VA Office of Inspector General

OFFICE OF AUDITS AND EVALUATIONS

Veterans Health Administration

Review of Allegations of Inappropriately Completed Consults and Inappropriate Bonuses at the St. Louis VA Health Care System

September 29, 2015
14-03434-530

ACRONYMS AND ABBREVIATIONS

ADPAC	Automated Data Processing Applications Coordinator
FY	Fiscal Year
HCS	Health Care System
OIG	Office of Inspector General
RVU	Relative Value Unit
VA	Department of Veterans Affairs
VHA	Veterans Health Administration

Report Highlights: Review of Allegations of Inappropriately Completed Consults and Inappropriate Bonuses at the St. Louis VA Health Care System

Why We Did This Review

We performed this review to determine the merits of allegations made to the VA Office of Inspector General (OIG) during May and June 2014. The complainant alleged that the mental health clinics at the St. Louis VA Health Care System (HCS) inappropriately completed consults prior to the appointment, which misrepresented patient wait times, and paid bonuses based on productivity data. The complainant made additional allegations regarding quality of care and erroneous productivity data. The OIG Office of Healthcare Inspections plans to address these allegations in a separate report.

What We Found

We substantiated the allegation that the St. Louis VA HCS inappropriately changed the status of consults to "Complete" prior to the provider actually completing the appointment with the patient. Starting in October 2013 and continuing through June 2014, an HCS employee inappropriately changed the status of 12 of 20 sampled consults (60 percent) to "Complete" before the provider completed the appointment. However, this practice did not affect the Veterans Health Administration's (VHA) reported patient wait times because VHA measured wait times from the appointment create date and not from the consult dates.

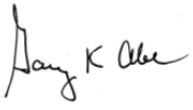
We substantiated the allegation that St. Louis VA HCS psychiatrists received performance pay based on productivity data. We reviewed the fiscal year 2013 performance pay assessments completed by the Associate Chief of Staff for Mental Health for eight full-time outpatient psychiatrists. The psychiatrists each received an average of $13,710 in total performance pay. Seven of the psychiatrists met or exceeded the productivity goal. As a result, each received an average of $2,920 for meeting that goal. The psychiatrist who did not meet the productivity goal received no performance pay for productivity, but received 80 percent of his performance pay because he met other goals of his assessment. VHA allows performance pay to recognize achievements of goals and performance objectives prescribed per fiscal year by an appropriate management official. We did not make recommendations pertaining to this allegation.

What We Recommended

We recommended the Director of the St. Louis VA HCS ensure staff receive appropriate training and guidance on consult management, and perform a follow-up analysis of completed consults to ensure they are not completed inappropriately.

Agency Comments

The Acting Director of the St. Louis VA HCS concurred with our report. The Acting Director's actions are acceptable and we consider the recommendations closed.



GARY K. ABE
Acting Assistant Inspector General
for Audits and Evaluations

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INTRODUCTION

Purpose of the Review

In May and June 2014, the VA Office of Inspector General (OIG) received allegations regarding the mental health clinics at the John Cochran and Jefferson Barracks VA Medical Centers in the St. Louis VA Health Care System (HCS). The complainant alleged the HCS:

- Inappropriately completed consults prior to the scheduled appointment date, which misrepresented patient wait times
- Paid bonuses based on productivity data

The complainant made additional allegations regarding quality of care and erroneous productivity data. The OIG Office of Healthcare Inspections plans to address these allegations in a separate report.

Scope and Methodology

We conducted our review from June 2014 through July 2015. We performed the following analysis.

- Reviewed mental health consults completed during fiscal year (FY) 2014
- Reviewed clinic schedules from March through May 2014, and Relative Value Units (RVU) of psychiatrists in FY 2013 and FY 2014
- Interviewed officials from St. Louis VA HCS, including the Chief of Staff, the Associate Chief of Staff for Mental Health, the Chief of Psychiatry, and other mental health staff and clinicians
- Reviewed applicable VA and Veterans Health Administration (VHA) policies, procedures, handbooks, and guidelines related to the allegations

We used computer-processed data obtained from VHA's Support Service Center to identify completed outpatient consults to the St. Louis VA HCS's mental health clinics from October 1, 2013, through June 30, 2014. To test the reliability of these data, we compared relevant computer-processed data of 20 completed consults with records in VA's Compensation and Pension Records Interchange system. We also obtained productivity data from the HCS and tested the reliability of that data with VHA's Physician Productivity Cube. We concluded the data were sufficiently reliable for the review objectives. We did not evaluate or validate the adequacy of VHA's national standard for RVUs.

Government Standards

We conducted this review following the Council of Inspectors General on Integrity and Efficiency's *Quality Standards for Inspection and Evaluation*.

RESULTS AND RECOMMENDATIONS

Allegation 1 Did the St. Louis VA HCS Inappropriately Complete Consults and Misrepresent Patient Wait Times?

Assessment

We substantiated the allegation that the St. Louis VA HCS inappropriately changed the status of consults to "Complete" prior to the provider actually completing the appointment with the patient. We determined this particular practice did not affect VHA's reported patient wait times because VHA measures wait times from the appointment create date to the appointment completion date, and not from the consult request date.

Criteria

VHA's *Memorandum on Inappropriate Scheduling Practices* (April 26, 2010) detailed multiple inappropriate scheduling practices that were not in line with patient-centered care. One of those practices was completing the consult when the appointment is scheduled rather than when the patient is seen. VHA's *Consult Management Business Rules* (May 2014) provided rules on which status—such as Pending, Scheduled, or Complete—facility staff should place a clinical consult in throughout the consult request process.

What We Did

To address whether the St. Louis VA HCS inappropriately changed the status of consults to "Complete" prior to the provider actually completing the appointment with the patient, we interviewed the mental health clinic nurse in charge of consult management. We also reviewed a sample of 20 completed consults from about 1,300 total outpatient completed consults at the HCS's mental health clinics from October 1, 2013, through June 30, 2014. In addition, we interviewed the Chief of Staff, Associate Chief of Staff for Mental Health, Chief of Mental Health, Chief of Psychiatry, and the Lead Psychiatrist.

Inappropriately Completed Consults

Starting in October 2013 and continuing through June 2014, the mental health clinic nurse in charge of consult management inappropriately changed the status of consults to "Complete" before the mental health provider saw the patient. Completing the consult when the appointment is scheduled rather than when the patient is seen was one of the many inappropriate scheduling practices outlined in VHA's *Memorandum on Inappropriate Scheduling Practices*. According to VHA's *Consult Management Business Rules*, a status change to "Scheduled" is required to link the consult request to the scheduled appointment. The clinic nurse told us there is no automatic tracking in the system to ensure the HCS reschedules the veteran for his appointment if the patient does not show up for the appointment or the appointment is canceled by the clinic. This practice increases the risk that veterans may become lost in the system if they missed their consult appointment.

Of the 20 completed consults we reviewed, the clinic nurse inappropriately changed the status of 12 consults (60 percent) to "Complete" before the provider completed the appointment. Of the eight consults acted on correctly, the clinic nurse addressed three, and other staff addressed five.

The clinic nurse stated this occurred due to his lack of knowledge of appropriate consult management procedures. He stated that he never received formal training or the policy on consult management. VHA's *Consult Management Business Rules* provides instructions on changing the status of clinic consults. In addition, he stated that no one instructed him to change the consult status to "Complete" prior to the provider seeing the patient. He acknowledged he should have handled them differently and that he made this error on numerous consults. In June 2014, the Associate Chief of Staff for Mental Health instructed the clinic nurse to stop changing the status of the consults to "Complete" prior to the provider seeing the patient.

Appointment Wait Times

We determined this particular practice did not affect VHA's reported patient wait times because VHA measures wait times from the appointment create date to the appointment completion date, and not from the consult request date. The consult request date and consult completion date are not included in VHA's appointment wait time calculations.

Recommendations

1. We recommended the Director of the St. Louis VA Health Care System ensure scheduling staff receive appropriate training and guidance on proper consult management.

2. We recommended the Director of the St. Louis VA Health Care System perform a follow-up analysis and regular oversight of completed consults to ensure consults are not designated as "Complete" before the provider sees the patient.

Management Comments

The Acting Director of the St. Louis VA HCS concurred with our report. She stated the VA HCS completed its review of completed mental health consults, provided training on consult management to scheduling and Automated Data Processing Applications Coordinator (ADPAC) staff as appropriate, and implemented consult monitoring and oversight of consult management and timely scheduling of consults.

The St. Louis VA HCS conducted a follow-up analysis of completed consults before the provider sees the patient. The VA HCS identified and removed an individual from the consult group that was incorrectly assigned to the group. In addition, the individual received re-training on proper documentation within consults.

The facility reviewed the business rules for consult notifications with ADPAC staff and Administrative Officers to ensure only individuals with the appropriate scope of practice or privileges can complete a consult. Finally, the St. Louis VA HCS Director of Quality Management monitored consults for 3 months to ensure compliance with consult management policy.

OIG Response The Acting Director's corrective actions are acceptable and we consider the recommendations closed. Appendix A provides the full text of the Acting Director's comments.

Allegation 2 Did the St. Louis VA HCS Pay Bonuses Based on Productivity Data?

Assessment

We substantiated the allegation that St. Louis VA HCS psychiatrists received performance pay based, in part, on meeting a VHA-established productivity goal. We determined that seven of eight St. Louis VA HCS psychiatrists met or exceeded their productivity goal. As a result, each received an average of $2,920 for meeting the productivity goal. We determined St. Louis VA HCS did not pay psychiatrists any additional bonuses related to productivity.

All VA physicians, including psychiatrists at the St. Louis VA HCS, are considered for performance pay based on the specific goals established at the beginning of the fiscal year. A physician's performance pay is part of the total pay package, along with base and market pay. To meet the productivity goal, the St. Louis VA HCS psychiatrists needed to meet the RVU workload target as set in the FY 2013 VHA Productivity Directive. According to the complainant, RVUs were not a good performance measure because they did not truly reflect productivity. We did not assess the adequacy or appropriateness of the national productivity standards.

Criteria

VHA Directive 1161 *Productivity and Staffing in Outpatient Clinical Encounters for Mental Health Providers* (June 7, 2013) provides specific annual RVU production standards. For a full-time equivalent psychiatrist, the national goal is 2,574 RVUs per year. This goal is adjusted based on the individual's leave during the period and time allotted for direct patient care. VA Handbook 5007 provides procedures on pay administration, including performance pay for VA physicians. VHA allows performance pay to recognize the achievement of specific goals and performance objectives prescribed on a fiscal year basis by an appropriate management official. The purpose of performance pay is to improve the quality of care and health care outcomes through the achievement of specific VA goals and objectives. A physician's performance pay is included in the total pay package, along with base and market pay.

What We Did

To address the merits of this allegation, we reviewed FY 2013 performance pay evaluations, salary information, and bonus pay information for eight full-time outpatient psychiatrists. In addition, we interviewed the St. Louis VA HCS Chief of Staff, Associate Chief of Staff, Chief of Psychiatry, and the Lead Psychiatrist for Mental Health. We also reviewed HCS's reported RVU productivity data to determine if the psychiatrists met annual RVU production goals.

Performance Pay and Bonuses

In addition to annual pay, all VA physicians, including psychiatrists at the St. Louis VA HCS, are considered for performance pay (not to exceed the lesser of $15,000 or 7.5 percent of annual pay) based on the specific goals established at the beginning of the fiscal year. In order to receive individual performance pay, the St. Louis VA HCS psychiatrists needed to meet certain

performance goals. The five goals for each of the psychiatrists in FY 2013 were as follows.

1. Quality–Less than two complaints recorded by the patient advocate and judged to be valid by the Chief of Psychiatry
2. Productivity–RVU workload is 100 percent or greater than the target set in the FY 2013 VHA Productivity Directive
3. Institutional Improvement Standard–Less than or equal to 0.5 percent of all encounters remain "Incomplete" for greater than 7 days due to provider error (for example, the provider had not completed documenting the encounter)
4. Institutional Specific Team Goal–Continuity of care in which the facility meets or exceeds 7-day follow-up after inpatient hospitalization (Target 75 percent)
5. Institutional Specific Strategy Goal–Meet or exceed target (95 percent) for all second-level mental health screens completed in a timely manner following positive initial screen for depression and Post Traumatic Stress Disorder

The productivity target outlined in the second goal was set according to VHA's 2013 Productivity Directive. That portion of the performance pay assessment was worth 20 percent of the psychiatrists' potential performance pay. We reviewed the HCS's reported RVU productivity data to determine if the psychiatrists met the established goals in order to meet that portion of the performance pay assessment.

We reviewed the FY 2013 performance pay assessments completed by the Associate Chief of Staff for Mental Health for eight full-time outpatient psychiatrists. The eight psychiatrists each received an average of $13,710 in total performance pay. Seven of the eight psychiatrists met or exceeded the productivity goal (goal number 2 above). As a result, each received an average of $2,920 for meeting the productivity goal.

The one psychiatrist who did not meet the productivity goal received no performance pay for productivity. He did receive 80 percent of the performance pay—a total of $11,896—because he met the other four goals of his performance pay assessment. That psychiatrist had the lowest productivity level among those full-time outpatient psychiatrists at 99 percent. The highest productivity level by a psychiatrist at the HCS was 228 percent. We did not make recommendations pertaining to this allegation.

Appendix A Acting Director of St. Louis VA HCS Comments

Department of Veterans Affairs **Memorandum**

Date: August 20, 2015

From: Acting Director, VA St. Louis Health Care System

Subj: Draft Report, Review of Allegations of Inappropriately Completed Consults and Inappropriate Bonuses at the St. Louis VA Health Care System

Project No. 2014-03434-R5-0248

To: Acting Assistant Inspector General for Audits and Evaluations (52)

1. Thank you for the opportunity to review the report. I concur with the report.

2. VA St. Louis Health Care System will ensure scheduling staff receive appropriate training and guidance on proper consult management.

    a. All scheduling staff completed training on consult management. The Health Administration Service Chief is responsible for ensuring all incumbent complete the training and for all new hires to complete during orientation. The appropriate training was completed in 2014 and 2015.

    b. All service ADPAC received training on consult scheduling and reports to monitor timeliness of scheduling. The Clinical Applications Coordinator provided the training to all incumbent ADPACs in August 2014 and the content is included in orientation for new ADPACs.

    c. Acting Chief of Staff and Chairperson of the Consult Committee provide monitoring and oversight of consult management and timely scheduling of consults. The timely scheduling of consults is monitor as committee performance measure. This was implemented in December 2014.

3. VA St. Louis Health Care System completed a follow up analysis of "completed" consults before the provider sees the patient.

    a. The facility completed an analysis of issue "completed" before seen when it was identified by a mental health provider on June 3, 2014. The issue brought forward was that a mental health clinic registered nurse was utilizing the "consult result" note to document communication and appointment scheduling with Veterans. The Director, Quality Management completed a chart review on 285 outpatient mental health consults submitted between April 1, 2014 and June 20, 2014 to determine the scope of this potential issue. The results of this reviewed showed that the only a single individual had utilized "consult result" note to document communication with the Veteran. The individual was incorrectly assigned to notification group that gave permission to complete the consult. Once identified the individual was removed from the consult group on June 20, 2014. The individual was re-trained on the proper method to document communication with the

Veteran regarding their appointment using the "add comment" function on the consult. A detail review was completed of all consult notification group and did not identify any other individuals that did not have the scope of practice or privilege to complete the consult they were assigned to.

b. The business rules for assignment of individual to consult notification groups were reviewed with the clinical ADPAC and Administrative Officers by the Clinical Application Coordinators to ensure only individuals with the appropriate scope of practice or privileges are assigned to notification group that allow the individuals to complete the consult with "consult results" function.

c. Director of Quality Management monitored "consult result" function for three months July to September 2014. This review did not identify any further occurrence of consult completion before Veterans appointment was completed.

4. If you have any questions about this report please contact Patricia Hendrickson, Associate Director Patient Care Services at patricia.hendrickson2@va.gov or 314-289-7097.

PATRICIA L. TEN HAAF, RN PhD, FACHE
Acting Medical Center Director

Appendix B Office of Inspector General Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Larry Reinkemeyer, Director Lance Kramer Brad Lewis Daniel Morris Jason Schuenemann Melanie Tsai

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