



Department of Veterans Affairs  
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-04530-414

**Healthcare Inspection**  
**Mental Health-Related Deficiencies**  
**and Inadequate Leadership**  
**Responsiveness**  
**Central Alabama VA Health Care**  
**System**  
**Montgomery, Alabama**

July 29, 2015

Washington, DC 20420

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## Executive Summary

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted a review in response to allegations involving unsafe and improper mental health (MH) practices and inadequate leadership responsiveness at the Central Alabama Veterans Health Care System (CAVHCS), Montgomery, AL.

We substantiated that psychiatrist staffing at the Dothan MH community based outpatient clinic (CBOC) had been inadequate to assure timely and appropriate care and that there were waiting lists to see Dothan MH CBOC providers. Further, patients on the Recall Reminder list were not scheduled appropriately, in part because schedulers were not appropriately managing the lists.

We did not substantiate that multiple patients committed suicide due to MH care delays although we did identify opportunities to improve coordination and documentation. We also did not substantiate that CAVHCS leaders refused to provide inpatient detoxification (detox) services; that patients were sent home with no medical treatment for substance-related disorders; that some patients were seen in the emergency department (ED) and sent home with an anti-anxiety medication; that patients needing detox had to pay out-of-pocket for private-sector services; or that 24-hour ED observation for detox was insufficient. Further, we did not substantiate that the Substance Abuse Treatment Program had a long screening process and unclear admission guidelines. CAVHCS policy outlines referral, screening, and assessment guidelines, all of which conform to the *VA DoD Clinical Guideline on Substance Use Disorder*.

While we did not substantiate that the Disturbed Behavior Committee (DBC) *refused* to issue a behavioral patient record flag (PRF) in a case involving a patient with a loaded assault weapon, we found that it took an excessive amount of time to do so. We also substantiated that the process for identifying, managing, and flagging disruptive patients was not consistently followed by some CAVHCS staff or members of the DBC.

We substantiated that some CBOC-based MH patients requiring non-emergent hospitalization at CAVHCS waited an excessive amount of time for ambulance transport. When nursing staff had to provide extended 1:1 observation, other nursing duties and patient care responsibilities went unattended.

While we confirmed that an inpatient psychiatrist prescribed benzodiazepines to high-risk patients, we did not substantiate that the prescriptions were always improper. We did, however, identify several cases where the combination of discharge medications was not optimal and could have placed those patients at risk.

We did not substantiate that CAVHCS did not assign MH treatment coordinators although we did determine that the practice was inconsistent. We substantiated that CAVHCS has not established primary care (PC)-MH integration between the Dothan PC CBOC and the Dothan MH CBOC and that the Dothan PC contractor did not comply with the contract regarding MH staffing. We also substantiated that Dothan PC CBOC

providers did not complete medication trials for management of uncomplicated psychiatric disorders prior to submitting a consult to the Dothan MH CBOC. We confirmed that some PC providers could not enter a MH consult, but we did not substantiate the implied inappropriateness of this condition. PC-MH integration at some CBOCs promotes “warm” (in-person) hand-offs rather than contact via consult.

We could not substantiate that Dothan CBOC providers could not be reached after hours, as the precise complaint was unclear. We noted, however, that some patients did not receive clear instructions about what to do if they had a MH emergency after hours.

We did not substantiate that CAVHCS did not conduct MH peer reviews. However, we determined that the MH Service Line had not assured completion of peer-to-peer medical record reviews for the purpose of ongoing professional practice evaluation in more than a year.

We could not substantiate that there were not “enough” acute MH unit beds although we did confirm that MH patients were routinely sent to other health care facilities due to a lack of beds at the Tuskegee campus.

We substantiated that CAVHCS leaders were aware of many of the identified issues, that some corrective actions were not always implemented timely, and that others did not appear to have been implemented at all. Many CBOC employees reported feeling marginalized by CAVHCS leaders and managers. The CAVHCS Director and Chief of Staff were removed from their positions in 2014.

We made 17 recommendations to improve operations.

## **Comments**

The Veterans Integrated Service Network and Facility Directors concurred with our recommendations and provided acceptable action plans. (See Appendixes A and B, pages 25–32 for the Directors’ comments.) We will follow up on the planned actions until they are completed.



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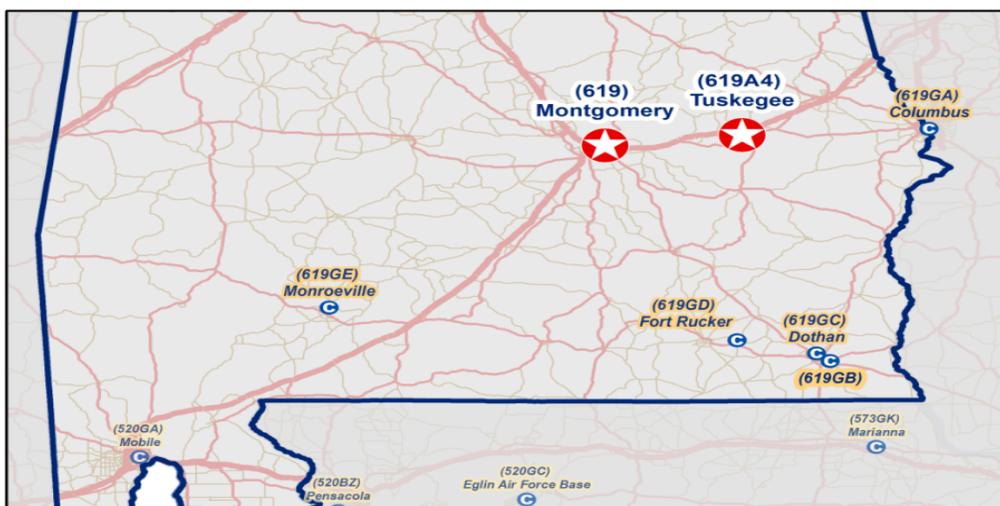
## Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted a review in response to allegations involving unsafe and improper mental health (MH) practices and inadequate leadership responsiveness at the Central Alabama Veterans Healthcare System (CAVHCS), Montgomery, AL. During this review, OIG assessed the merit of the allegations and followed up on employee assessment review (EAR) survey responses from the 2014 OIG Combined Assessment Program (CAP) review at CAVHCS.

## Background

More than 15 years ago, the Montgomery VA Medical Center (VAMC) and the Tuskegee VAMC merged, forming the CAVHCS. This two-division health care system provides a broad range of inpatient and outpatient medical, surgical, MH, and long term care services.

Outpatient care is also provided at four community-based outpatient clinics (CBOCs). The Columbus, GA, CBOC is located about 90 miles from Montgomery and 45 miles from Tuskegee. VA employees provide primary care (PC) and MH services in two buildings separated by a parking lot. The Dothan, AL, CBOC is located approximately 100 miles from the Montgomery campus and provides PC through a contract with a local medical group. MH services are provided by VA employees in a separate building approximately 5 miles from the Dothan PC location. The Wiregrass, AL, CBOC is located on the Fort Rucker Army Base, which is approximately 20 miles from Dothan and 86 miles from the Montgomery campus. VA employees provide PC and MH services. The Monroeville, AL, CBOC opened in April 2013 and is located about 105 miles from Montgomery. VA employees provide PC daily, and a nurse practitioner provides MH care on Fridays.



CAVHCS is part of Veterans Integrated Service Network (VISN) 7 and serves a veteran population of about 134,000 in central and southeastern Alabama and western Georgia.

### **CAVHCS Senior Leadership**

In August 2014, the CAVHCS Director and long-tenured Chief of Staff (COS) were placed on administrative leave pending the results of an external review. During the course of our review, many of the key leaders and managers were in “acting” roles including the Director, COS, Chief of Ambulatory Care, Chief of MH, Chief Nurse Executive, and Chief of Human Resources, among others. It was often difficult to interview the people with historical knowledge of, or responsibility for, many of the issues identified in this report.

### **Quality and Performance Measure Data**

VHA’s Office of Operational Analytics and Reporting developed a model for understanding a facility’s performance in relation to nine quality domains and one efficiency domain in comparison to other VHA medical centers. The Strategic Analytics for Improvement and Learning (SAIL) model reflects the facility’s performance over a rolling 12-month period ending as of the 4<sup>th</sup> quarter fiscal year (FY) 2014. Based on these measures, the facility achieved an overall “1-star in quality” ranking amongst all VHA medical facilities. VHA facilities with 1-star rankings are in the lowest 10-percent of all VHA facilities.

The MH Domain Composites of Population Coverage, Continuity of Care, and Experience of Care are new additions to the SAIL report (beginning in the 3<sup>rd</sup> quarter FY 2014); however, most of the individual metrics that make up the composites have been part of VHA’s performance measure tracking and reporting for months or years. In general, the Population Coverage composite includes the percentage of certain patients receiving MH care and the percentage of patients with certain MH diagnoses receiving specified care. The Continuity of Care composite generally includes the percentage of patients receiving follow-up care after discharge from an inpatient or residential treatment setting and the percentage of patients receiving diagnosis-specific treatment and therapies. The Experience of Care composite includes the survey results of both patients and MH providers regarding their perceptions of, and satisfaction with, MH care. In both the 3<sup>rd</sup> and 4<sup>th</sup> quarters FY 2014, CAVHCS had substantially lower standardized scores<sup>1</sup> than 5-star VHA facilities in the Continuity of Care and Experience of Care composites. We noted, however, that the 4<sup>th</sup> quarter scores were slightly improved over the 3<sup>rd</sup> quarter scores.

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<sup>1</sup> Standardized scores convert measures made on different scales to a standard score, enabling comparisons and combinations. These scores are used when comparing a data item to the averages for the rest of the data sample or population. <http://www.chegg.com>.

As of the 4<sup>th</sup> quarter FY 2014, CAVHCS had a lower percentage<sup>2</sup> (than 5-star facilities) of both new and established patients who could get MH appointments in less than 14 days.

### **OIG CAP and CBOC Reviews**

The OIG conducted a CAP review at CAVHCS the week of August 25, 2014. CAP reviews are one element of the OIG's efforts to ensure that our nation's veterans receive high quality VA health care services. One objective of the CAP review is to conduct recurring evaluations of selected health care facility operations. As part of the CAP, we also surveyed all employees via an online employee assessment review (EAR). We made 22 recommendations for improvement, and corrective actions are in process. See *Combined Assessment Program Review of the Central Alabama Veterans Health Care System, Montgomery, Alabama*, Report No. 14-02079-10, November 25, 2014, for details.

The OIG also conducted CBOC reviews at two randomly selected CBOCs the week of August 25, 2014. The purpose of the reviews was to evaluate selected patient care activities to determine whether the CBOCs provide safe, consistent, and high-quality health care. Review activities included site visits of the Dothan and Wiregrass CBOCs. We made 19 recommendations for improvement, and corrective actions are in process. See *Community Based Outpatient Clinic and Primary Care Clinic Reviews at Central Alabama Veterans Health Care System Montgomery, Alabama*, Report No. 14-00930-14, December 4, 2014, for details.

### **Allegations**

On July 16, 2014, a confidential complainant contacted the OIG Hotline and made a variety of allegations generally related to MH and PC services and practices at the Dothan and Wiregrass CBOCs. Further, many CAVHCS employees who responded to the EAR survey and other employees we interviewed made similar complaints about MH-related issues and practices. The initial complainant, several EAR respondents, and multiple interviewees reported that facility leaders had been notified of many of these concerns; however, the problems frequently went unaddressed. We grouped the allegations into the following categories:

- Staffing, Wait Lists, and Suicide Prevention
- Detoxification and Treatment Services
- Disruptive Behavior Management
- Ambulance Transport of High-Risk Patients
- Medication Management
- MH Coordination of Care Issues
- Other MH Service Line Administrative Issues
- Leadership Responsiveness

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<sup>2</sup> Represents a statistically significant difference.

## Scope and Methodology

The review period for this inspection was from August 2014 to February 2015. We conducted site visits August 25–28, September 22–25, and November 3–5, 2014. We interviewed the complainant; the acting CAVHCS Director, acting COS, Associate Director, acting Chief of Ambulatory Care, and the acting Chief of MH; Human Resource managers; Quality Management staff and the Patient Safety Manager; Assistant Chief of VA Police; a patient advocate; clinical and administrative staff from all four CBOCs; VISN employees; and other CAVHCS staff knowledgeable about the issues.

To understand the scope of concerns and to assess the physical environments, we visited all four CBOCs and the Tuskegee and Montgomery campuses. We interviewed more than 150 employees.

Prior to and during our site visits, we reviewed extensive system documentation, including VHA and local policies, VHA's Office of MH Oversight (OMHO) site visit report, the Human Resources Restoration and Revitalization (HR<sup>3</sup>) Program site visit report, meeting minutes, and other performance data. We also reviewed electronic health records (EHRs), employee-related quality monitoring data, Issue Briefs, staffing data, and relevant literature.

We **substantiated** allegations when the facts and findings supported that the alleged events or actions took place. We **did not substantiate** allegations when the facts showed the allegations were unfounded. We **could not substantiate** allegations when there was no conclusive evidence to either sustain or refute the allegation.

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

CAVHCS provides a broad range of MH services at the main campuses and all four CBOCs. In April 2013, the MH Service Line (MHSL) chief left CAVHCS employment and a series of acting chiefs were rotated into the position to cover for more than 18 months.

During this period of leadership instability, it appeared that strategic improvements and corrective action planning were not implemented timely, and staff complained of “siloes” care and poor coordination and support among the different clinical services. Several staff members we interviewed felt that working conditions and oversight had deteriorated in the absence of permanently assigned MH leadership.

### Issue 1: Staffing, Wait Lists, and Suicide Prevention

**Allegation: An inadequate number of MH providers at the Dothan MH CBOC has resulted in an extensive list of patients waiting to see providers.**

We substantiated that psychiatrist staffing at the Dothan MH CBOC has been inadequate to assure timely and appropriate care. For part of 2012, the CBOC had only one psychiatrist on staff, and she was on extended leave from January to August 2012. During this time, patients reportedly utilized tele-MH services provided by the MHSL chief and two other psychiatrists, or the patients would drive to either the Montgomery or Tuskegee campus for care. Another psychiatrist started at the Dothan MH CBOC in December 2013. The Dothan MH CBOC currently has two psychiatrists, one psychologist, one social worker, two registered nurses, and one licensed practical nurse.<sup>3</sup>

Upon interview in November 2014, both CBOC psychiatrists stated that the workload continued to be overwhelming and expressed the need for additional providers. One of the psychiatrists gave us multiple case examples of patients who should have returned to clinic in 3–4 months but could not be scheduled for 8 or 9 months. Some of these patients needed medication refills, so they had to be seen as walk-ins, which impeded scheduled workflow. While the Clinic Utilization report reflects high workload for the period July 1, 2013–July 1, 2014, in comparison to the equivalently staffed Wiregrass MH clinic, it also reflects that there were more than 800 “open” appointment slots.

We substantiated that the Dothan MH CBOC had waiting lists to see the psychiatrists, psychologist, and social worker. We did not substantiate, however, that inadequate MH staffing at the Dothan MH CBOC was the sole factor resulting in extensive waiting lists. We also found that schedulers were not familiar with wait list management programs

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<sup>3</sup> The Dothan MH CBOC has been approved to hire another psychologist and social worker, and has requested approval to hire a third psychiatrist.

and requirements, and as a result, some patients were improperly placed or left on these lists without timely action.

### Electronic Waiting List and Recall Reminder List

VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures*, June 9, 2010, defines the Electronic Wait List (EWL) as a list used to keep track of patients with whom the clinic does not have an established relationship while they are waiting to be scheduled or waiting for a panel assignment.<sup>4</sup> The Recall Reminder list includes patients who will need to return to a clinic in the future, usually greater than 90 to 120 days. Patients on the Recall Reminder list are supposed to receive a notification letter prior to the recall date advising them to call the clinic to schedule a follow-up appointment. Schedulers can generate a variety of reports to help them manage the EWL and Recall Reminder lists.<sup>5</sup>

*Psychologist EWL.* While we confirmed that 96 patients were on the psychologist EWL, 60 of those patients (63 percent) were incorrectly placed on this list.<sup>6</sup> Of the remaining 36 patients, 5 had scheduled appointments with the psychologist and 7 were no longer interested in receiving care.<sup>7</sup> The remaining 24 patients were appropriately listed on the EWL as they still required and desired MH care but did not have a scheduled appointment. OIG provided a copy of the psychologist EWL (all 96 patients) to CAVHCS management for review and scheduling, as appropriate.

*Social Work EWL.* We confirmed 20 patients were on the social work EWL; however, 9 of these patients had already been seen or had a scheduled future appointment, 1 patient had relocated, and 1 patient was receiving care through a private-sector psychiatrist. Nine patients were appropriately on the list as they still required and desired the service and did not have a scheduled appointment. The oldest appointment request dated back to March 2014. OHI provided the list to the social worker for review and follow-up as indicated.

*Recall Reminder List.* We confirmed that 484<sup>8</sup> patients were on the Recall Reminder list waiting for an appointment with a psychiatrist or psychologist as of October 21, 2014, including 129 from 2014, 212 from 2013, 106 from 2012, 8 from 2011, and 3 from 2008–2010. We could not determine the dates the remaining 26 patients were entered onto the Recall Reminder list.

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<sup>4</sup> [http://www.va.gov/vhapublications/ViewPublication.asp?pub\\_ID=2252](http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2252), page 3. Accessed October 20, 2014.

<sup>5</sup> [http://www.va.gov/vdl/documents/Clinical/Scheduling/sd\\_53\\_536\\_ug.pdf](http://www.va.gov/vdl/documents/Clinical/Scheduling/sd_53_536_ug.pdf), page 7. Access October 20, 2014.

<sup>6</sup> Specifically, 47 patients declined care with the psychologist; 6 patients had no documented referral to the psychologist; 3 patients never received care at CAVHCS; 3 patients received their MH care at the Wiregrass CBOC; and 1 patient was not in need of MH services.

<sup>7</sup> The EHR did not always indicate why patients were no longer interested in care.

<sup>8</sup> The complainant alleged that there were 800 patients on this list as of July 2014; however the list provided by the complainant and various other Recall Reminder lists were not consistent. We collated the lists and identified 484 unique patients.

We reviewed the 484 EHRs and found that 267 patients (55 percent) should have been removed from the list because the patients declined care, relocated, transferred care, died, no-showed for appointments, never received care at the Dothan MH Clinic, had either completed an appointment, or had a scheduled follow-up appointment. The remaining 217 patients (45 percent) had not been scheduled for a follow-up appointment as of October 21, 2014. A subsequent review, completed on January 19, 2015, reflected that 117 patients had since been scheduled for MH appointments. We noted that when patients were scheduled, the average wait time between appointments was 174 days (range 1–939). Although not a rule, most MH providers prefer to see stable patients every 4–6 months, if not sooner, for follow-up.

Seventeen of the remaining 100 patients had participated in MH group sessions, but none had been seen or had a future individual MH appointment scheduled. On average, those 100 patients had been on the Recall Reminder list for 543 days (as of January 19, 2015.)<sup>9</sup>

### Wait List Management Deficiencies

While suboptimal staffing and workload demand was most likely central to the need to place patients on waiting lists and delays in scheduling care, we found that clinic schedulers were not appropriately managing the lists, which contributed to the problem. Specifically:

- The lists were not being worked from oldest appointment request date to newest appointment request date. Upon completion of an appointment, the MH provider would suggest a return-to-clinic date for the next appointment. One clinic scheduler told us that before a patient leaves the clinic, the schedulers typically schedule the patient's next follow-up appointment. While this is an appropriate practice, the scheduler told us that it limits availability of future appointment slots for patients on the EWL or Recall Reminder list.
- Schedulers reportedly reviewed the Recall Reminder list every few months (rather than every week) because there were no available appointment slots to schedule patients.
- Recall Reminder letters (which ask the patient to call the clinic to schedule their next appointment) were not being sent to patients because the clinic schedulers reportedly could not handle the volume of return phone calls. Patients were not able to leave a voice message if their call was not answered during regular business hours.

### **Allegation: Multiple patients committed suicide while waiting for MH care.**

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<sup>9</sup> OHI provided a copy of the 100 patients from the original Recall Reminder List to CAVHCS management for review and scheduling.

We did not substantiate that multiple patients committed suicide due to MH care delays. The complainant provided us with three case examples.<sup>10</sup> In one case, the EHR did not contain documentation about the cause of death. Further, the patient was stable and denied suicidal ideation during a MH appointment several days before his death.<sup>11</sup>

We reviewed the other two cases as part of a larger review of completed suicides<sup>12</sup> (per VHA Support Service Center [VSSC] data) in FYs 2012–2014. We found no evidence that any of the 12 patients had difficulty accessing MH care in the months preceding their deaths. In 4 of the 12 cases described below, however, we found poor coordination of care and/or poor documentation of efforts to identify and monitor patients at high risk for suicide.

### Suicide Prevention Coordination

Category II Patient Record Flags (PRFs) are used to identify and track patients who are at high risk for suicide. The PRF remains in place for 90 days during which time the patient receives weekly follow-up for the first month and monthly thereafter. The Suicide Prevention Coordinator (SPC) and/or the Suicide Prevention Case Manager are responsible for placing PRFs, ensuring that providers conduct follow-up on missed appointments for high risk patients,<sup>13</sup> and working with the patient's PC team to monitor and address the patient's mental and physical health needs.

The following cases illustrate coordination of care and Suicide Prevention program deficiencies:

*Patient 1:* The patient had a history of depression and presented to the outpatient MH clinic in spring 2012 complaining of suicidal ideation with a plan. The evaluating social worker documented seeing "several red flags" with regard to the patient's presentation, completed a Suicide Risk Assessment (which listed the SPCs as additional signers<sup>14</sup>), and wrote a Suicide Safety Plan.<sup>15</sup> The covering psychiatrist was on leave, and the social worker had difficulty contacting the back-up psychiatrist. A third psychiatrist, contacted by phone, suggested hospitalization, but the patient declined, stating he

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<sup>10</sup> The complainant actually provided six case examples, but three of the cases were duplicates of ones listed in VSSC.

<sup>11</sup> This patient's EHR did not contain evidence that an inpatient provider consulted the Suicide Prevention staff as reflected in the discharge summary.

<sup>12</sup> The VSSC report contains 12 names; however, 2 of those patients did not commit suicide so their cases were excluded from our review.

<sup>13</sup> VHA 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.

<sup>14</sup> "Additional signer" is a communication tool used to alert a clinician about information pertaining to the patient. This functionality is designed to allow clinicians to call attention to specific documents and for the recipient to acknowledge receipt of the information. VHA Handbook 1907.01, *Health Information Management and Health Records*, September 9, 2012.

<sup>15</sup> A template progress note that reviews what the patient can do to keep himself/herself safe.

would follow up with his private-sector provider.<sup>16</sup> The patient cancelled his next scheduled appointment in late spring 2012 and committed suicide shortly thereafter.

Despite the patient's initial presentation, there was no contact from the SPC,<sup>17</sup> nor was there a PRF. The facility subsequently completed a root cause analysis (RCA) of the incident and followed through on the recommendations.

*Patient 2:* In fall 2011, the patient's EHR was updated with a PRF, which was removed after an inpatient stay approximately 6 months later. Shortly after discharge, providers recorded several contacts with the patient and/or his wife about the patient's antidepressant medication, which he reported as being less effective. In spring 2012, the provider increased the antidepressant and advised the patient to return to the MH clinic in 4 months. The provider documented that the patient denied suicidal or homicidal ideation.

The patient's EHR reflects that he was scheduled for a "call back" appointment in summer, but there was no associated note for that encounter, nor was another MH appointment scheduled. The following month, the patient's wife requested an increase in his antidepressant medication dosage due to worsening depression; however, no changes were made. In late summer, a social worker documented that the "*Veteran has begun to have significant medical changes which has affected memory, severe headaches, easily agitated.*" Two days after this note, the patient committed suicide.

We found no evidence that a staff member called the patient to follow up after the wife reported the worsening depression, nor was the antidepressant re-evaluated. Although the patient no longer had a PRF, we did not see communication that would have alerted the SPC to resume involvement.

*Patient 3:* The patient, who had multiple prior suicide attempts, had a PRF placed in spring 2012 while an inpatient at a VA facility in another state. A CAVHCS psychiatrist saw him after discharge from the other VA facility. The patient's next psychiatry appointment was scheduled for late spring in Tuskegee; however, the patient committed suicide 3 days prior to the appointment. Between the time of the CAVHCS psychiatrist visit and the date of his death, the patient was a no-show or cancelled three MH appointments, yet there was no documentation of follow-up for the missed appointments. Further, we found no documentation of follow-up contact by an SPC despite there being additional signers on EHR notes on several occasions during this time period.

*Patient 4:* The patient was seen for a MH visit in early 2011 with complaints of worsening depression with suicidal ideations. The nurse added the psychiatrist and SPC to sign and acknowledge the EHR note. The psychiatrist documented that the patient declined inpatient treatment, was not suicidal at that time, and had good family

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<sup>16</sup> There is confusion as to whether the third psychiatrist actually talked to the patient directly.

<sup>17</sup> The SPC wrote a note a few months after learning of the incident.

support. The psychiatrist also documented that the patient declined to remove guns from his home, so he was provided with a gun safety brochure. Per the psychiatrist's instructions, the patient was scheduled for a follow-up appointment in early summer. However, this appointment was cancelled by the clinic because the provider was on leave. A subsequent appointment was cancelled by the clinic after the provider left CAVHCS employment. The patient then "no-showed" for a rescheduled MH appointment late the following month. Dothan MH CBOC staff later found out that the patient had committed suicide in mid-summer 2011.

The EHR did not contain evidence of SPC follow-up, the patient was not flagged as high risk, and we found no explanation as to the reason there was no PRF.

## **Issue 2: Detoxification and Treatment Services**

**Allegation: CAVHCS does not provide adequate and/or appropriate detoxification (detox) services. Specifically:**

- a) Executive leadership refuses to provide inpatient detox services to patients with drug and alcohol issues. Patients are sent home with no medical treatment for substance-related disorders. Some patients are just sent home with diazepam.**
- b) Dothan CBOC patients needing detox must pay out-of-pocket for private-sector services.**
- c) 24-hour Emergency Department (ED) observation for detox is not sufficient.**

Detox is the process by which the body clears itself of alcohol and drugs. In a monitored setting, detox is designed to manage the acute and potentially dangerous physiological withdrawal effects of stopping drug or alcohol use.<sup>18</sup>

### Leadership Refusal to Provide Inpatient Detox

We did not substantiate the allegation that leadership refused to provide inpatient detox services; CAVHCS does provide inpatient detox services to appropriate patients. The *VA/DoD Clinical Practice Guideline for Management of Substance Use Disorders (SUD)*,<sup>19</sup> dated August 2009, outlines the clinical algorithms for stabilization and withdrawal management in both the inpatient and outpatient settings. In CAVHCS, all patients seeking or being referred for detox must be assessed and medically "cleared" through the Montgomery ED. Typically, the ED provider determines the treatment setting based on the patient's psychiatric and medical co-morbidities, withdrawal symptoms, laboratory results, and standardized SUD assessments. While patients can be admitted to a medical ward at the Montgomery campus, they are more often admitted to the Tuskegee inpatient MH unit for detox and treatment of co-existing

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<sup>18</sup><http://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/drug-addiction-treatment-in-united-states/types-treatment-programs>, retrieved November 13, 2014.

<sup>19</sup> Clinical practice guidelines are generic tools to improve patient care by reducing errors and providing consistent quality of care. VHA's National Clinical Practice Guidelines Council endorses this guideline.

MH conditions. Some intoxicated patients are observed in the ED and, once sober, are discharged home without detox services.

The complainant did not provide us with specific examples of when patients requiring acute detox were sent home without medical treatment. Therefore, we reviewed a random selection of 30 patients admitted to the Tuskegee MH unit in the previous 2 years. Nine of those patients received some level of detox during their hospitalizations, often in conjunction with other MH services. Each of the records reflected that the patients received appropriate treatment for the SUD-related condition.

We did not substantiate that patients in need of detox were sent home (from the ED) on diazepam. While we could not say whether this has occurred in the past, we did not find evidence that it was routine practice for the patients' records we reviewed. Diazepam (Valium) and chlordiazepoxide (Librium) are the most commonly used long-acting benzodiazepines in alcohol detox.<sup>2021</sup> The complainant did not provide us with case examples, so we randomly selected eight ED and MH consult providers to cross-reference with diazepam prescriptions written during September 2014. Only 12 oral diazepam prescriptions were written, 11 of those by psychiatrists. None of the patients were seen for detox-related issues.

#### CBOC Patients Must Pay for Private-Sector Detox

We did not substantiate that CBOC patients *must* pay out-of-pocket for detox at private-sector facilities. We noted that CBOC patients do receive detox services through CAVHCS, although some patients may choose (or be “encouraged” via external sources such as family or law enforcement) to receive prompt detox in the private-sector. Some insurance carriers cover detox services.

The complainant provided us with an example of a patient who allegedly had no choice but to seek detox in the community at his own expense. We found, however, that the patient had repeatedly refused detox and SUD recovery programs when offered by VA providers. While it appears that the patient did receive non-VA detox services, we found no evidence that he did so because he was refused CAVHCS-based services.

We note that it may be more difficult to access CAVHCS-based detox for CBOC patients due to the logistical issues of distance and transportation to the Montgomery ED. CBOC providers are aware that if a patient has an emergent medical need, including certain syndromes related to acute intoxication, they may call 911 for transport to, and stabilization at, the nearest local ED. Once a patient is stable, ongoing treatment would be provided by CAVHCS or another VHA health care facility. Non-VA care is only authorized when VA medical facilities are not “feasibly available.”

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<sup>20</sup> Benzodiazepines are often used for the management of alcohol withdrawal by reducing withdrawal discomfort and preventing seizures and delirium. Short-acting benzodiazepines are less common in detoxification as they are considered to be more vulnerable to abuse.

<sup>21</sup> <https://www.psychologytoday.com>, retrieved March 19, 2015.

### 24-Hour ED Observation for Detox

We did not substantiate that ED observation for patients under the influence of alcohol or drugs is insufficient or improper. The complainant did not provide specific details or case examples of patients requiring inpatient detox but who were only observed in the ED. As discussed above, patients requiring medical detox and/or associated MH support are regularly admitted for treatment. According to one of the ED physicians, there are occasions when intoxicated patients are observed in the ED while they “sober up.” When patients do not meet criteria for admission, ED observation is an acceptable and appropriate alternative.

**Allegation: The Substance Abuse Treatment Program (SATP) has a long screening process and unclear admission guidelines.**

We did not substantiate the allegation. Detox alone does not address the psychological, social, and behavioral problems associated with addiction and should be followed by a formal assessment and referral to drug addiction treatment. CAVHCS policy<sup>22</sup> outlines referral, screening, and assessment guidelines, all of which conform to the *VA DoD Clinical Guideline on Substance Use Disorder*. The length of the screening and assessment process is dependent on several factors but, according to policy, should be completed within 30 days of initial consult. The SATP will not screen patients who are under the influence of drugs or alcohol at the time of screening; those patients may be referred for detox or other appropriate services. Program admission is made on a case-by-case basis.

As of August 2014, the SATP did not have a waiting list. However, for patients requiring residential placement in a domiciliary-type setting while enrolled in SATP, the waiting list can be up to 60 days for admission.<sup>23</sup>

### **Issue 3: Disruptive Behavior Management**

**Allegation: MH leaders and the Disruptive Behavior Committee (DBC) refused to issue a behavioral PRF for a dangerous patient.**

While we did not substantiate that the DBC refused to issue a behavioral PRF in this case, we found that it took an excessive amount of time to do so given the circumstances and the potential risk to staff and other patients.

Behavioral PRFs describe patient behavior that may pose a threat to the safety of themselves, other patients, visitors, or employees. Behavioral PRFs notify staff, via an electronic alert, of patients who have exhibited threatening or risky behavior and

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<sup>22</sup> Memorandum 116-12-23, *Substance Abuse Treatment Program*, February 17, 2012.

<sup>23</sup> Many patients with addiction problems are either homeless, transient, or live in situations where drugs and alcohol are readily available. Therefore, residential placement in a safe, controlled environment is often critical to a patient’s recovery efforts.

recommend specific behavioral limit setting and treatment planning actions designed to reduce risk.<sup>24</sup> The DBC is responsible for reviewing provider documentation and CAVHCS police information related to disruptive incidents, conducting a risk/threat assessment, consulting with the treatment team, and activating behavioral PRFs as appropriate.

The case in question occurred in the spring of 2014 when a patient, armed with a loaded assault rifle, was heading for the Wiregrass CBOC “to get medications.” The patient’s wife notified the police who intercepted him before he arrived on the Ft. Rucker Army Base. He aimed his weapon at a police officer and was subsequently arrested and charged with attempted murder. He was banned by U.S. Army Command from Ft. Rucker property within days of the event and, with this action, was no longer able to receive care at the Wiregrass CBOC.

The patient is an eligible veteran and is entitled to medical and MH care; however, restrictions may be placed on the type and location of care to assure patient and provider safety. The absence of a behavioral PRF allows the patient to go to any CAVHCS campus or CBOC, or to another VHA facility, where staff may not be aware of the patient’s past threat of violence and security measures would not have been activated.

None of CAVHCS’ CBOCs have the same level of police resources or security measures as the Montgomery campus to assure the safe delivery of health care in these circumstances. Staff at the Dothan MH CBOC, located 20 miles away, were particularly concerned about the lack of a behavioral PRF and refused to provide care to this patient due to safety concerns. After numerous emails and discussions between Dothan and Wiregrass CBOC providers, CAVHCS leaders, MH leaders, and the DBC chairperson, and after questioning from the OIG, a Category I<sup>25</sup> behavioral PRF was activated in the patient’s EHR 155 days following the threatening incident and the patient was reassigned to a Montgomery-based provider. The reason for the delay involved several factors:

- DBC Alert Notes are the preferred method to notify the DBC of incidents requiring review and possible flagging. The patient’s MH provider did not document the incident in a DBC Alert Note, fearing that the patient would learn who initiated the PRF and retaliate.
- Although the MH provider requested the DBC chairperson or someone else complete the Alert Note, the chairperson did not do so, indicating that the person who witnessed the event should write the note. In this case, none of the CBOC employees witnessed the incident as the patient was intercepted before he got to the clinic. However, the incident was reported on the local news.

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<sup>24</sup> MCM 11-10-115, *Management and Coordination of Care for the Difficult Patient, Disruptive Behavior Committee-Patient Record Flag Advisories*, September 7, 2010.

<sup>25</sup> Category I PRFs are VHA-wide alerts; Category II PRFs are local facility alerts.

- None of the other CBOC staff members documented the incident in a DBC Alert Note although nothing in policy precluded this.
- The DBC unnecessarily insisted on completion of the Alert Note (before placing a flag) despite learning of the incident through other means, having knowledge that it involved a loaded assault weapon and extra rounds of ammunition and understanding that the patient would likely be receiving some or all of his future medical and MH care at CAVHCS.

We acknowledge the importance of complying with policy to ensure that events are appropriately documented, that criteria are applied fairly and uniformly, and that patient rights are observed. The emergent nature of this case, however, required immediate DBC attention. The delay in activating a behavioral PRF placed providers, patients, and visitors at risk.<sup>26</sup>

**Allegation: The DBC is not responsive to disruptive patient events.**

We substantiated that the process for identifying, managing, and flagging disruptive patients is not consistently followed by some CAVHCS staff or members of the DBC. The DBC chairperson provided the list of 32 CAVHCS patients<sup>27</sup> with behavioral PRFs as of October 17, 2014.<sup>28</sup> Of those, CAVHCS line staff did not consistently document incidents as required:

- Only 23 records contained one or more DBC Alert Notes
  - 1 note was entered 3 months after the incident
  - 3 notes were not forwarded to designated DBC representatives as a means of notification

The DBC did not conduct its duties as required:

- Only 11 (of the 32) records contained some evidence of an incident/threat assessment.
- It took an average of 61 days (range 0–187 days) to complete the threat assessment.
- It took an average of 145 days (range 0–656 days) from the date of the DBC Alert Note (or incident, if no alert note existed) to activation of a behavioral PRF.
- None of the 29 PRFs where re-evaluations were due had been re-evaluated according to schedule.

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<sup>26</sup> We identified a case from 2012 that involved a patient’s telephone threats of violence using a handgun. The incident threat assessment stated, “Setting Risk Factors: Lack of adequate VA police at Dothan CBOC.” A behavioral PRF was activated 2 days later.

<sup>27</sup> This list included two patients whose PRFs were placed by other VHA medical facilities. It did not include a patient with a behavioral PRF placed by the Miami VA.

<sup>28</sup> The list was generated using a Computerized Patient Record System (CPRS) menu tool related to DBC activities.

We identified a different patient who had been banned from Ft. Rucker (and, therefore, the Wiregrass CBOC) for verbally threatening behavior. A DBC Alert Note was entered in summer, 2014, but no incident/threat assessment had been conducted as of early 2015. The patient was seen at least one time at the Dothan PC CBOC before the DBC chairperson recommended that the patient should receive future care at the Montgomery or Tuskegee campus.

#### **Issue 4: Ambulance Transport**

**Allegation: High-risk MH CBOC patients requiring hospital admission wait an excessive amount of time for contract ambulance transport services.**

We substantiated that CBOC-based MH patients requiring non-emergent hospitalization at CAVHCS can wait an excessive amount of time for ambulance transport to the Montgomery ED (for medical clearance).

Effective January 1, 2014, the ambulance transport contract was changed from a large, multi-location contractor to a smaller, veteran-owned company that had a lower cost but still met the minimum (performance and administrative) requirements. The new ambulance vendor is based near Montgomery, and all ambulances are dispatched from that location. As a result, CBOC patients needing ambulance transport for non-emergent concerns, including MH patients, waited a minimum of 1.5–2 hours for the ambulance to arrive at the CBOC. Patients then traveled back to Montgomery (another 1.5–2 hours) and were medically cleared through the ED. We confirmed several cases of patients waiting 7–8 hours from the time the ambulance was requested to the time of arrival in the Montgomery ED.

This arrangement is uniquely challenging for CBOC staff caring for MH patients who do not meet criteria for emergent or involuntary hospitalization (which could be completed via 911) but are still in need of urgent admission to an acute MH unit. Specifically:

- The CBOCs have insufficient nursing staff to conduct extended 1:1 (within arm's reach) observation of at-risk patients who are awaiting ambulance transport. Other nursing duties and patient care responsibilities go unattended while a nurse conducts 1:1 observation.
- Some patients who initially agree to voluntary hospitalization may become increasingly tired and agitated waiting for ambulance transport and may change their mind about admission. Although these patients may not meet criteria for involuntary hospitalization, and therefore cannot be held against their will, they are often still at-risk for accidental or intentional self-injury. In one case, ambulance transport was delayed, and the patient reported that she would ride with a friend to the Montgomery ED. The patient never went.

## Issue 5: Medication Management

### **Allegation: An inpatient psychiatrist inappropriately prescribes benzodiazepines at discharge to high-risk patients.**

While we confirmed that an inpatient psychiatrist does prescribe benzodiazepines to high-risk patients, we did not substantiate that the prescriptions were always inappropriate. We did, however, identify several cases where the combination of discharge medications was not optimal and could have placed those patients at risk.

While VHA guidelines<sup>29</sup> recommend against the use of benzodiazepines for patients with Post-Traumatic Stress Disorder (PTSD) or SUD, these medications continue to be widely used in clinical practice. Providers are obligated to conduct a risk-benefit analysis, consider alternative treatment options, monitor for drug-drug interactions, and, if they elect to prescribe benzodiazepines to high-risk patients, proceed with appropriate clinical monitoring. Guidelines are not absolute rules, and individual practitioners use them in conjunction with clinical judgment in making treatment decisions.

We reviewed 10 randomly selected EHRs of patients admitted to the Tuskegee MH unit between September 2012 and September 2014 with admitting diagnoses that included PTSD, substance abuse, or high risk for suicide, and who had been prescribed benzodiazepines during the admission. Eight of these patients were prescribed benzodiazepines at discharge. While the discharge medications for three of the patients seemed reasonable given the patients' clinical presentation, we found that the discharge medications for the remaining five patients were sub-optimal or possibly sub-optimal. In one case, the patient was prescribed a combination of benzodiazepines and high-dose opioids that could potentially put the patient at increased risk for central nervous system (CNS) and respiratory depression, hypotension, and psychomotor impairment. A second patient was prescribed a benzodiazepine dose above the recommended off-label maximum and a combination of medications that put him at risk for acetaminophen toxicity, CNS and respiratory depression, profound sedation, and other adverse effects.

We noted that both of these patients exhibited challenging behaviors and that providers may have prescribed these medication combinations to deal with difficult clinical presentations. However, the providers did not document their reasoning for prescribing these specific medication combinations or plans for medication monitoring.

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<sup>29</sup> [http://www.healthquality.va.gov/guidelines/MH/ptsd/cpg\\_PTSD-FULL-201011612.pdf](http://www.healthquality.va.gov/guidelines/MH/ptsd/cpg_PTSD-FULL-201011612.pdf), see page 110, 11, 151, accessed April 8, 2015.

## Issue 6: MH Coordination of Care Issues

### **Allegation: CAVHCS does not assign MH Treatment Coordinators.**

We did not substantiate this allegation although the practice of assigning MH Treatment Coordinators (MHTCs)<sup>30</sup> was inconsistent. A March 26, 2012, VHA memorandum requires that all patients receiving MH services be assigned a MHTC by their third MH visit to ensure patients “maintain an enduring relationship with a MH provider who can serve as a point of contact, especially during times of care transitions.”<sup>31</sup> The MHTC is also tasked to ensure the MH treatment plan is monitored and revised as necessary. We reviewed 30 randomly selected EHRs from a list of consults submitted by PC providers to MH from October 1, 2013, to December 5, 2014. We found that 19 patients had completed three MH visits, thereby qualifying for a MHTC. However, 6 of the 19 patients did not have an assigned MHTC.

CAVHCS did not have an approved MHTC policy and several MH providers told us that they were unaware of how MHTCs are assigned and were unclear about the role’s expectations. Providers expressed frustration that they were sometimes erroneously identified as the MHTC for patients that were assigned to other providers.

### **Allegation: CAVHCS has not established PC-MH Integration (PC-MHI) between the Dothan PC CBOC and the Dothan MH CBOC.**

We substantiated the allegation. PC-MHI involves co-located, collaborative care services offered by an embedded MH clinician. MH services are provided in the PC practice area, structured so that the patient views meeting with the MH clinician as a routine PC service and medical providers are supported across a broad scope of behavioral health concerns.

CAVHCS contracts with a local medical group to provide PC to veterans. The Dothan PC CBOC occupies a small building with limited space about 5 miles from the Dothan MH CBOC. The Dothan PC CBOC is considered a mid-size<sup>32</sup> CBOC and is therefore required to adhere to PC-MHI guidelines.<sup>33</sup> The contract requires that “the quality of services provided by the Contractor must be comparable to services provided to veterans seen at [CAVHCS]. Contractor must adhere to the standards set forth annually in VA regulations and policy.”<sup>34</sup> The contract also identifies health care

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<sup>30</sup> Formerly known as the Principal Mental Health Provider (PMHP).

<sup>31</sup> MHTC role is to ensure continuity of care through mental health care and its transitions; serve as a point of contact; serve as a clinical resource. Deputy Under Secretary for Health for Operations Management, “Assignment of the Mental Health Treatment Coordinator,” March 26, 2012.

<sup>32</sup> A *mid-size* designation is based upon the number of unique patients (1,500-5,000) seen as defined by VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.

<sup>33</sup> In cases where co-located PC-MHI is not feasible due to building design and space limitations, VHA Handbook 1101.10 recommends use of tele-health and telephone care.

<sup>34</sup> Paragraph quoted from online template; signed contract includes same unaltered paragraph. VA Contract VA-247-07-RP-0210, 2008, p. 6 retrieved from

[https://www.fbo.gov/?s=opportunity&mode=form&id=4c2483ad1746d78c37ed60f166a5d2e6&tab=core&\\_cview=1](https://www.fbo.gov/?s=opportunity&mode=form&id=4c2483ad1746d78c37ed60f166a5d2e6&tab=core&_cview=1)

services, including MH, which should have been made available within 60 calendar days of the 2009 contract award.

Despite these requirements, there was no embedded MH provider, and the VISN told us that PC-MHI was not included in the contract and that the contracting agency has been unwilling to accommodate VHA requirements outside of those specified in the contract. We confirmed that the PC contractor does not treat and follow patients with some uncomplicated psychiatric conditions (see below) and has been reluctant to care for some MH patients with medical conditions. We noted discord between the Dothan CBOC-based PC and MH teams, usually involving primary MH patients who present to their appointments with medical concerns. We were provided with several examples of a Dothan PC provider refusing to see Dothan MH patients with elevated blood pressures. The Dothan MH CBOC providers expressed frustration by this perceived lack of medical support.

We also noted that CAVHCS' policy for PC-MHI does not list the Dothan CBOC as one of those identified for PC-MHI implementation.<sup>35</sup> This omission is not in compliance with VHA policy.<sup>36</sup> We were told that CAVHCS plans to relocate the MH CBOC to a larger space and review the contract.

**Allegation: Dothan PC CBOC (contract) providers do not complete medication trials for management of uncomplicated psychiatric disorders.**

We substantiated the allegation. We reviewed 30 randomly selected EHRs and found 11 of 12<sup>37</sup> consults submitted to the Dothan MH CBOC by Dothan PC CBOC providers in FY 2014 did not have documentation of an antidepressant trial prior to submission. The diagnoses and provider narratives for the 11 consults referenced uncomplicated<sup>38</sup> depression and/or anxiety.

VHA policy states that Patient Aligned Care Team (PACT) staff typically provide treatment for uncomplicated MH disorders such as anxiety, depressive, and adjustment disorders.<sup>39</sup> CAVHCS policy defines typical PC providers' roles in collaborative care for patients diagnosed with depression, which includes responsibility for ordering antidepressants if indicated.<sup>40</sup> CAVHCS' MH outpatient consult template prompts the PC provider to attempt a trial of certain antidepressant medications before submitting the consult, specifically asking, "*Has a trial of medication been attempted?*"

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<sup>35</sup> MCM 11-13-52 *Primary Care-Mental Health Integration (PC-MHI) Team*, October 10, 2013.

<sup>36</sup> VHA Handbook 1101.10 *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014.

<sup>37</sup> Thirty records were randomly selected for review. Eighteen of those were excluded because the patient had a diagnosis outside of uncomplicated depression or anxiety; wanted substance abuse treatment; was already on meds or transferring care to the Dothan CBOC.

<sup>38</sup> The term uncomplicated refers to mood disorders that lack severe symptoms, prolonged presentation or co-morbid mental health disorders that require referral and/or consultation to mental health.

<sup>39</sup> VHA Handbook 1101.10 *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014.

The Dothan PC CBOC contractor is not in compliance with specifications in the contract that state, “The Contractor is bound by VHA Directive 2012-011, *Primary Care Standards*.” This Directive states that the PC team is responsible for “Screening for mood disorders and substance abuse, and promptly treat[ing] uncomplicated anxiety and depression.”

Dothan MH CBOC staff told us and provided email documentation reflecting that they have repeatedly complained to supervisors and CAVHCS leadership about Dothan PC CBOC providers’ unwillingness to follow patients for uncomplicated MH disorders.

## **Issue 7: Other MH Administrative Issues**

### **Allegation: The MH Consult option was deleted in CPRS.**

While we confirmed that some PC providers could not enter a MH consult, we did not substantiate the implied inappropriateness of this condition. MH consults were routinely being requested throughout CAVHCS. However, PC providers at the Wiregrass and Columbus CBOCs did not have a menu option allowing them to enter a MH consult. These two CBOCs have PC-MHI, and PC providers were to provide a “warm” (in-person) hand-off to the PC-based MH clinician.

### **Allegation: [Dothan CBOC] providers cannot be reached after hours.**

We could not substantiate the allegation as the precise complaint was unclear. In the Dothan PC CBOC, a physician is “on-call” to receive critical or abnormal lab or imaging results after hours.

We noted, however, that some patients do not receive clear instructions about what to do if they have a MH emergency after hours. While the Dothan PC CBOC did provide patients with these instructions via a written brochure and a recorded phone message, the Dothan MH CBOC did not. We called the Dothan MH CBOC after hours and received a recorded message instructing us to hang up and dial 9-1-1 in the event of a medical emergency. There was no mention of what to do for a MH emergency nor was there an option to connect to VHA’s Suicide/Crisis Line or a Nurse Advice line.

### **Allegation: CAVHCS does not conduct MH peer reviews.**

We did not substantiate the allegation. Peer review is intended to promote confidential and non-punitive processes with a primary goal to improve the overall care provided to veterans through a review of individual provider decisions and actions.<sup>41</sup> Peer Review Committee (PRC) minutes for the period January 2012 through September 2014 reflected that MH-related quality peer reviews were being completed and followed-up.

We determined that the MHS� had not assured completion of peer-to-peer EHR reviews in more than a year. Ongoing Professional Practice Evaluation (OPPE) is a means of

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<sup>41</sup> VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.

evaluating professional performance on an ongoing basis: 1) as part of the effort to monitor professional competency; 2) to identify areas for possible performance improvement by individual practitioners; and 3) to use objective data in decisions regarding continuance of clinical practice privileges. OPPE for MH providers involves, among other things, EHR reviews for documentation of specific treatment elements. Generally, a psychiatrist will review several EHRs of another MH provider quarterly and forward the results to the MHS Chief for consideration at the time of reprivileging.

According to VHA Handbook 1100.19, “the timeframe for on-going monitoring is to be defined locally. It is suggested that, at a minimum, Service Chiefs must be able to demonstrate that relevant practitioner data is reviewed on a regular bases (that is, at a minimum of each 6 months).” We reviewed the most recent EHR reviews of three randomly selected MH providers and found that they were generally completed between 2012 and 2013. MH providers we interviewed confirmed during interviews that they had not been asked to complete any EHR reviews since a former MH secretary retired the previous year.

**Allegation: There are not enough acute MH unit beds, so patients often must be admitted to private-sector psychiatric beds.**

We could not substantiate the allegation. CAVHCS has 30 inpatient MH unit beds. The number of operational hospital beds, including acute MH unit beds, is typically based on space, staffing, and clinical demand, and the number that constitutes “enough” hospital beds is likely one of perception. We confirmed that CAVHCS routinely sends patients to other VAMCs or private-sector psychiatric units because there are no vacant acute MH unit beds.

## **Issue 8: Leadership Responsiveness**

**Allegation: CAVHCS leaders had been notified of many of the concerns (detailed in this report); however, the problems frequently went unaddressed.**

We substantiated that CAVHCS leaders were aware of many of the identified issues, that some corrective actions were not always implemented timely, and that others did not appear to have been implemented. Because we were unable to interview the former director and COS, we could not evaluate whether, and the extent to which, there were legitimate management reasons (such as budget priorities and mandates) for CAVHCS leaders taking some actions but not others.

During the course of this review, we identified, were told of, or were provided evidence showing that CAVHCS leadership was aware of staffing deficiencies, management of disruptive behavior concerns, and ambulance transport issues.

With little variation, CBOC employees (both MH and PC) told us that CAVHCS leaders rarely visited their sites and that when they reported their concerns to supervisors, the employees felt “dismissed,” “left out,” or “unheard” by CAVHCS leaders and managers.

In August 2014, VHA senior leaders placed the CAVHCS Director and COS on administrative leave pending the results of an internal investigation. These actions imply that there were high-level concerns about the quality and effectiveness of CAVHCS leadership and may support employees' perceptions of leadership engagement and responsiveness.

## Conclusions

We substantiated that psychiatrist staffing at the Dothan MH CBOC had been inadequate to assure timely and appropriate care. For part of 2012, there was only one psychiatrist on staff, and she was on extended leave from January to August 2012.

We substantiated that CAVHCS has waiting lists to see MH providers at the Dothan CBOC and that patients on the Recall Reminder list were not scheduled according to suggested timeframes. While suboptimal staffing and workload demand was most likely central to waiting lists and delays in scheduling care, we found that clinic schedulers were not appropriately managing the lists. We provided CAVHCS leaders with the waiting lists so that they could take appropriate action.

We did not substantiate that multiple patients committed suicide due to MH care delays. In four cases, however, we found poor coordination of care and/or poor documentation of efforts to identify and monitor patients at high risk for suicide.

We did not substantiate that CAVHCS leaders refused to provide inpatient detox services, that patients were sent home with no medical treatment for substance-related disorders, or that some patients were sent home with diazepam therapy alone. We also did not substantiate that patients needing detox had to pay out-of-pocket for private-sector services or that 24-hour ED observation for intoxicated patients was insufficient. CAVHCS does provide inpatient detox and patients do receive medical treatment for substance-related conditions, as appropriate. On occasion, ED observation as patients "sober up" is an acceptable alternative to hospital admission.

We did not substantiate that the SATP had a long screening process and unclear admission guidelines. CAVHCS policy outlines referral, screening, and assessment guidelines, all of which conform to the *VA DoD Clinical Guideline on Substance Use Disorder*.

While we did not substantiate that the DBC *refused* to issue a behavioral PRF in a case involving a patient with a loaded gun, we found that it took an excessive amount of time to do so given the circumstances and the potential risk to staff and other patients. We also substantiated that the process for identifying, managing, and flagging disruptive patients was not consistently followed by some CAVHCS staff or members of the DBC.

We substantiated that some CBOC-based MH patients requiring non-emergent hospitalization at CAVHCS waited an excessive amount of time for ambulance transport. We confirmed several cases of patients waiting 7–8 hours from the time the ambulance was requested to their arrival in the Montgomery ED. When nursing staff

had to provide extended 1:1 observation, other nursing duties and patient care responsibilities go unattended. Further, some patients who initially agree to voluntary hospitalization may become increasingly tired and agitated waiting for ambulance transport, and may change their mind about admission. Although they may not meet requirements for involuntary admission, those patients may still be at risk.

While we confirmed that an inpatient psychiatrist prescribed benzodiazepines to high-risk patients, we did not substantiate that the prescriptions were always improper. We did, however, identify several instances where the combination of discharge medications was not optimal and could have placed those patients at risk.

We did not substantiate that CAVHCS did not assign MHTCs although we did determine that the practice was inconsistent. We substantiated that CAVHCS has not established PC-MHI between the Dothan PC CBOC and the Dothan MH CBOC and that the Dothan PC contractor did not comply with the contract regarding MH staffing.

We also substantiated that Dothan PC CBOC providers did not complete medication trials for management of uncomplicated psychiatric disorders prior to submitting a consult to the Dothan MH CBOC and was not in compliance with specifications in the contract that state, "The Contractor is bound by VHA Directive 2012-011, *Primary Care Standards*." This Directive specifies that medication trials be initiated by PC providers.

While we confirmed that some PC providers could not enter a MH consult, we did not substantiate the implied inappropriateness of this condition. PC-MHI at some CBOCs promotes "warm" hand-offs rather than contact via consult.

We could not substantiate the allegation that Dothan CBOC providers could not be reached after hours as the precise complaint was unclear. In the Dothan PC CBOC, a physician is "on-call" to receive critical or abnormal lab or imaging results after hours. We noted, however, that some patients did not receive clear instructions about what to do if they had a MH emergency after hours.

We did not substantiate the allegation that CAVHCS did not conduct MH peer reviews. However, we determined that the MHSI had not assured completion of peer-to-peer EHR reviews for the purpose of OPPE in more than a year.

We could not substantiate the allegation that there were not "enough" acute MH unit beds, so patients were often admitted to private-sector psychiatric beds. We did confirm, however, that MH patients were routinely sent to other health care facilities due to a lack of beds at the Tuskegee campus.

We substantiated that CAVHCS leaders were aware of many of the identified issues, that some corrective actions were not always implemented timely, and that others did not appear to have been implemented at all. Many CBOC employees reported feeling marginalized by CAVHCS leaders and managers. The CAVHCS Director and COS were removed from their positions in 2014.

## Recommendations

1. We recommended that the Central Alabama VA Health Care System Director ensure adequate mental health staffing in the community based outpatient clinics to provide timely and appropriate patient care.
2. We recommended that the Central Alabama VA Health Care System Director ensure appropriate review and scheduling of patients on the electronic wait list and Recall Reminder lists provided to management.
3. We recommended that the Central Alabama VA Health Care System Director ensure that staff are trained on the proper use and management of the electronic wait list and the Recall Reminder list, that recall reminder letters are sent to patients, and that compliance is monitored.
4. We recommended that the Central Alabama VA Health Care System Director ensure that clinical staff and the Suicide Prevention program staff follow guidelines on the identification, tracking, treatment, and follow-up of patients at high risk for suicide.
5. We recommended that the Central Alabama VA Health Care System Director ensure that Substance Abuse Treatment Program patients have more timely access to residential/domiciliary beds, as needed.
6. We recommended that the Central Alabama VA Health Care System Director ensure that staff receive appropriate training on the policy requirements for managing disruptive behavior.
7. We recommended that the Central Alabama VA Health Care System Director ensure that the Disturbed Behavior Committee complies with policy on completing and documenting incident/threat assessments and initiating Patient Record Flags.
8. We recommended that the Central Alabama VA Health Care System Director ensure that all Disturbed Behavior Committee Alert Notes, both recent and remote, have been reviewed and appropriate actions taken, if indicated.
9. We recommended that the Central Alabama VA Health Care System Director ensure behavioral Patient Record Flags are re-evaluated within established timeframes.
10. We recommended that the Central Alabama VA Health Care System Director evaluate options available to improve the timeliness of Emergency Department clearance and acute mental health unit admission for high risk patients.
11. We recommended that the Central Alabama VA Health Care System Director ensure that mental health providers adequately document their clinical reasoning when their treatment decisions do not comply with VA/DoD guidelines for medication management in Post-Traumatic Stress Disorder and Substance Use Disorder patients.

12. We recommended that the Central Alabama VA Health Care System Director approve and issue a Mental Health Treatment Coordinator policy and train appropriate staff on same.
13. We recommended that the Central Alabama VA Health Care System Director ensure assignment of Mental Health Treatment Coordinators for all appropriate patients.
14. We recommended that the Central Alabama VA Health Care System Director monitor to ensure the Dothan Primary Care contractor complies with staffing and care specifications as outlined in the contract.
15. We recommended that the Central Alabama VA Health Care System Director ensure that the Dothan Primary Care contract complies with Veterans Health Administration policy on the treatment of uncomplicated psychiatric disorders.
16. We recommended that the Central Alabama VA Health Care System Director update the Dothan Mental Health Community Based Outpatient Clinics recorded message to instruct callers on what to do for a mental health emergency and how to access the Suicide Prevention/Crisis lines.
17. We recommended that the Central Alabama VA Health Care System Director reinstate ongoing professional practice evaluation-related mental health chart reviews.

## VISN Director Comments

### Department of Veterans Affairs

### Memorandum

**Date:** June 5, 2015  
**From:** Interim Director, VA Southeast Network (10N7)  
**Subj:** Healthcare Inspection— Mental Health-Related Deficiencies and Inadequate Leadership Responsiveness, CAVHCS, Montgomery, AL  
**To:** Director, Atlanta Office of Healthcare Inspections (54AT)  
Director, Management Review Service (VHA 10AR MRS OIG Hotline)

1. I have reviewed the Veterans Affairs (VA) Office of Inspector General Office of Healthcare Inspections draft report on the Mental Health-related Deficiencies and Inadequate Leadership Responsiveness, CAVHCS, Montgomery, AL.
2. I concur with the recommendations in the attached draft report and the responses and target dates submitted by Central Alabama Veterans Health Care System.
3. Should you have additional questions, please contact Brenda Winston, Chief Quality Management Officer, at (334) 272-4670, ext. 6297, or via email at [Brenda.Winston@va.gov](mailto:Brenda.Winston@va.gov).

*(original signed by Brenda Schmitz, CFO VISN for:)*

  
Thomas C. Smith III, FACHE  
Attachments

## CAVHCS Director Comments

### Department of Veterans Affairs

### Memorandum

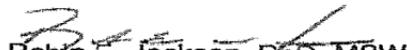
**Date:** May 27, 2015

**From:** Interim Director, CAVHCS (619/00)

**Subj:** Healthcare Inspection— Mental Health-Related Deficiencies and Inadequate Leadership Responsiveness, CAVHCS, Montgomery, AL

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

Please see the actions and dates for the recommendations cited in the Healthcare Inspection-Mental Health Related Deficiencies and Inadequate Leadership Responsiveness, CAVHCS, Montgomery, AL Draft Report.

  
Robin E. Jackson, PhD, MSW  
Interim Director

## CAVHCS 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 that the Central Alabama VA Health Care System Director ensure adequate mental health staffing in the community based outpatient clinics to provide timely and appropriate patient care.

Concur

Target date for completion:

Organizational Chart Approved: June 1, 2015

Positions in to Human Resources: July 31<sup>st</sup>, 2015

Vacancy rate goal of <10% met: December 31<sup>st</sup>, 2015

Facility response: A Mental Health Organizational Chart with Psychiatry, Psychology, Social Work, and Nursing as a service line has been submitted to the Pentad. The new Organizational Chart includes additional staffing as determined by the VA Behavioral Health Interdisciplinary Program (BHIP) guidelines, VA Primary Care-Mental Health Integration (PC-MHI) guidelines, and Uniform Mental Health Services Handbook guidelines.

**Recommendation 2.** We recommended that the Central Alabama VA Health Care System Director ensure appropriate review and scheduling of patients on the electronic wait list and Recall Reminder lists provided to management.

Concur

Target date for completion:

Monthly Scheduling Audits started: June 30<sup>th</sup>, 2015

Additional Training of Medical Support Assistants (MSAs): Ongoing

Facility response: Scheduling has been pulled from the services and aligned with the Business Office. Multiple new MSAs have been hired and trained. Scheduling audits have started and will become routine. Additional training will be provided as needed per monthly scheduling audits.

**Recommendation 3.** We recommended that the Central Alabama VA Health Care System Director ensure that staff are trained on the proper use and management of the electronic wait list and the Recall Reminder list, and that compliance is monitored.

Concur

Target date for completion:

Monthly Scheduling Audits started: June 30<sup>th</sup>, 2015

Additional Training of MSAs: Ongoing

Facility response: Multiple new MSAs have been hired and trained. Scheduling audits have started and will become routine. Additional training will be provided as needs are identified in the audits.

**Recommendation 4.** We recommended that the Central Alabama VA Health Care System Director ensure that clinical staff and the Suicide Prevention program staff follow guidelines on the identification, tracking, treatment, and follow-up of patients at high risk for suicide.

Concur

Target date for completion:

Training: July 31<sup>st</sup>, 2015

Monthly Chart Review started: July 31<sup>st</sup>, 2015

Facility response: The Suicide Prevention Coordinators (SPCs) will train all CAVHCS in the identification, tracking, treatment, and follow-up of patients at high risk for suicide through presentations at staff meetings. The SPCs will perform a review of at least 10 charts from Primary Care and Mental Health for accuracy monthly and present the results to Mental Health Leadership and the Pentad.

**Recommendation 5.** We recommended that the Central Alabama VA Health Care System Director ensure that Substance Abuse Treatment Program patients have more timely access to residential/domiciliary beds, as needed.

Concur

Target date for completion:

Review of Consults: June 30<sup>th</sup>, 2015

Morning Huddles: already occurring

Length of Stay review: July 31<sup>st</sup>, 2015

Facility response: The Program Director for the Residential/Domiciliary, along with Mental Health Leadership, will review the number of consults that are Substance Abuse related to determine the demand for beds. Length of stay for the programs will be reviewed for appropriateness. If the length of stay is determined to be longer than

warranted, a plan of action will be developed and alternative resource explored. Utilization of Substance Abuse programs on an outpatient basis will be pursued as appropriate. The Program Director will participate in the inpatient morning huddles to help with communication and coordination. If additional beds are needed, Mental Health will request additional beds from the Pentad.

**Recommendation 6.** We recommended that the Central Alabama VA Health Care System Director ensure that staff receive appropriate training on the policy requirements for managing disruptive behavior.

Concur

Target date for completion: July 31<sup>st</sup>, 2015

Facility response: The Disruptive Behavior Committee (DBC) will distribute all policies on disruptive behavior electronically to all CAVHCS staff. The DBC will hold live Town Halls to train staff at Tuskegee and Montgomery and hold Telehealth Conferences to train the CBOC staff.

**Recommendation 7.** We recommended that the Central Alabama VA Health Care System Director ensure that the Disturbed Behavior Committee complies with policy on completing and documenting incident/threat assessments and initiating Patient Record Flags.

Concur

Target date for completion: July 31<sup>st</sup>, 2015

Facility response: The DBC will track timeliness of clinical threat assessments and time to initiate PRFs. This report will be submitted to Mental Health Leadership and the Pentad and presented in the Quality Leadership Board meetings.

**Recommendation 8.** We recommended that the Central Alabama VA Health Care System Director ensure that all Disturbed Behavior Committee Alert Notes, both recent and remote, have been reviewed and appropriate actions taken, if indicated.

Concur

Target date for completion: July 31<sup>st</sup>, 2015

Facility response: The DBC will run the DBC Alert Note report for Fiscal Year 2014 through the present and document all actions on a tracking spreadsheet including the date the case was reviewed and the date the flag was entered.

**Recommendation 9.** We recommended that the Central Alabama VA Health Care System Director ensure behavioral Patient Record Flags are re-evaluated within established timeframes.

Concur

Target date for completion: July 31<sup>st</sup>, 2015

Facility response: The DBC will run a report listing all disruptive behavior flags and the date they are to be reviewed. All reviews due will be completed in 60 days.

**Recommendation 10.** We recommended that the Central Alabama VA Health Care System Director evaluate options available to improve the timeliness of Emergency Department clearance and acute mental health unit admission for high risk patients.

Concur

Target date for completion: July 31<sup>st</sup>, 2015

Facility response: The ACOS for Specialty Care and Mental Health Service, Chief and Staff will review the ED Flow and the timeliness of Emergency Department (ED) care for Mental Health Patients develop a plan to improve the timeliness.

**Recommendation 11.** We recommended that the Central Alabama VA Health Care System Director ensure that mental health providers adequately document their clinical reasoning when their treatment decisions do not comply with VA/DoD guidelines for medication management in Post-Traumatic Stress Disorder and Substance Use Disorder patients.

Concur

Target date for completion: July 31<sup>st</sup>, 2015

Facility response: The ACOS for Mental Health will discuss the need to document clinical decisions that don't follow published VA/DoD guidelines for medication management for patients with PTSD and Substance Use Disorders. The Inpatient Medical Director will organize a review of 10 charts monthly to ensure compliance with the guidance and the report will be sent to Mental Health Leadership and the Pentad.

**Recommendation 12.** We recommended that the Central Alabama VA Health Care System Director approve and issue a Mental Health Treatment Coordinator policy and train appropriate staff on same.

Concur

Target date for completion: July 31<sup>st</sup>, 2015

Facility response: The Mental Health Service will develop a Standard Operating Procedure reflecting the Uniform Mental Health Services Handbook (UMHSH) requirements for a Mental Health Treatment Coordinator. This policy will be distributed by e-mail to all staff and presented at a General Mental Health Staff meeting.

**Recommendation 13.** We recommended that the Central Alabama VA Health Care System Director ensure assignment of Mental Health Treatment Coordinators for all appropriate patients.

Concur

Target date for completion: July 31<sup>st</sup>, 2015

Facility response: Mental Health will meet the National target for assignment of a Mental Health Treatment Coordinator (MHTC) as measured by MHTC1.

**Recommendation 14.** We recommended that the Central Alabama VA Health Care System Director monitor to ensure the Dothan Primary Care contractor complies with staffing and care specifications as outlined in the contract.

Concur

Target date for completion: July 31<sup>st</sup>, 2015

Facility response: Facility Leadership will review VA Health Care requirements and make sure these are both included in the contract along with contractor's compliance. Compliance with these requirements will be submitted monthly to the ACOS for Primary Care and the Pentad.

**Recommendation 15.** We recommended that the Central Alabama VA Health Care System Director ensure that the Dothan Primary Care contract complies with Veterans Health Administration policy on the treatment of uncomplicated psychiatric disorders.

Concur

Target date for completion: July 31<sup>st</sup>, 2015

Facility response: Compliance with the requirement for Primary Care to start Psychotropics promptly for uncomplicated depression and anxiety will be monitored monthly by the Dothan Mental Health CBOC providers; all non-compliant cases will be submitted to Mental Health and Primary Care Leadership monthly.

**Recommendation 16.** We recommended that the Central Alabama VA Health Care System Director update the Dothan Mental Health Community Based Outpatient Clinic recorded message to instruct callers on what to do for a mental emergency and how to access the Suicide Prevention/Crisis lines.

Concur

Target date for completion: June 30<sup>th</sup>, 2015

Facility response: The message for the Dothan Mental Health CBOC will be changed to instruct callers on what to do for a mental health emergency and will include instructions on how to access the Suicide Prevention/Crisis line.

**Recommendation 17.** We recommended that the Central Alabama VA Health Care System Director reinitiate ongoing professional practice evaluation-related mental health chart reviews.

Concur

Target date for completion: June 30<sup>th</sup>, 2015

Facility response: The ACOS for Mental Health will develop and distribute an Ongoing Professional Practice Evaluation form. The forms will be completed quarterly

## Office of Inspector General Contact and Staff Acknowledgments

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