Department of Veterans Affairs
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Office of Healthcare Inspections

Report No. 14-05158-377

Healthcare Inspection

Mismanagement of Mental Health Consults and Other Access to Care Concerns
VA Maine Healthcare System
Augusta, Maine

June 17, 2015

Washington, DC 20420

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Telephone: 1-800-488-8244
E-Mail: vaoighotline@va.gov
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Executive Summary

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection at the request of former Ranking Member of the House Committee on Veterans' Affairs, Michael Michaud, regarding allegations of mismanagement of mental health (MH) consults and other access to care concerns at the VA Maine Healthcare System (facility), Augusta, ME.

We substantiated the allegations that (1) staff were directed to discontinue using the consult package to make referrals for MH services in certain circumstances and (2) language in the consult package directed providers not to request MH consults if the patient was not willing to be seen within 14 days. Incidental to our review, we found that processes used to refer patients within the MH service made it difficult to track whether patients' requests for services were met and that some patients had unmet needs.

We did not substantiate the allegation that staff were directed to restrict who could submit MH consults. Two of the facility's Clinical Applications Coordinators told us that, consistent with Veterans Health Administration (VHA) guidance, they typically grant access to enter and release requests for consultation in VHA's Computerized Patient Record System to specific categories of staff, including physicians, social workers, and psychologists. Based on our interviews and documents we reviewed, we did not identify staff who should have been able to enter and release consults but were unable to do so.

Although we did not substantiate the allegation that staff were *directed* to close consults before the requested services were rendered, we found that this practice occurred. For example, based on our medical record reviews and interviews, we identified instances of patients whose MH consults were closed once appointments were scheduled but before the patients received requested services.

We did not substantiate the allegation that facility leadership inappropriately directed staff to utilize workshops to meet VHA's benchmark for timely MH assessments and follow up. However, we did find that: (1) some patients participated in group MH workshops, and interviewees raised concerns about the clinical appropriateness of those workshops; (2) patients' attendance in workshops did not "count" towards meeting VHA performance measures; and, (3) some of the Chief of MH's correspondence with staff emphasized meeting performance measures.

We did not substantiate the allegation that, in order to meet VHA's benchmark for same day access, staff were directed to discontinue scheduling MH appointments in advance and instead utilize drop-in clinics. None of the interviewees told us that this had occurred, and we were not provided documentation to support the merit of this allegation.

We did not substantiate the allegation that staff were directed to omit information related to MH conditions that could be service connected from clinical notes in order to limit the number of veterans seeking MH services. None of the interviewees told us that this had

occurred, and we were not provided documentation to support the merit of this allegation.

We did not substantiate the allegation that licensed independent providers, such as social workers and psychologists, were directed to see patients for medication management, even though this was outside of their scope of practice. We found that during certain time periods, these types of staff were directed to contact veterans to check on whether they had any urgent needs or needs for medication refills or renewals, which was within their scope.

We substantiated the allegation that some of the alleged practices have persisted, despite other reviews, including an Administrative Review, routine reviews by VHA's Office of MH Operations, and a review by VHA's National Center for Organizational Development that was requested by the Facility Director.

During the course of our review, other concerns were brought to our attention, including concerns about the overall availability of MH services, extent of MH coverage for the Emergency Department, and the appropriateness of some scheduling practices. We incorporated many of those concerns into our review.

We made eight recommendations.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with our recommendations and provided acceptable action plans. (See Appendixes B and C, pages 17–22, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection at the request of former Ranking Member of the House Committee on Veterans' Affairs, Michael Michaud, regarding allegations of mismanagement of mental health (MH) consults and other access to care concerns at the VA Maine Health Care System (facility), Augusta, ME. The purpose of the review was to determine whether those allegations had merit.

Background

The facility is part of Veterans Integrated Service Network (VISN) 1 and comprises the Togus Medical Center in Augusta, ME, and community based outpatient clinics (CBOCs) in Bangor, Calais, Caribou, Lewiston, Lincoln, Portland, Rumford, and Saco, ME. The facility also operates access points in Bingham, Fort Kent, and Houlton, ME. The facility provides acute medical, surgical, neurological, rehabilitation, and MH care for the veterans throughout Maine.

MH Care

VHA medical facilities must provide access to general and specialty MH services, when clinically appropriate.[1] General MH services include treatment planning evaluations and services for a range of MH concerns. Specialty MH services include evidence-based psychotherapy, such as cognitive processing therapy (CPT) and prolonged exposure therapy for post-traumatic stress disorder (PTSD), and intensive case management for patients with serious mental illness. VHA emphasizes recovery-focused, evidence-based treatment, though medical facilities should be responsive to the needs and preferences of those who have been receiving long-term, supportive care.

Interdisciplinary Team

MH services are generally rendered by an interdisciplinary team comprising providers with prescribing authority (such as, physicians, nurse practitioners, and physician assistants), psychologists, and social workers, among others. Team members are expected to work within their scope of practice and to collaborate with other team members to meet veterans' needs. For example, consistent with VHA job descriptions, licensed independent providers (LIPs), including social workers and psychologists, are expected to assess the psychosocial functioning and needs of patients and determine if assistance is needed, in collaboration with the interdisciplinary team. LIPs generally should not initiate, modify, or discontinue medication orders, since those are responsibilities of providers with prescribing authority, including physicians, physician assistants, and nurse practitioners. The service line chief is responsible for ongoing monitoring of team members' professional performance.

[1] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008. This VHA Handbook was scheduled for recertification on or before the last working date of September 2013 but has not yet been updated.

MH Referrals

Non-MH providers, including primary care providers, can have a role in assisting patients to access MH services by providing "warm handoffs" to MH providers or by entering requests for consultation into the Computerized Patient Record System (CPRS) consult package.[2] In addition, Emergency Department (ED) providers may request MH evaluations for patients 24 hours per day, 7 days per week, since facilities are required to have a designated MH provider on site or on call at all times.[3] MH providers also have a role in assisting patients to access additional MH services and should enter consults for all referrals that cross programs of care, such as from general MH to the PTSD care team.[4] Consults can be closed in a number of ways, such as the following.[5]

- Cancellation – This option is appropriate when the consult prework is inadequate, incomplete, or outdated.

- Discontinuation – This selection should be utilized when the service is no longer needed, when the patient refuses the service, and when the patient is already an established patient.[6]

- Complete via CPRS progress note – This option should be used when appropriate documentation is available within CPRS and linked to the consult.

Scheduling MH Appointments

VHA policy delineates the processes facilities should follow when scheduling patient appointments, including those for MH services.[7] For example, VHA facilities should:

- Utilize the electronic waiting list (EWL)—the official VHA waitlist—to track patients who cannot be scheduled within 90 days, or who are waiting to be assigned a provider. In general, the EWL is used to keep track of patients with whom the clinic does not have an established relationship (for example, the patient has not been seen before in the clinic).

[2] A warm hand-off generally involves introducing a patient to a specific MH provider so that the provider can begin to engage the patient in treatment.
[3] VHA Handbook 1160.01.
[4] Assistant Deputy Under Secretary for Health for Clinical Operations Memorandum, "Implementation of the Consult Package for Mental Health," June 3, 2013.
[5] Under Secretary for Health Memorandum, "Consult Business Rules Implementation," May 23, 2013.
[6] When consults are discontinued because the patient is already established with the service, a remark must be added regarding when an appointment has been scheduled.
[7] VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures*, June 9, 2010. This Directive expires June 30, 2015.

- Provide priority care for non-emergent outpatient medical services for any condition of a service-connected veteran rated 50 percent or greater or for a veteran's service-connected disability.[8]

Timely Access to MH Care

VHA policy requires that all first-time patients referred to or requesting MH services receive an initial evaluation within 24 hours and a more comprehensive diagnostic and treatment planning evaluation within 14 days.[9] To promote timely access, MH services may be rendered through in-person appointments at VHA facilities or through telehealth. In instances when facilities are unable to meet patients' needs timely, facility staff may refer the patient to other VHA facilities or may assist them to access services outside VHA through sharing agreements, contracts, or non-VA care. VHA has performance measures intended to monitor access to MH services, including measures of the percentage of new and established MH patients whose appointment wait times were longer than 14 days.

Allegations

Former Ranking Member of the House Committee on Veterans' Affairs, Michael Michaud, forwarded a letter to the OIG that included the following allegations:

1. Beginning in the 2011 timeframe, VA Maine Healthcare System leadership instructed staff to utilize the following inappropriate practices:

    a. For an unspecified amount of time, discontinue using the consult package to make referrals for MH services.

    b. After resuming the use of the consult package to track referrals to MH services, restrict who could submit MH consults.

    c. Implement practices to close consults before the requested services were rendered.

    d. For an unspecified amount of time, include language in the consult package to direct providers not to request MH consults if the patient was not willing to be seen within 14 days.

    e. Utilize "intake workshops," MH classes, or any other type of MH-related individual or group session in order to meet VHA's benchmark for timely MH assessments and "MH workshops" to meet VHA's benchmark for timely follow up referrals, despite staff concerns about the clinical appropriateness of these practices.

[8] A service-connected disability is one that was incurred or aggravated as part of duty in the U.S. Armed Forces. See 38 U.S.C. §101 (16). A separate entity within VA, the Veterans Benefits Administration determines whether veterans have service-connected disabilities and, if so, the severity of such disabilities (from 0 to 100 percent). To assist with the determination of the extent of disability, Veterans Benefit Administration staff may review information contained in veterans' EHRs.
[9] VHA Handbook 1160.01.

f. For a several week period, in order to meet VHA's benchmark for same day access, discontinue scheduling MH appointments in advance and instead utilize drop-in clinics.

g. Omit information related to MH conditions that could be service connected from clinical notes in order to limit the number of veterans seeking MH services.

h. For licensed independent practitioners, such as social workers, see patients for medication management, even though this was outside of their scope of practice.

2. Some of these inappropriate practices have persisted, despite an Administrative Review and reviews by VHA's Office of MH Operations and National Center for Organizational Development.

Scope and Methodology

The period of our review was September 29, 2014 through March 31, 2015. We conducted a site visit from October 27–29, 2014. Prior to this visit, we distributed an email to facility MH staff as well as staff from Vet Centers located in Maine to describe the purpose of our visit and to offer to meet with them either on or off-site to discuss facts pertaining to the allegations.

We conducted more than 40 interviews of individuals and groups regarding the issues under review, including the Facility Director, Chief of MH, Chief of Psychology, several schedulers, two clinical applications coordinators, three primary care providers, two ED providers, numerous MH providers, and members of a veterans' support group.[10] We also interviewed the Acting Chief of VHA's Office of MH Operations, VISN MH Lead, and VISN Chief Health Informatics Officer.

We reviewed relevant VHA, VISN, and facility policies and procedures; data and documents posted on the Veterans Support Service Center; facility documents regarding MH staffing, scheduling, and consults; waitlists; quality management documents; e-mails; and other pertinent data and documents provided by interviewees and others with knowledge about the issues under review. We also reviewed the electronic health records (EHRs) of selected patients, identified by interviewees and through our review of facility consult data, to determine whether the facility was processing consults and scheduling appointments in a timely and appropriate manner.

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.

[10] At the time of our site visit, the Facility Director had been in that role since August 2012 and, before that, he was the Associate Director for about 6 years. The Chief of MH had been in that role since May 2010.

Inspection Results

Issue 1: Extent of Use of the Consult Package to Track MH Referrals

We substantiated the allegation that staff were directed to discontinue using the consult package to make referrals for MH services in certain circumstances. Incidental to our review, we found that processes used to refer patients within the MH service made it difficult to accurately track whether patients' requests for services were met and that some patients had unmet needs.

Consult Language

At the time of our site visit, two types of MH consults—consults for Togus outpatient MH and outpatient psychological testing—contained language that directed providers not to use the consult package to make referrals. (For screen shots of those consults, see Appendix A.) This is inconsistent with VHA policy.[11] Other types of MH consults, including consults for services at CBOCs, did not contain this language. The inappropriate Togus outpatient MH consult language was added to the consult package in March 2012. We were unable to determine when the language was added for the psychological testing consult. The Facility Director told us that it was his understanding that the language contained in the Togus outpatient MH consult was added to the consult package to encourage warm hand offs and not to circumvent the use of the consult package. Encouraging providers to enter MH consults, as appropriate, is important for efficiently communicating requests for services. Further, use of the consult package enables the facility and VHA to efficiently determine which patients are awaiting requested services and how long they have been waiting.

Because of the volume of patients whose care could have been impacted by the language that directed providers not to enter Togus outpatient MH consults into CPRS under certain circumstances, we alerted the Chief of MH and Facility Director to this issue prior to publication of this report. The Facility Director told us that he promptly had the "confusing" language removed from the consult package. He also provided us with an email sent to all medical and dental staff to clarify the steps that should be taken when making MH referrals for patients that are not able or willing to be seen timely. These steps did not address the problematic language in the outpatient psychological testing consult.

Making Referrals Within MH

Interviewees told us that referrals among MH providers were generally not entered into the consult package. Instead, these referrals were generally made via telephone; by adding another provider as an additional signer to a note in CPRS, which will trigger an alert to that signer (referred to as a "view alert"); and through email. Interviewees also told us that they used various strategies, including maintaining spreadsheets and paper notes, to track these patient referrals. Several interviewees told us that managers, including the Chief of MH, told them not to use the consult package to make referrals

[11] Assistant Deputy Under Secretary for Health for Clinical Operations Memorandum, "Implementation of the Consult Package for Mental Health," June 3, 2013; and VHA Directive 2008-056, *VHA Consult Policy*, September 16, 2008. This Directive expired September 30, 2013 and has not yet been updated.

whereas others told us that they were not sure when or why these practices began. Nonetheless, interviewees acknowledged that patients may be "slipping through the cracks." From the list of names provided to us while we were on-site, we reviewed examples of referrals among MH providers and confirmed that some were not entered into the consult package, as required. Other referrals were not entered in the consult package, but there was no requirement to do so because the referrals were within subspecialty, such as from PTSD group to PTSD individual therapy. We also found instances in which referrals among MH providers appear to have been overlooked and, as a result, the patients may have unmet needs. For example:

- Patient A: In mid-2014, while establishing care at the facility, a patient in his 30s who was 50 percent service connected for PTSD was seen by a psychologist for a MH intake assessment. After the assessment, the psychologist referred the patient for individual therapy via an email to a therapist and did not enter a consult into CPRS as required. Initially, the therapist indicated that the patient should attend the "Understanding PTSD" workshop.[12] When the psychologist replied that the patient was not interested in attending the workshop, the therapist agreed to see the patient, noting that the therapist could "fit two more in so he'll be number #1[sic]." There was no documentation in CPRS that the therapist attempted to contact the patient and no appointments were scheduled for the patient with that therapist. About 8 months later, the patient was scheduled for individual therapy with a different therapist.

- Patient B: In mid-2014, while transferring care from another VA medical facility, a patient in his 40s who was 30 percent service connected for PTSD communicated an interest in continuing the course of CPT, a specific type of individual therapy, which he began at the other facility. A social worker submitted a MH consult, which was closed after the patient was seen for a MH intake assessment. The note from this assessment stated that the patient was not interested in group therapy and that the psychologist would "contact MH providers regarding the request for individual therapy." No consult related to this request was entered into CPRS as required. About 2 weeks later, a provider documented a conversation with the patient regarding the CPT protocol's recommendation for weekly sessions for 13 weeks. About 1.5 months later, the patient relayed that he could only commit to therapy sessions every other week. In response, a therapist reiterated that weekly sessions were needed for CPT. There was no documentation that alternate treatment options were discussed. No further contacts between facility providers and the patient were documented until about 1.5 months later when the patient restated his interest in CPT, experience that another VA medical facility had been willing to accommodate his schedule, and perception that the facility was not helpful to patients. Later that day, the patient was informed that providers would be willing to meet with the patient on a biweekly basis via telemedicine and that there was a waiting period for in-person therapy at Togus. The patient opted to wait for in-person

[12]This workshop was a two session group for veterans with a diagnosis of PTSD and their significant others or adult family members.

appointments.[13] About 3 months later, 7 months after the patient initially requested individual therapy, the patient was offered and began CPT.

- Patient C: In late 2014, a family member of a patient in his 30s who was 100 percent service connected for bipolar disorder contacted the facility to request that a therapist meet with the patient.[14] The patient was an established MH patient at the facility but had previously been seen for medication management only. No consult for individual therapy was entered into the consult package as required. Rather, an email was circulated that indicated that a patient needed a therapist. The patient was scheduled with a psychologist for the following week.

Issue 2: Alleged Limitations of Providers' Capability to Enter MH Consults

We did not substantiate the allegation that staff were directed to restrict who could submit MH consults.

The facility's Clinical Applications Coordinators told us that, consistent with VHA guidance, they typically grant access to enter and release consults in CPRS to specific categories of staff, including physicians, social workers, and psychologists.[15] Although two interviewees told us that some providers who should have been capable of entering MH consults were unable to do so, we did not substantiate those claims. In particular, one interviewee told us that she did not think she was able to enter MH consults until within the last year. However, data the facility provided suggested that the interviewee had the ability to enter consults for several years. The interviewee acknowledged that she may have had the ability to enter consults but simply did not know how to do so. Another interviewee told us that some primary care providers told him that they were unable to enter MH consults. However, primary care providers we interviewed told us that they could enter MH consults and were unaware of a time during which providers in their service did not have such a capability.

Issue 3: Closure of MH Consults Before Requested Services Were Rendered

We did not substantiate the allegation that staff were *directed* to close consults before the requested services were rendered; however, we found that this practice had occurred.

Based on our EHR reviews and discussions with interviewees, we identified examples of patients whose MH consults were closed before the requested services were rendered. For example:

[13] Because interviewees who were knowledgeable about facility scheduling practices told us that the facility does not generally maintain an EWL for MH services, it is unlikely that this patient was added to that list after this conversation as required. For further discussion of this type of noncompliant scheduling practice, see the corresponding section under Issue 10.
[14] The EHR contained documentation that the patient had granted them permission to discuss the patient's care with the family member.
[15] VA, *Computerized Patient Record System (CPRS) System Setup Guide,* April 2011.

- Patient D: In mid-2014, the primary care provider for a patient in his late 60s who was 50 percent service connected for PTSD submitted a consult for MH care to a CBOC. The patient was subsequently scheduled to see a MH provider but called to reschedule once and later missed the rescheduled appointment. There was no documentation in the EHR that the patient's need for the service was reassessed and that attempts were made to reschedule the appointment, as appropriate. This was inconsistent with VHA policy.[16] Further, about 4 months later, after a primary care appointment during which the patient indicated that he was not interested in therapy at the time, the consult was completed via a CPRS progress note that stated, "This consult is closed," rather than being discontinued as required.[17]

- Patient E: In mid-2014, the primary care provider for a patient in his late 50s with no service connected MH conditions submitted a consult for MH care to the Togus Medical Center. Two days later, at the patient's request, an appointment was scheduled for about 1 month later. The consult was subsequently discontinued, and a remark was added to indicate that the provider explained to the patient the facility's policy for scheduling patients within 14 days and that, since the patient desired to be seen in about a month, the consult was being closed. This was inconsistent with VHA policy; the consult should have been closed via a CPRS note after the patient was seen by MH.[18]

- Patient F: In mid-2014, the MH prescriber for a patient in his mid-20s who was 70 percent service connected for PTSD submitted a consult indicating the patient requested individual treatment for PTSD and that the patient understood that there may be a wait, but was willing to wait because he was not comfortable with group therapy. The same day, a provider with the PTSD clinic screened the patient, added a therapist from a CBOC as an additional signer on that note, and closed the consult, noting that the patient had been "set up with" individual therapy at a CBOC. This action was inconsistent with VHA policy.[19] Rather, the consult should have been closed about 2.5 months later, after the patient was a no show for his appointment and staff were unable to reach him to reschedule.

Issue 4: Consult Package Language that May Dissuade Providers from Entering Consults for Patient Who Cannot Be Seen Timely

We substantiated the allegation that language in the consult package directed providers not to request MH consults if the patient was not willing to be seen within 14 days, as described under Issue 1. Because of the volume of patients whose care could have been impacted by the consult language, we alerted the Chief of MH and Facility Director of this issue prior to publication of this report. The facility has already taken appropriate action to remedy this issue.

[16] VHA Directive 2010-027.
[17] Under Secretary for Health Memorandum, "Consult Business Rules Implementation," May 23, 2013.
[18] VHA Directive 2010-027 and Under Secretary for Health Memorandum, "Consult Business Rules Implementation," May 23, 2013.
[19] VHA Directive 2010-027.

Issue 5: Alleged Utilization of Intake Workshops, MH Classes, or Irrelevant MH Services to Meet VHA's Benchmarks for MH Access

We did not substantiate the allegation that facility leadership inappropriately directed staff to utilize workshops to meet VHA's benchmark for timely MH assessments and follow-up. However, we did find the following.

- Some patients participated in group MH workshops, and interviewees raised concerns about the clinical appropriateness of those workshops.
- Some of the Chief of MH's correspondence with staff emphasized meeting performance measures.
- Patients' attendance in workshops did not "count" towards meeting VHA performance measures.

With respect to workshops, we found that the facility had offered a number of group MH workshops, some of which were designed to present options for additional MH treatment. For example, in early 2014, patients referred for PTSD treatment were expected to receive a MH intake assessment and participate in the "Understanding the Effects of Trauma" class. At the end of the class, each patient was supposed to meet with a provider who would help him or her consider options for further treatment, as appropriate. Options for treatment may have included an Intensive Outpatient Program, evidence-based psychotherapy, and additional group sessions. Several interviewees raised concerns about the appropriateness of these workshops. For example, one interviewee referred to these workshops as a "holding pen for patients that we couldn't get into treatment." Another interviewee told us that, following the workshop, some patients were not referred for appropriate services, such as individual therapy, because there were insufficient staff available to render those services.

We found that some of the Chief of MH's correspondence with staff emphasized meeting performance measures, which may have contributed to the perception that the facility had established the workshops in order to "game" the measures. For example, we reviewed correspondence in which the Chief of MH expressed an interest in avoiding being an outlier on measures and an effort to try to "fly under the radar."

With respect to performance measures, VHA had measures that were intended to assess whether patients received the required MH evaluations timely. We found that the facility's performance on those measures was not affected by patients' participation in the workshops because documentation we reviewed indicated that those sessions were appropriately coded as group sessions, which are not included in those measures.

Issue 6: Alleged Discontinuation of Scheduled Appointments to Meet VHA's Benchmarks for Same Day Access

We did not substantiate the allegation that, in order to meet VHA's benchmark for same day access, staff were directed to discontinue scheduling MH appointments in advance and instead utilize drop-in clinics. None of the interviewees told us that this had occurred, and we were not provided documentation to support the merit of this allegation.

Issue 7: Alleged Instruction to Omit Information Related to Potentially Service-Connected MH Conditions

We did not substantiate the allegation that staff were directed to omit information related to MH conditions that could be service connected from clinical notes in order to limit the number of patients seeking MH services. None of the interviewees told us that this had occurred, and we were not provided documentation to support the merit of this allegation.

Issue 8: Alleged Instruction to LIPs to Practice Outside Their Scope

We did not substantiate the allegation that LIPs were directed to see patients for medication management even though this was outside of their scope of practice.

We found that during certain time periods, including in April and October 2014, facility LIPs were directed to contact patients to check on whether they had any urgent needs or needs for medication refills or renewals. Such contacts were deemed necessary since those patients' appointments had been cancelled and were unable to be rebooked timely due to appointment availability. We concluded that contacting the patients was within the scope of the LIPs because we were not provided with evidence that they were expected to make judgments about medication orders.

Issue 9: Extent to Which Inappropriate Practices Have Persisted at the Facility Despite Prior Reviews

We substantiated the allegation that some of the alleged practices have persisted, despite reviews by an Administrative Review Board, VHA's Office of MH Operations, and VHA's National Center for Organizational Development.

We reviewed reports that summarized the findings of four internal reviews that involved the facility's MH department, from FY 2011 through FY 2014. These reviews included an administrative investigation, two routine reviews by VHA's Office of MH Operations, and one review by VA's National Center for Organizational Development.[20] Some of the allegations that were examined during the administrative review from August to November 2012 were similar to those that prompted this inspection, particularly concerns about the appropriateness of group workshops and the extent to which scheduled appointments were being eliminated. That review relied heavily on staff interviews, did not substantiate the allegation related to scheduled appointments, and did not result in formal recommendations to facility management. The final report also highlighted communication challenges between MH managers and other staff. The review by the National Center for Organizational Design was completed in mid-2013 at the request of the Facility Director. This review focused on communication challenges and staff morale and did not explicitly review the allegations included in this inspection. Because the Office of MH Operations' reports are protected under 38 U.S.C. 5705,

[20] Administrative investigations refer to fact finding efforts regarding matters of significant interest to VA. VHA's Office of MH Operations periodically completes consultative site visits to review aspects of MH care at VA medical facilities. VA's National Center for Organizational Development is charged with conducting individual and organizational assessments, consultation, and intervention to strengthen VA workforce engagement, satisfaction, and development in order to improve services to veterans and their families.

further discussion of the objectives, findings, and recommendations, if any, in this report is prohibited by law.

Issue 10: Other Findings

During our review, other concerns about facility MH services were brought to our attention. We incorporated many of those concerns into our review (as discussed below). In a small number of instances, concerns were outside the scope of our review, were referred to OIG's Hotline Division, and will be addressed as appropriate.

Availability of MH Services

Interviewees told us that many MH providers had limited appointment availability, which made it difficult to provide timely services as required. Interviewees described factors that may have contributed to limited availability of appointments, including staff turnover, delays in filling vacant positions, insufficient target staffing levels, and a reluctance to utilize non-VA care. Additional factors, such as missed opportunities, may have contributed to the limited availability of appointments.[21] Due at least in part to limited appointment availability, we found that some of the patients we reviewed did not receive requested MH services and others experienced lengthy wait times. For example:

- Patient G: In late 2013, a prescriber referred an established MH patient in his mid-40s who was 70 percent service connected for PTSD for individual therapy by adding a provider as an additional signer to the note. The second provider subsequently added a third provider as an additional signer on an addendum to that note. About 3 weeks later, a fourth provider documented in the patient's chart that the patient was still waiting to hear back regarding individual therapy. An addendum to this note indicated that the patient was on a list for treatment.[22] The patient participated in several group therapy sessions and workshops through March 2014, when EHR reflects that the patient reiterated his interest in individual therapy, understood that there would be a wait for the next available provider, and would be added to a waitlist. Since then, the patient has engaged in group therapy and other MH services. However, as of mid-May 2015, nearly 1.5 years after the initial request, there was no documentation in the CPRS that the patient was offered individual therapy.

- Patient H: In 2014, a patient in his 50s who was 100 percent service connected for psychosis was unable to obtain intensive case management services through VA, and a request for non-VA case management services was denied. In particular, in mid-2014, an inpatient provider entered a consult for non-VA care case management. The provider noted that the needed services were not available through the facility and that the patient was a "highly complex case," had multiple psychiatric hospitalizations, was on the high risk list for suicide, and had family members who specifically requested case management services. No response to this consult was documented for about 4.5 months until the provider

[21] The missed opportunity rate for individual patient visits increased from 16.4 to 18.71 percent, between fiscal years 2011 and 2014. These rates exceed VHA's target of less than 10 percent.
[22] As discussed elsewhere in this report, interviewees who were knowledgeable about facility scheduling practices told us that the facility does not generally maintain an EWL for MH services.

who oversees non-VA MH care discontinued the consult noting that the patient had been referred for in-house MH services. In the interim, multiple notes in the CPRS reiterated the providers' impression that the patient would benefit from case management services and additional consults for these services were entered into CPRS and subsequently denied because the services were unavailable at the facility. No alternatives were presented by the provider who oversees the facility's non-VA MH care or the other consultants. To try to meet the patient's needs, a psychologist began meeting with the patient every 1–2 weeks. This may have been helpful for that patient, but may have adversely affected the availability of therapy appointments for other patients.

- Patient I: In early 2014, an established MH patient in his 60s who was 30 percent service connected for PTSD told his psychiatrist that he was interested in receiving individual therapy. That provider referred the patient for this service by adding another provider as an additional signer. About 2 weeks later, that provider documented a conversation with the patient during which the patient was informed that the psychologist had a waitlist and that neither medical residents had availability.[23] The patient expressed a desire to stay on the waitlist for individual treatment. About 10 months later, the patient was screened by a provider with the PTSD program and subsequently began receiving individual therapy.

At the time of our site visit, the facility had taken several steps intended to improve the facility's ability to meet demand for MH services, including trying to recruit and hire staff to fill vacant positions and having the Chief and Associate Chief of MH provide direct patient care.[24] Since our site visit, the facility also began recruiting and hiring MH staff using additional funds appropriated by Congress.[25]

Timeliness of MH Services in the ED

One weekend in June 2014, MH coverage was not available for the ED. The facility put a plan in place to defer admitting patients to the inpatient psychiatric unit from 5 p.m. Saturday until noon on Sunday (19 hours). This was inconsistent with VHA and local policy.[26] Interviewees told us that similar instances had occurred during other time periods. This is problematic because plans to defer admissions could result in unnecessarily lengthy ED stays and delay patients' admission to more appropriate care settings. Based on review of clinical notes and ED data, interviewees told us that the historical coverage issues they described did not adversely affect patients.

[23] Interviewees who were knowledgeable about facility scheduling practices told us that the facility does not generally maintain an EWL for MH services, as discussed elsewhere in this report.
[24] One of the positions that was vacant at the time of our site visit was that of the required full-time local recovery coordinator who is charged with ensuring that recovery-oriented MH services were available to patients.
[25] The additional funds were appropriated under Public Law 113-146, Veterans Access, Choice, and Accountability Act of 2014.
[26] VHA Handbook 1160.01 and VA Maine Healthcare System, *After-Hour Admissions to Inpatient Mental Health*, March 9, 2012.

Noncompliant Scheduling Practices

Knowledgeable interviewees told us that the facility does not generally use the EWL for MH as required. In particular, rather than using the EWL to track new MH patients who cannot be scheduled within 90 days as required, the facility typically schedules patients in appointment slots in the distant future. For example, as of mid-March 2015, 37 new MH patients had appointments scheduled more than 90 days in the future (range100–204 days). One interviewee reported being instructed by a manager not to use the EWL. Failure to use the EWL is problematic because it makes it more difficult for VHA to consistently and accurately measure demand for services across VHA.

Additionally, one interviewee raised concerns that the facility was not providing priority care for service-connected veterans as required. That interviewee told us that a manager had provided instruction to disregard service connection when scheduling appointments.

Fear of Reprisal

Numerous interviewees described chronically low morale among staff and a pervasive fear of reprisal should they raise concerns to management. The Facility Director told us that, in the past, the Chief of MH's statements and actions could have been interpreted as threatening, though they were not intended to be so. However, he told us that he had taken steps to try to improve communication between MH managers and staff and that he believed that relations had improved.

Alleged Inappropriate Restriction of Access to a Specific Treatment

One interviewee raised concerns that he was being prohibited from administering a necessary treatment to certain patients. We found that the Chief of MH directed a provider to discontinue providing a specific pharmacological intervention for certain patients, citing concerns about cost relative to perceived therapeutic benefit. The provider told us that the decision was unsuccessfully appealed with the Chief of Staff. The Chief of Staff told us that the matter had also been reviewed by several other providers, including the Chief of Pharmacy. It is noteworthy that the intervention in question was not among the recommended treatments in pertinent evidence-based practice guidelines. Nonetheless, the provider asserted that this intervention was indicated for certain patients and that withholding it was detrimental.

Conflict Between Facility Leadership and Support Group Members

Members of a longstanding veterans support group alleged that the facility failed to provide an acceptable facilitator or formally recognize their group since July 2014. Consistent with VHA policy, we found that, following turnover of the facilitator of a longstanding patient support group in November 2013, the facility took multiple steps to accommodate group members' preferences and has acceptable plans for further group sessions.[27] In particular, through July 2014, the facility offered multiple alternate facilitators and teams of facilitators with varied professional backgrounds and approaches to care, including a peer support specialist, chaplain, psychiatrist, addiction therapist, social worker, and three psychologists.

[27] VHA Handbook 1160.01.

In July 2014, the group ended abruptly because of what the facilitators perceived as the members' "increasingly angry, threatening behavior." Members of the support group told OIG that, since that time, the facility failed to provide a facilitator for their group. However, email exchanges between the Facility Director and a liaison from the support group reflected that members of the group met with facility leadership in fall 2014 and that the group was offered the option of resuming sessions with a peer support specialist as a facilitator. The email exchanges also reflected that the group decided to defer discussion of potential group facilitators until after publication of this report. In the interim, the Facility Director told us that many of the longstanding support group members are engaged in other services. In addition, the Director told us that the facility is organizing a new support group that will be facilitated by a peer support specialist.

Conclusions

In summary, we substantiated the allegations that:

- Staff were directed to discontinue using the consult package to make MH referrals in certain circumstances.
- Language in the consult package directed providers not to request MH consults if the patient was not willing to be seen within 14 days.
- Inappropriate practices have persisted despite other reviews of the facility's MH services.

However, we did not substantiate the allegations that:

- Staff were directed to restrict who could submit MH consults.
- Staff were directed to close consults before the requested services were rendered, though we did find that this practice occurred.
- Facility leadership inappropriately directed staff to utilize workshops to meet VHA's benchmark for timely MH assessments and follow-up.
- In order to meet VHA's benchmark for same day access, staff were directed to discontinue scheduling MH appointments in advance and instead utilize drop-in clinics.
- Staff were directed to omit information related to MH conditions that could be service connected from clinical notes in order to limit the number of veterans seeking MH services.
- LIPs were directed to see patients for medication management, even though this was outside of their scope of practice.

Although the majority of the allegations were unsubstantiated, we found many of the same inappropriate referral and scheduling practices within this facility's MH service that we previously reported as nationwide systemic problems. During our work, other concerns were brought to our attention and incorporated into our review, including concerns about the overall availability of MH services, extent of MH coverage for the ED, and appropriateness of some scheduling practices. We note that the chronically

low morale and fear of reprisal among MH staff may present added challenges to the Facility Director while implementing necessary changes.

Recommendations

1. We recommended the Facility Director remove the language in the Computerized Patient Record System outpatient psychological testing consult that may be interpreted as instructing providers not to enter a consult.

2. We recommended the Facility Director reevaluate and make the appropriate changes to the methods for referring patients for mental health care, including the extent to which the consult package is being used appropriately.

3. We recommended the Facility Director ensure that mental health consults are reviewed and closed in accordance with Veterans Health Administration policy.

4. We recommended the Facility Director ensure that Veterans Health Administration appointment scheduling guidance is followed and that schedulers utilize the electronic waiting list and give priority to service connected veterans, as appropriate.

5. We recommended the Facility Director review all existing mental health wait lists to identify patients who may be at risk because of a delay in the delivery of mental health care and provide the appropriate care.

6. We recommended the Facility Director expand access to mental health services, particularly required evidence-based psychotherapy and intensive case management services.

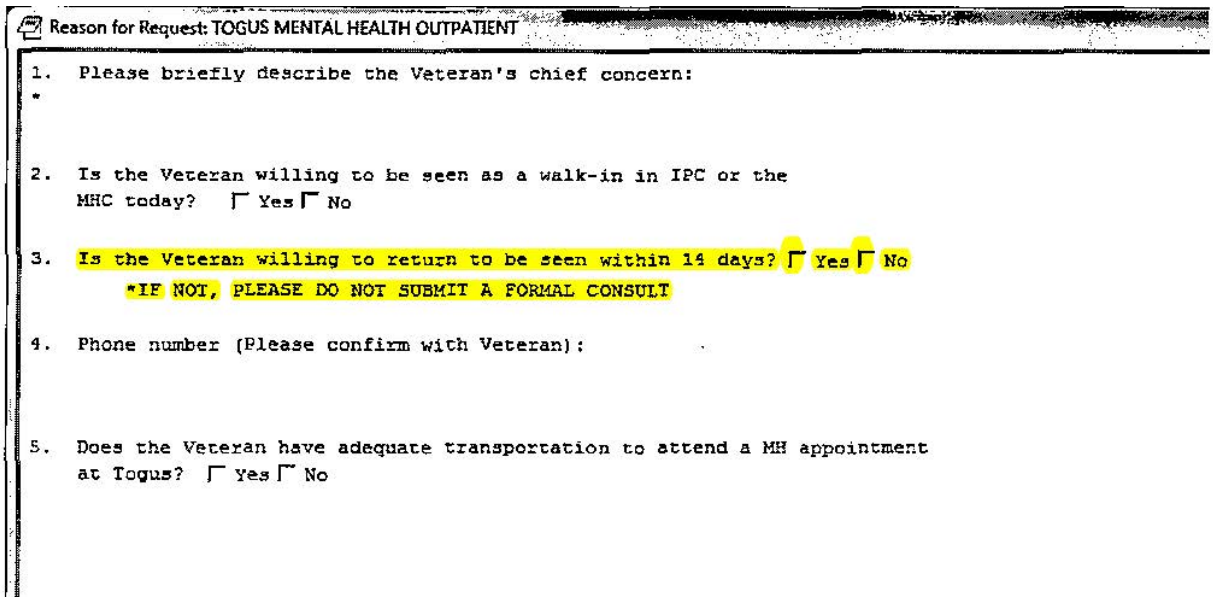
7. We recommended the Facility Director ensure that mental health staff is available in the Emergency Department as required by Veteran Health Administration and local policy to avoid potential delays in admission to the inpatient psychiatry unit.

8. We recommended the Facility Director review guidance provided to staff about meeting performance measures and confer with the Office of Human Resources and the Office of General Counsel to determine the appropriate administrative action to take, if any.

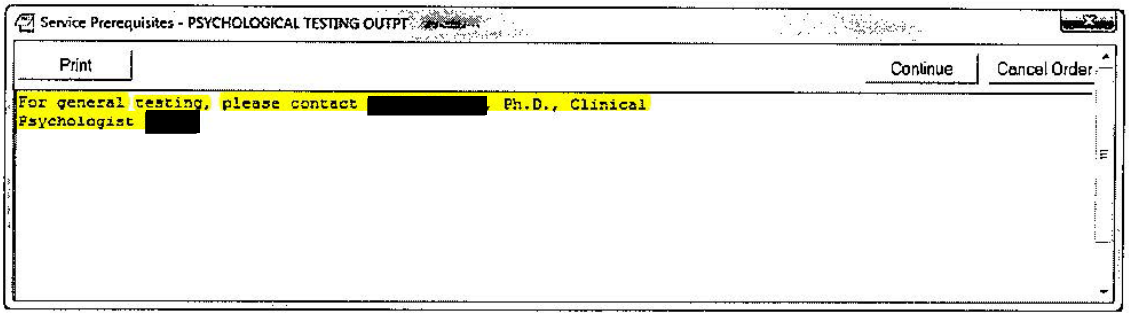
Appendix A

Screenshots of Selected Consults

Consult for Togus Outpatient Mental Health:



Consult for Outpatient Psychological Testing:



Appendix B

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: May 15, 2015

From: Director, VA New England Healthcare System (10N1)

Subj: Draft Report - Healthcare Inspection – Management of Mental Health Consults and Other Access to Care Concerns, VA Maine Healthcare System, Augusta, Maine

To: Director, Clinical Review Management, Office of Healthcare Inspections (54D)
Director, Management Review Service (VHA 10AR MRS OIG Hotlines)

I have reviewed and concur with the attached facility responses to the recommendations.

Sincerely,

Michael Mayo-Smith, M.D., M.P.H.
Network Director

Appendix C

System Director Comments

Department of Veterans Affairs

Memorandum

Date: MAY 14 2015

From: Director, VA Maine Healthcare System (402/00)

Subj: Draft Report - Healthcare Inspection – Management of Mental Health Consults and Other Access to Care Concerns, VA Maine Healthcare System, Augusta, Maine

To: Director, VA New England Healthcare System (10N1)

1. I concur with the attached draft responses to the recommendations. I have provided information to be included in the report.

2. If you have any additional questions or concerns, please contact Joel Murphy, Administrative Officer to the Chief of Staff at 207-623-8411 ext. 5197.

Sincerely,

Ryan Lilly
Facility Director

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 the Facility Director remove the language in the Computerized Patient Record System outpatient psychological testing consult that may be interpreted as instructing providers not to enter a consult.

Concur

Target date for completion: Completed

Facility response: The language in the Computerized Patient Record System outpatient psychological testing consult, that may have been interpreted as instructing providers not to enter a consult, has been removed and the consult has been reconstructed consistent with VHA policy. Further, every other Mental Health consult was reviewed to ensure that it did not contain any language that could be misinterpreted and there were no other instances of this language found in the remaining consult templates.

Recommendation 2. We recommended the Facility Director reevaluate and make the appropriate changes to the methods for referring patients for mental health care, including the extent to which the consult package is being used appropriately.

Concur

Target date for completion: September 30, 2015

Facility response: In December 2014, Mental Health Access Champions were identified locally and at our Community Based Outpatient Clinics. Each Champion was provided SSN level access to VHA Support Service Center (VSSC), and education on the process of consult tracking by the Facility Access Champion. Additionally, the Facility Access Champion provides oversight and weekly updates to Mental Health leadership.

On December 15, 2014, the requirement for use of Mental Health consults was reviewed with the Chief of Mental Health. Subsequently, providers were educated regarding the use of the Mental Health consult package when referring from one Mental Health service to another in order to increase transparency and prevent Veterans from potentially being lost to follow up.

On February 12, 2015, the Facility Access Champion attended the all-employee Mental Health staff meeting and provided education about the correct use of the consult package for Mental Health referrals. This specifically included the need for consults when referring between Mental Health services, and the correct method for consult

closure. The Facility Access Champion has also provided follow up to any providers seeking additional education or clarification.
Beginning June 2015, the VA Maine HCS will audit 30 new/existing Mental Health patient records each month for compliance with consult usage until 95% compliance has been achieved for three consecutive months. Ongoing audits to assure that targets are maintained will be implemented once targets have been achieved.

Recommendation 3. We recommended the Facility Director ensure that mental health consults are reviewed and closed in accordance with Veterans Health Administration policy.

Concur

Target date for completion: September 30, 2015

Facility response: Mental Health Leadership, in conjunction with the Facility Access Champion, has ensured that the various Access Champions in Mental Health have received consult management training consistent with VHA policy. Beginning June 2015, the VA Maine HCS will audit 30 new/existing Mental Health patient records each month for compliance with consult usage until 95% compliance has been achieved for three consecutive months. Ongoing audits to assure that targets are maintained will be implemented once targets have been achieved.

Recommendation 4. We recommended the Facility Director ensure that Veterans Health Administration appointment scheduling guidance is followed and that schedulers utilize the electronic waiting list and give priority to service connected veterans, as appropriate.

Concur

Target date for completion: September 30, 2015

Facility response: The Business Service Line and Mental Health Service will provide training to new and refresher training to existing Mental Health schedulers on proper utilization of the EWL in accordance with VHA policy giving priority to service connected veterans, as appropriate.

Proper utilization of the EWL will be audited by the MSA Clinic Management Committee beginning June 2015. Each audit will include review of 30 random appointments for appropriate use of EWL, and will occur monthly until at least 95% compliance for three consecutive months has been achieved, at which time the reviews will shift to the Supervisor of Inpatient and Mental Health Clinic MSA's as part of the routine performance reviews with periodic oversight by the MSA Clinic Management Committee.

Recommendation 5. We recommended the Facility Director review all existing mental health wait lists to identify patients who may be at risk because of a delay in the delivery of mental health care and provide the appropriate care.

Concur

Target date for completion: Completed

Facility response: Veterans referred to Mental Health are actively triaged and engaged; appointments negotiated; and are subsequently either referred to the Veteran's Choice List (VCL), or are voluntarily awaiting service at VA Maine HCS in accord with clinical necessity. The response to Recommendation 2, specific to the education on correct use of consult package for Mental Health referrals, use of EWL and the defined audit process, will ensure ongoing compliance in this area.

VA Maine HCS has completed review of new/existing Mental Health patients with scheduled appointments greater than 90 days, and patients were determined not to be at risk or were offered earlier appointments.

Recommendation 6. We recommended the Facility Director expand access to mental health services, particularly required evidence-based psychotherapy and intensive case management services.

Concur

Target date for completion: September 30, 2015

Facility response: VA Maine HCS is committed to evidence-based psychotherapy and intensive case management services. We provide a wide range of EBP program offerings, which will only be further enhanced through the execution of existing initiatives, including the hiring of 17 additional staff members through the VA Choice and Accountability Act (VACAA) funding. Additionally, Mental Health has taken every opportunity to develop staff with training opportunities to enhance our Mental Health services including the delivery of EBP services. We will achieve hiring of at least 9 of the 17 VACAA positions by September 30, 2015, which will expand access to mental health services. The education noted in response to Recommendation 2, regarding correct use of consult package for Mental Health referrals and utilizing the VCL, will address the need to expand access to mental health services in the interim. Note: Currently 151 mental health patients (new/existing) have been referred to the VCL.

Recommendation 7. We recommended the Facility Director ensure that mental health staff is available in the Emergency Department as required by Veteran Health Administration and local policy to avoid potential delays in admission to the inpatient psychiatry unit.

Concur

Target date for completion: Completed

Facility response: Mental Health services in the Emergency Department are available 24/7 through Consultation-Liaison Services during the day, and during the weekend, holiday, evening and night (WHEN) shifts through a combination of on-site Mental Health Physician Assistants, as well as on-call Psychiatrists and Social Workers. We have reviewed the previous 120-days, which were free of any availability issues. Also, representatives from the Emergency Department, Mental Health Service, and the Hospitalist Section met on April 6, 2015, to collaboratively implement a consistent product.

Recommendation 8. We recommended the Facility Director review guidance provided to staff about meeting performance measures and confer with the Office of Human Resources and the Office of General Counsel to determine the appropriate administrative action to take, if any.

Concur

Target date for completion: June 30, 2015

Facility response: VA Maine HCS has referred this matter to the Office of Human Resources and the Office of General Counsel for conference in reviewing guidance provided to staff about meeting performance measures to determine appropriate administrative action to take, if any.

Appendix D

OIG Contact and Staff Acknowledgements

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Melanie Krause, PhD, RN, Team Leader Kathy Gudgell, JD, RN Terri Julian, PhD Alan Mallinger, MD Michael Shepherd, MD

Appendix E

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