Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-03531-402

Healthcare Inspection

Alleged Delayed Mental Health Treatment and Other Care Issues Kansas City VA Medical Center Kansas City, Missouri

September 2, 2015

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection at the request of Representative Kevin Yoder in response to concerns about the extent to which a patient received timely and adequate care for post-traumatic stress disorder (PTSD) and other health care needs at the Kansas City VA Medical Center (facility), Kansas City, MO.

We did not substantiate the allegation that the patient was told he would have to wait 30 days for inpatient treatment for PTSD. We found that the patient had multiple health issues and had been screened for admission to another inpatient program and assigned an admission date to the other program 35 days after being screened. However, the patient died a few days after acceptance into the program.

We substantiated that aspects of the patient's care were inadequate. In particular, we found that some requests for outpatient consultations were inappropriately cancelled or discontinued, the patient's abnormal findings and/or care needs were not fully assessed, and appropriate consults were not made when the patient was treated in the Emergency Department.

Whether addressing these issues previously would have resulted in a different outcome for the patient is unknown. However, addressing these issues now will help facilitate a more patient-centered environment, especially for those veterans with complex medical and mental health issues.

We noted that because the facility did not have a signed release of information, staff were unable to discuss the patient's care with a family member.

In addition to general privacy laws that govern release of medical information, disclosure of certain veteran health or other private information may be prohibited by various Federal statutes including, but not limited to, 38 U.S.C. §§ 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, OIG adheres to the privacy and confidentiality laws and regulations protecting veteran health or other private information in this report.

We made one recommendation to the Interim Under Secretary for Health and three recommendations to the Facility Director.

Comments

The Interim Under Secretary for Health and the Veterans Integrated Service Network and Facility Directors concurred with our recommendations and provided an acceptable action plan. (See Appendixes A, B, and C, pages 8–13.) We will follow up on the planned actions until they are completed.

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

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection at the request of Representative Kevin Yoder in response to concerns about the extent to which a patient received timely and adequate care for post-traumatic stress disorder (PTSD) and other health care needs at the Kansas City VA Medical Center (facility) in Kansas City, MO. The purpose of the review was to determine whether these concerns had merit.

Background

The facility is part of Veterans Integrated Service Network (VISN) 15 and comprises a medical center in Kansas City, MO, and community based outpatient clinics (CBOCs) in Belton, Cameron, Excelsior Springs, Kansas City, Nevada, and Warrensburg, MO, and Paola, KS. The facility also operates a mobile medical unit. VISN 15 has additional medical centers in Columbia, Saint Louis, and Poplar Bluff, MO; Leavenworth, Topeka, and Wichita, KS; and Marion, IL. The facility provides acute medical, surgical, neurological, rehabilitation, and mental health (MH) care for the veterans in Kansas City and surrounding areas.

Allegations

- The patient was told he would have to wait 30 days to begin inpatient treatment for PTSD, an excessive delay in light of the patient's clinical circumstance.
- The care provided to the patient was inadequate.

Access to MH Care

Veterans Health Administration (VHA) policy requires that all first-time patients referred to or requesting MH services receive an initial evaluation within 24 hours and a more comprehensive diagnostic and treatment planning evaluation within 14 days.[1] Further, according to VHA policy, "the primary goal of the initial 24-hour evaluation is to identify patients with urgent care needs and to trigger hospitalization or the immediate initiation of outpatient care when needed."

VHA policy does not specify the interval within which or the maximum amount of time a patient should wait for admission to specific programs. However, whenever there is a gap of greater than 2 weeks for patients accepted into certain programs, providers must maintain clinical contact with the patient until the time of admission and address any urgent mental health care needs that arise.

[1] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.

Care for Certain Types of Veterans

VA health care facilities are required to meet various requirements when caring for certain types of veterans. For example, facilities may be required to:

- provide appropriate health and MH care services including screening for specific health conditions, and
- assign a case manager for those who are severely injured and ill and for those otherwise in need of care management services.

In addition, VA medical facilities must meet VHA policy requirements that are applicable to the care of all patients. Examples of these requirements are as follows:

- For patients scheduled in response to consults, when a patient does not show for scheduled appointments, staff is expected to review the electronic health records (EHRs), determine and initiate appropriate follow-up actions, and document those actions in the patients' EHRs.
- When patients are evaluated as appropriate candidates for admission to inpatient or residential treatment settings for certain conditions and are willing to be admitted, but admission to those settings is not immediately available, interim services must be provided, as needed, to ensure patient safety and promote treatment engagement.
- Medical center directors are responsible for ensuring that policies and procedures are established and followed regarding the identification, evaluation, and treatment of health concerns such as those presented by this patient.

Scope and Methodology

We reviewed VHA, VISN, and facility policies related to the care of certain types of veterans and relevant policies related to the care of all patients, relevant facility-specific policies, and the patient's EHR. We reviewed reports generated by the facility to describe its review of the care rendered to the patient, including issue briefs and other internal reviews.

In addition, we conducted a site visit to the facility in 2014 and interviewed the Facility Director, Acting Chief of Staff, Chief of MH, Program Manager for certain inpatient programs, staff involved in the patient's care, and a member of the patient's family. We conducted additional interviews via telephone with the VISN MH leadership, a city official, and additional clinical staff from the facility, as well as clinical staff affiliated with programs at two other VA medical centers in the VISN.

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.

Case Summary

The patient was a male who was diagnosed with PTSD and other health conditions.

The patient was seen by a primary care provider at the facility in 2013. The patient reported a history of PTSD and other health conditions. During this visit, he screened positive for PTSD. He underwent evaluation for the PTSD and another reported health condition 10 days later. On the basis of that evaluation, he was referred to multiple specialty clinics and disciplines.

Within 3 weeks of the 2013 primary care appointment, the patient was treated at two specialty clinics. He was prescribed medications to treat both the PTSD symptoms and other health concerns. He was referred for various outpatient treatments and advised to return to one of the clinics in 6 months.

Approximately a month later, the patient was evaluated and treated by his primary care provider for a health condition unrelieved by prescribed medication for which the provider ordered an evaluation.

Later that month, the patient was evaluated by a different specialist who made several treatment recommendations and changed the patient's medication. The patient ultimately elected to discontinue some of the medications. A follow-up appointment with this specialist was scheduled for several months later, but the patient did not come and did not call to cancel the appointment.

Shortly thereafter, the patient attended both a PTSD group treatment session and an individual session with a provider who recommended an evidence-based therapy for the patient's PTSD. The patient indicated that he would contact this provider regarding his interest in therapy after consulting his employer about leave time. The patient did not attend any further group or individual sessions.

Over the next several months, the patient was seen four times in the facility's Emergency Department (ED) for both PTSD and non-PTSD related symptoms. He was then assessed by multiple outpatient providers. Although both inpatient and outpatient treatment was offered, the patient declined treatment.

In spring 2014, however, the patient agreed to undergo screening for admission to a program other than the PTSD program. In collaboration with an interdisciplinary team, an admission date was scheduled for 35 days after the screening. One of the providers gave the patient information on outpatient sessions that he could attend while awaiting admission to the program.

Prior to admission to the program, the patient died.

Inspection Results

Issue 1: Timeliness of Treatment for PTSD

We did not substantiate the allegation that the patient was told he would have to wait 30 days for inpatient treatment for PTSD. However, we did find that the patient was assigned an admission date for another inpatient program 35 days after he was screened for admission. We noted opportunities for improvement associated with the patient's screening and admission process.

Alleged Delayed Treatment for PTSD. In 2013, the patient attended a PTSD group therapy session and an individual session with a provider to be evaluated for PTSD. He was offered additional group and individual treatment as an outpatient but elected not to attend further PTSD treatment.

Delayed Treatment for Another Health Condition. The patient was offered treatment for another health condition in 2014. He indicated that he was open to being screened for admission to a program to treat that condition. However, during the screening interview held on the same day, the patient declined treatment. Later that month, the patient was screened again for admission to that program. The following day, in collaboration with an interdisciplinary team, the patient was assigned a program admission date of 35 days after the screening. A provider noted in the patient's EHR that the program had a long wait list. The provider also noted that, if the patient would prefer an earlier admission date, another VA medical center in the VISN could be contacted. However, we could not find documentation in the EHR that facility staff attempted to coordinate admission with another VISN facility.

Issue 2: Adequacy of Care

We substantiated the allegation that aspects of the patient's care as described below were inadequate.

Cancelled or Discontinued Consults. Four of five consultations ordered during the patient's 2013 evaluation for a specific health issue were discontinued inappropriately. In particular, the disposition of the referrals was as follows:

- For Consult A, the patient was initially scheduled to be evaluated in late 2013. The patient later requested to reschedule that appointment and was provided with a new appointment. The patient did not come to the clinic and did not cancel that appointment. The service subsequently cancelled the consult, remarking that the patient did not show or call to cancel his appointment. The EHR does not contain documentation that the service reviewed the patient's medical record and then determined and initiated appropriate follow-up action, as required.

- For Consult B, the service cancelled the consult and asked that the referral be made again once preliminary tests were completed. The preliminary tests were completed, but a second consult was not entered and this patient was never evaluated.

- For Consult C, the service discontinued the consult, noting that the patient had already been provided an exam slot. The patient was scheduled to be seen but did not appear for the appointment and did not call to cancel. The patient's EHR does not contain documentation that the service reviewed the patient's EHR and then determined and initiated appropriate follow-up action.

- For Consult D, the service requested that different documentation be submitted, then discontinued the consult. The patient's EHR does not contain documentation that further actions were taken to facilitate scheduling this patient for this.

In June 2014, the facility issued a local policy after the events in question, to clarify the steps that staff are expected to take when patients either do not show for an appointment, including an appointment scheduled in response to a consult, or when the clinic cancels the appointment. In particular, this policy indicates that when a patient does not show for scheduled appointments, staff are expected to review the EHR, determine and initiate appropriate follow-up action, and document that action in the patient's EHR. To the extent that facility staff meet those expectations, the issue we identified regarding inappropriately canceled consults would be partially resolved.

Lack of Assessment. During an ED visit, some abnormal findings were not addressed or communicated to other providers involved in the patient's care.

Evaluation and Referral Related to Other Health Issues. The patient was not evaluated and offered services related to other health issues, as required. In particular, when the patient presented to the facility's ED after an episode that may have been related to a specific health issue, the facility did not offer evaluation by or a referral to a provider to determine whether he had unmet care needs.

Lack of Consultation of Specialty Providers. During a different visit to the ED, two members of the patient's family voiced concerns that the patient needed to be admitted to the facility because of a specific health issue. According to an EHR note, staff were unable to obtain additional information from the patient's family regarding why they felt he needed to be admitted. The patient was not evaluated by a specialty provider for this specific health concern during this visit nor was the patient's assigned provider alerted to this concern. A facility official told us that the facility is taking steps to improve communication between the ED and other providers and establishing an automated mechanism wherein a patient's assigned provider will be alerted when a patient is seen in the ED.

Issue 3: Communication with Patient's Family

We noted that the absence of a signed release of information to allow facility staff to discuss the patient's treatment with a family member was a missed opportunity for enhanced communication. We also noted that the patient's medical record reflected that the family member made multiple attempts to try to discuss the patient and his care with facility staff. However, facility staff could not share information with the family member because the patient had not signed a formal release of information. The

patient had provided the facility with the family member's contact information and filled out, but did not sign, a release of information.

Conclusions

We did not substantiate the allegation that the patient was told he would have to wait 30 days for inpatient treatment for PTSD. However, we did find that the patient was assigned an admission date of 35 days after he was screened for admission to another program. However, we noted shortcomings associated with the patient's screening and admission process.

We substantiated that aspects of the patient's care provided by the facility were inadequate. In particular, we found that some requests for outpatient consultations were inappropriately cancelled or discontinued, the patient's care needs were not fully assessed, and/or appropriate consults were not made when treated in the ED.

Whether addressing these issues previously would have resulted in a different outcome for the patient is unknown. However, addressing these issues now will help facilitate a more patient-centered environment, especially for those veterans with complex medical, mental health, and psychosocial issues.

We noted that the patient had provided the facility with a family member's contact information and filled out, but did not sign, a release of information. While this suggests that the patient may have been amenable to engaging the family member in his care, the facility never had a signed release of information from the patient and, therefore, was unable to discuss the patient with the family member.

We made one recommendation to the Interim Under Secretary for Health and three recommendations to the Facility Director.

Recommendations

1. We recommended that the Interim Under Secretary for Health review relevant inpatient program occupancy rates and wait times system-wide and determine whether additional guidance to facilities is needed to help ensure that the number of patients served through those programs is optimized.

2. We recommended that the Facility Director ensure that processes be strengthened to ensure appropriate follow through on consults that are cancelled for administrative reasons.

3. We recommended that the Facility Director ensure that Emergency Department providers fully evaluate patients with abnormal findings and make those evaluations readily accessible to other providers.

4. We recommended that the Facility Director ensure that patients are evaluated and referred for treatment for certain health concerns if exhibited by patients presenting to the Emergency Department, when appropriate.

Appendix A

Interim Under Secretary for Health Comments

Department of Veterans Affairs

Memorandum

Date: June 24, 2015

From: Interim Under Secretary for Health (10N)

Subj: Office of Inspector General (OIG) Draft Report, Healthcare Inspection – Alleged Delayed Mental Health Treatment and Other Care Issues, Kansas City VA Medical Center (VAMC), Kansas City, Missouri (VAIQ 7556289)

To: Associate Director Office Of Healthcare Inspections (54D)

1. Thank you for the opportunity to review the revised draft report, *Healthcare Inspection – Alleged Delayed Mental Health Treatment and Other Care Issues, Kansas City VAMC, Kansas City, Missouri.* I understand and appreciate that OIG revised the report to ensure it adheres to Federal laws protecting the rights of Veterans.

2. I concur with the findings and recommendations in the revised draft report.

3. I ask that OIG replace my original memorandum and attachment dated December 12, 2014, with the current memorandum and revised action plan for recommendation 1.

4. I included the facility action plans in response to recommendations 2 through 4 for your reference.

5. If you have any questions, please contact Karen M. Rasmussen, MD, Director, Management Review Service (10AR) at VHA 1OARMRS2@va.gov.

(original signed by:)

Carolyn M. Clancy, M.D.

Comments to OIG's Report

The following Under Secretary for Health comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

VETERANS HEALTH ADMINISTRATION (VHA)

Action Plan

OIG Draft Report, Healthcare Inspection— Alleged Delayed Post Traumatic Stress Disorder Treatment and Other Care Issues, Kansas City VA Medical Center, Kansas City, Missouri

Date of Revised Draft Report: June 19, 2015

Recommendations/ Actions	Status	Completion Date

Recommendation 1: We recommended that the Interim Under Secretary for Health review relevant inpatient program occupancy rates and wait times system-wide and determine whether additional guidance to facilities is needed to help ensure that the number of patients served through those programs is optimized.

VHA Comments: Concur. VHA will conduct a review of relevant inpatient or residential program occupancy rates and wait times system-wide and determine whether additional guidance to facilities is needed. In fiscal year 2014, 86.9 percent of all episodes of care in the residential programs identified were Veterans diagnosed with the relevant disorder. As such, VHA will include all beds assigned to relevant residential programs in the analysis of occupancy and wait times to ensure that the number of Veterans served is optimized.

To complete this action, VHA will submit documentation of:

1. A summary of existing national policy or guidance related to access and wait times in the relevant residential programs.
2. A summary of the review of program occupancy rates and other identified metrics related to access and wait times for the program.
3. A determination on whether additional guidance to facilities is needed.

Target date for completion: December 2015.

Appendix B

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: June 22, 2015

From: Director, VA Heartland Network (10N15)

Subj: Healthcare Inspection—Alleged Delayed Post Traumatic Stress Disorder Treatment and Other Care Issues, Kansas City VAMC, Kansas City, Missouri

To: Assistant Inspector General for Healthcare Inspections (54)

1. Attached, please find the response to the Healthcare Inspection—Alleged Delayed Post Traumatic Stress Disorder Treatment and Other Care Issues, Kansas City VAMC, Kansas City, Missouri (Conducted the week of July 21, 2014). I understand and appreciate that the OIG revised the report to ensure that it adheres to federal laws protecting the rights of Veterans.

2. I have reviewed and concur with the Medical Center Director's response. Thank you for this opportunity to focus on continuous performance improvement.

3. For additional questions, please feel free to contact Mary O'Shea, VISN 15 Quality Management Officer at 816-701-3000 or Mary.Oshea@va.gov.

(original signed by:)

WILLIAM P. PATTERSON, MD, MSS

Network Director

VA Heartland Network (VISN 15)

Appendix C

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: June 22, 2015

From: Acting Medical Center Director, Kansas City VA Medical Center (589/00)

Subj: Draft report—Healthcare Inspection— Alleged Delayed Post Traumatic Stress Disorder Treatment and Other Care Issues, Kansas City VAMC, Kansas City, Missouri

To: Director, VA Heartland Network (10N15)

1. The draft report of the Inspector General's Healthcare Inspection of the Kansas City VA Medical Center has been reviewed. There were three (3) recommendations made to the Facility Director (Recommendations 2, 3 and 4).

2. I concur with the recommendations. One of the recommendations is completed and will be sustained. Actions are currently in process to address the remaining recommendations.

3. I appreciate the opportunity for this review as a continuing process to improve the care to our veterans.

4. Please refer questions to Dr. Rebecca Cahill, Chief, Performance and Patient Care Improvement, at (816) 861-922-2701.

(original signed by Michael Moore, PhD, Acting Associate Director for:)

Kevin Q. Inkley

Acting Medical Center Director

Comments to OIG's Report

The following comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 2. We recommended that the Facility Director ensure that processes be strengthened to ensure appropriate follow through on consults that are cancelled for administrative reasons.

Concur

Target date for completion: Completed and ongoing.

Facility response: Since the OIG visit we have strengthened our processes to ensure appropriate follow through on consults that are cancelled for administrative reasons by doing the following.

Our consult management committee has developed new standard operating procedures (SOP) and guidelines for staff including policy for Consult Management and Management of Clinic Appointments. Training was given to both clinical and administrative employees.

We have reviewed consult management clinic groups/groupers and trained clinic administrators to ensure the appropriate employees are receiving action notifications for consults to facilitate more active management of consults and more thorough review in this management. We have included consult closure review in our consult audit process to include areas with high consult cancellation rates.

We feel appropriate measures are in place through SOP, approval requirement, training, refinement and reduction of those with electronic access, and audit procedures to request closure of Recommendation 2.

Recommendation 3. We recommended that the Facility Director ensure that Emergency Department providers fully evaluate patients with abnormal findings and make those evaluations readily accessible to other providers.

Concur

Target date for completion: January 15, 2015.

Facility response: The Kansas City VA provided a detailed action plan to resolve the recommendation.

Recommendation 4. We recommended that the Facility Director ensure that patients are evaluated and referred for treatment for certain health concerns if exhibited by patients presenting to the Emergency Department, when appropriate.

Concur

Target date for completion: November 30, 2015.

Facility response: The Kansas City VA provided a detailed action plan to resolve the recommendation.

Appendix D

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Melanie Krause, PhD, RN, Team Leader Stephanie Hensel, RN, JD Michael Shepherd, MD

Appendix E

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