatient Programs, Atlanta VA Medical Center, Decatur, Georgia.
2. Thank you for the opportunity to review the draft report. Attached are the facility responses for these recommendations.

(original signed by Thomas Grace, MBA/MHA for:)

Leslie Wiggins
Director, Atlanta VA Medical Center (508/00)

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that the Facility Director ensure that a standardized and facility-wide repository be developed and implemented to monitor patients referred to community service boards.

Concur

Target date for completion: August 15, 2014

Facility response: In addition to existing consult management practices, a database management tool specific to supporting referred patients to non-VA contracted outpatient and residential behavioral health care is currently under development and testing. The tool is designed to track and enhance documentation and reporting relative to patient treatment to include admission, census, interventions, and disposition.

Recommendation 2. We recommended that the Facility Director ensure that processes are strengthened to ensure that patients are tracked for follow-up beyond the first contracted mental health care appointment.

Concur

Target date for completion: July 15, 2014

Facility response: Processes and procedures have been established for embedded Clinical Liaisons to coordinate with respective Community Partner treatment staff in order to track initial and follow-up appointments, and manage missed patient appointments in accordance with VA Patient No-Show policy. Review of processes and procedures are currently underway to ensure continuity among all partners and policy standards are being achieved.

Recommendation 3. We recommended that the Facility Director ensure that communication is strengthened between the facility and the community service boards to better integrate and coordinate medical and mental health aspects of patient care.

Concur

Target date for completion: September 30, 2014

Facility response: Clinical Liaisons have been assigned the dual role as patient Mental Health Treatment Coordinator (MHTC). In this dual role, Clinical Liaisons will have increased capability to share patient health information between VA and Community Partner treatment providers as appropriate. Procedures are currently being established

to include information sharing methods, documentation, and collaboration on patient treatment planning.

OIG Contact and Staff Acknowledgments

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