DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Director, VA Mid-Atlantic Health Care Network (10N7)

SUBJECT: Healthcare Inspection – Clinical and Administrative Issues in the Residential Treatment Programs, Carl Vinson VA Medical Center, Dublin, Georgia

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections received a confidential complaint that medication management practices do not comply with policy and that patients are not being adequately assessed for suicide risk in the mental health (MH) Psychosocial Residential Rehabilitation and Treatment Programs (PRRTPs) of the Carl Vinson VA Medical Center (the facility), Dublin, GA. We contacted the facility Director to notify him of our impending investigation, and he advised us that Mathematica Policy Research (an organization that contracts with VHA to perform quality reviews and consultation for MH PRRTPs) conducted a site visit in late March 2011 and (b)(3):38 U.S.C. 5705 The Director reported that (b)(3):38 U.S.C. 5705 (b)(3):38 U.S.C. 5705 (b)(3):38 U.S.C. The Director reported that the (b)(6) had been removed from his position and that additional staffing positions had been approved. (b)(3):38 U.S.C. 57 (b)(3):38 U.S.C. 5705 (b)(3):38 U.S.C. 5705 (b)(3):38 U.S.C. 5705 Our purpose was to determine addressed the complainant's allegations to the extent that a separate OIG review would not be necessary or productive.

Background

The facility is designated as a Veterans Rural Access Hospital. It is located in Dublin, GA, and provides a broad range of inpatient and outpatient health care services. Outpatient care is also provided at three community based outpatient clinics in Albany, Macon, and Perry, GA. The facility serves a veteran population of about 125,000 throughout 52 counties in Georgia and is part of VISN 7. The facility provides

behavioral health, long-term care, home care, and acute care services. It has 25 acute care, 145 domiciliary/PRRTP beds, and 161 community living center (CLC) beds.

We could not find a local policy describing the facility's PRRTP program. However, another VA medical center in VISN 7 includes this description in their policy: "The PRRTP operates as a supportive rehabilitative residential setting for veterans in need of a strong psychiatric, psychosocial, [and] recovery environment. The PRRTP focuses on recovery in support of the veterans participating within the intensive outpatient MH programs which include, but [are] not limited to Substance Abuse Treatment Program, PCT[1] Day Program, Veterans Industries Program, and the Day Treatment Program."

VHA's primary guidance is Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program*, dated December 22, 2010. In April 2011, a confidential complainant reported to the OIG that the facility's MH PRRTPs have not implemented some required elements of VHA Handbook 1162.02, as follows:

- The MH PRRTPs have not followed guidelines for the reconciliation of medications. There is no documentation of inspections that MH PRRTP patients are securing medications in personal lock-boxes as required.
- Inadequate staff supervision has led to instances of controlled substances being issued to patients in quantities greater than a 7-day supply. There have been suspected instances of patients selling controlled substances in the surrounding community.
- There is no indication that MH PRRTP patients are being assessed for suicide prior to admission as required.

Scope and Methodology

We reviewed VHA Handbook 1162.02, the facility's local policies on PRRTP admissions and drug screening, and the facility's (b)(3):38 U.S.C. 5705

Conclusions

The (b)(3):38 U.S.C. 5705 to the Mathematica site visit (b)(3):38 U.S.C. 5705
(b)(3):38 U.S.C. 5705

[1] PTSD clinical team

(b)(3):38 U.S.C. 5705

It appears (b)(3):38 U.S.C. 5705 addresses the complainant's primary issues. (b)(3):38 U.S.C. 5705 have been completed; (b)(3):38 U.S.C. 5705 are targeted for completion in late May 2011. Subsequent to receiving this referral, we learned that VHA has convened a team to visit the Dublin PRRTP and further evaluate the program and (b)(3):38 U.S.C. 570 corrective actions. Because the facility developed a comprehensive action plan, and in light of VHA's impending site visit, an OIG inspection at this stage would not be indicated.

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(b)(3):38 U.S.C. 5705