Administrative Closure
Mental Health Services Issues
El Paso VA Health Care System
El Paso, Texas
MCI # 2013-03001-HI-0437

On May 17, 2013, the Office of Inspector General Office of Healthcare Inspections received multiple allegations from an anonymous complainant regarding Mental Health (MH) Services at the El Paso VA Health Care System, El Paso, TX. We conducted a site visit May 28-31.

- We reviewed the following allegations related to MH care and services: Veterans went without MH services due to staff turnover; psychologists and interns were not supervised; the Intensive Out-Patient Program was inadequate; an [redacted] and a veteran patient had a dual relationship during community [redacted] meetings; and therapists entered current procedural terminology (CPT) codes for services that were not provided.
- We referred the following employment allegations to the System Director: poor relationships between MH service staff; the Human Resource (HR) Director did not have an HR degree and the Finance Director did not have a finance degree; Equal Employment Office complaints are squashed; and a staff member is often tardy and frequently takes smoking breaks.
- We referred the following allegations to the OIG Dallas Office of Investigations (51): employees are "beat up," framed, and forced to quit or risk having their families threatened; and "investigators are bought off."

While on site, we interviewed the System and Quality Management Directors, the Chiefs of Staff and MH Services, and 23 MH Service staff (psychiatrists, psychologists, social workers, addiction therapists, and peer counselors). We reviewed VA Directives and local policies, performance evaluations, meeting minutes, HR provider recruitment documents, and other pertinent documents. We reviewed CPT coding records from January-May, 2013. We reviewed a 2012 VACO MH Consultative Site Report and the System's Strategic Action Plan response.

Background: In August 2012, a VA Central Office MH consultant team conducted a site visit and made recommendations pertinent to allegations in this complaint. 1) Develop a comprehensive staff recruitment plan and Tele-Mental Health Program to address staffing shortages and patient MH access delays. 2) Conduct a system redesign and implement the Primary Care-MH Initiative blended model. 3) Hire a Licensed Rehabilitation Counselor and paid peer support specialists, and expand the Compensated Work Therapy program. The facility provided an action plan to VACO in August, met target dates, and completed the majority of the plan's goals prior to our review. The Board approved a system redesign allowing mid-level providers to be supervisors. The plan was awaiting Union approval at the time of our review. A new System Director and Chief of MH were appointed January 2013.

Staff Turnover and Patient Wait Times: We reviewed patient wait time performance indicators and found new patients waited, on average, 82 days before seeing a MH provider, compared to 57 days regionally and 39 days nationally. We learned that, in the last 4 years, there were at least eight MH Chiefs, which had a significant negative impact on staff satisfaction and many providers left soon after hire. The VACO consultants found a 30% provider vacancy rate in August 2012. At the time of our visit, most positions were filled, but not all hires were on station

yet. We learned a Tele-Mental Health Program was operational, and HR was aggressively trying to recruit new providers. Additionally, a "bridging" psychologist now prescribes medications until an appointment is made.

Supervision: Many staff did not receive timely performance evaluations and newly hired staff told us they did not receive unit-specific orientations, which was confirmed by program leaders and the MH Chief. We attribute this to frequent Chief of MH turnovers and the MH service reporting structure, which had most MH staff reporting directly to the Chief. We found the system addressed these concerns by hiring a Chief of MH who is committed to remaining at the system and redesigning the MH services reporting structure, which will allow for mid-level providers to be supervisors.

Dual Relationship: The [b3;b6;] 's supervisor had reviewed the dual relationship allegation prior to our receiving the allegation. The supervisor reviewed the facts, determined a dual relationship did not exist, and reported this to the system Director and MH Chief.

CPT Coding: In March 2013, during a routine peer record review, a staff found two MH providers had entered billing codes for biofeedback and psychophysiological therapy, which staff do not provide and are not privileged to conduct. System staff corrected the CPT coding prior to our receiving the allegation and the providers received CPT code training. We did not find incorrect coding for April or May. We determined there was no gain for incorrect coding and the miscoding was a simple error.

We determined management and leadership were aware of the quality of care and service allegations within the MH Service and had either appropriately addressed the issues or had plans in place to do so. Therefore, we are administratively closing this case.

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