Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-05075-447

Healthcare Inspection

Patient Care Deficiencies and Mental Health Therapy Availability Overton Brooks VA Medical Center Shreveport, Louisiana

January 7, 2016

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted inspections in response to two complaints received from Senator Richard Burr, then-Ranking Member of the Senate Veterans' Affairs Committee, concerning patient care deficiencies and the availability of mental health (MH) therapy at the Overton Brooks VA Medical Center (VAMC) (facility) in Shreveport, LA.

We did not substantiate that patients did not have enough linen or that it was of insufficient or poor quality.

We substantiated the allegation that toiletries were provided by volunteer organizations and unit staff. Although the facility does not provide toiletries to patients, the facility's Voluntary Service took steps to ensure an adequate supply of items on all units for both male and female patients so that staff would have access to toiletries during evening, night, and weekend hours.

We did not substantiate that a general lack of concern exists among nurses and nurse aides for patients or that nursing assistants do not follow the nursing chain of command.

We did not substantiate that public service messages on television screens throughout the facility at elevators and in waiting rooms displayed heavily slanted political or inappropriate content.

We substantiated that a patient died on a telemetry unit while not being actively monitored as ordered at the time of his death. The VA Office of Inspector General Office of Investigations reviewed the events surrounding the patient's death, reviewed the findings from a facility-conducted Administrative Investigation Board, and found no evidence to support any criminal activity occurred in this matter. We also reviewed the findings and recommendations from the facility-conducted Administrative Investigation Board, discussed the status of the recommendations with facility leadership, and found that the facility has taken and continue to take steps to improve the safety and quality of telemetry care.

We did not substantiate that MH group therapy programs are being dismantled or decimated; however, we found that focus had shifted to a recovery-oriented paradigm emphasizing treatment planning, smaller groups, and greater provision of individual evidence-based therapies.

We did not substantiate that MH staff have had to maintain large support groups in order to keep veterans stable while waiting for individual treatment.

We did not substantiate that the facility is severely understaffed with MH therapists.

We substantiated an allegation received onsite that a portion of an estimated 1300 patients who received MH care were lost to follow-up. Media sources had described these patients as being on a secret wait list. We did not find evidence of a secret wait list. In early 2014, during the planning and implementation phases

of establishing 2 Behavioral Health Interdisciplinary Program teams, the facility identified roughly 400 patients receiving MH care who were lost to follow-up and reviewed each patients' electronic health record for MH care needs. When appropriate, patients were contacted to determine if MH services were still desired or needed and assigned to a team if indicated. During this process, the facility identified and reviewed 68 patients who were deceased. We also reviewed the patients and found that none of the patients' deaths were related to an absence of MH care.

We recommended that the Facility Director ensure patients are notified and re-assigned timely when their MH providers leave the facility.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with our recommendation and provided an acceptable action plan. (See Appendixes A and B, pages 17–19 for the Directors' comments.) We consider this recommendation closed.

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Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted inspections to assess the merit of allegations received from Senator Richard Burr, then-Ranking Member of the Senate Veterans' Affairs Committee, concerning patient care deficiencies and the availability of mental health (MH) therapy at the Overton Brooks VA Medical Center (VAMC) (facility) in Shreveport, LA.

Background

The facility is a 111-bed secondary care facility that is part of Veterans Integrated Service Network (VISN) 16 and provides a broad range of inpatient and outpatient healthcare services.

MH Services. The Veterans Health Administration (VHA) has defined the minimal clinical requirements for VHA MH Services at VA facilities.[1] This includes requirements for all veterans with post-traumatic stress disorder (PTSD)[2] to have access to evidence-based psychotherapy (EBP), including Cognitive Processing Therapy[3] or Prolonged Exposure Therapy.[4] VHA has further outlined the expectations and procedures for providing EBP.[5] This includes requirements for EBP to be provided timely to existing and new patients in MH who choose to receive these treatments using individual and group EBP sessions.

VHA has required all VA health care systems and medical centers to implement a MH outpatient team, or Behavioral Health Interdisciplinary Program (BHIP) team, to provide interdisciplinary care for an assigned panel[6] of patients.[7] The goals of BHIP teams are to provide continuous access to ongoing recovery-oriented, evidence-based MH care for new and existing patients consistent with

[1] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008. This VHA Handbook was scheduled for recertification on or before September 30, 2013 but has not yet been recertified.
[2] Post-traumatic stress disorder can occur after experiencing a traumatic event such as combat exposure, abuse, assault, etc. (www.ptsd.va.gov).
[3] Cognitive Processing Therapy can provide effective treatment for PTSD by providing education and skills related to how trauma changes the way a person looks at the world, himself/herself, and others (www.ptsd.va.gov).
[4] Prolonged Exposure Therapy can help a person suffering from PTSD to approach trauma-related thoughts, feelings, and situations that have been avoided due to the stress they cause by repeatedly exposing the person to them in order to reduce the power they have to cause distress (www.ptsd.va.gov).
[5] VHA Handbook 1160.05, *Local Implementation of Evidence-Based Psychotherapies for Mental and Behavioral Health Conditions*, October 5, 2012.
[6] A panel represents the number of active patients for whom a provider should deliver care.
[7] Deputy Under Secretary for Health for Operations and Management (10N) memorandum, "General Mental Health Staffing Model Team Development: Behavioral Health Interdisciplinary Program (BHIP) Team-Based Care," August 5, 2013.

VHA requirements. BHIP teams are also intended to manage and coordinate transitions between MH services so that patients do not become "lost in the system."[8]

Allegations. The OIG received two anonymous complaints through Senator Burr's office concerning patient care deficiencies and the availability of MH therapy. Specifically, the first complainant alleged that:

- Patients go without laundry and linens for several days while awaiting delivery. Often, laundry and linens are threadbare and have holes. Further, nurses hoard these items for their patients knowing the hospital will run out.
- Patients rely on volunteer organizations or facility staff to supply them with toiletries because the facility does not supply them.
- A general lack of concern exists among nurses and nurse aides for the patients and nursing assistants do not follow nursing chain of command.
- Patients do not receive personal hygiene when needed.
- Televisions at elevators and in waiting rooms display public service messages that are politically slanted.
- A patient died while on the telemetry[9] unit due to lack of care.

The second complainant alleged that:

- MH group therapy programs are being dismantled and decimated.
- MH staff have had to maintain large support groups in order to keep patients stable while waiting for individual treatment.
- The facility is severely understaffed with MH therapists.

During onsite interviews, we became aware that local media sources had reported on an allegation that the facility had identified a list of roughly 1,300 established patients in MH that had been lost to follow-up care. This patient list was characterized as a secret wait list (that is, a list of patients maintained outside VHA's official electronic scheduling system who are awaiting care). This report addresses this additional allegation given its potential impact on direct patient care.

[8] VA Central Office, Office of Mental Health Operations (10NC5), "Behavioral Health Interdisciplinary Program (BHIP) Team Based-Care," 2014 Association of VA Psychologist Leaders (AVAPL) presentation.
[9] Telemetry monitoring provides a continuous electrocardiogram of the heart's electrical activity through external electrodes placed on the patient's body. The electrodes transmit data to a remote surveillance device typically located at a centralized station. The real-time ability to monitor the heart using telemetry provides clinicians the opportunity to recognize the need for intervention; however, effective intervention is generally dependent upon telemetry staff recognizing potentially harmful heart activity and quickly notifying unit staff.

Scope and Methodology

We conducted site visits September 24–25, 2014, and November 18–20, 2014, and held a telephone conference with facility leadership on February 5, 2015. We interviewed facility leadership, Environmental Management Service (EMS) and MH Service leadership; inpatient and outpatient MH staff; nurse managers of all acute care units; and the Nurse on Duty. We also spoke with several patients and staff on each of the acute care units.

We reviewed individual patient electronic health records (EHRs), relevant facility documents, incident reports, and patient complaints from the Patient Representation Program for fiscal year (FY) 2014 through September 24, 2014. We also reviewed the VA OIG Office of Investigations report and the findings from the facility-conducted Administrative Investigation Board (AIB) related to the patient death on the telemetry unit.

In addition, we reviewed relevant VHA Support Service Center (VSSC) and VHA Office of Productivity, Efficiency & Staffing data regarding overall MH encounters,[10] MH group therapy and individual therapy encounters, clinic access, and MH provider productivity. We requested and reviewed facility documents pertaining to BHIP implementation and staffing, MH clinic staffing, and MH psychologist and social worker labor mapping for provision of therapy versus other clinical and/or administrative duties. We requested and reviewed facility documents and internal reviews related to the patients alleged to have been lost to MH follow-up care.

We conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

[10] An encounter is a professional contact between a patient and a practitioner with responsibility for diagnosing, evaluating, and/or treating the patient's condition.

Inspection Results

Issue 1: Quality and Provision of Patient Supplies and Nursing Care Deficiencies

Linen Quality

We did not substantiate that there was not enough linen for patients or that it was of insufficient or poor quality.

We found each unit stocked with linens including pajamas, sheets, towels, and blankets that were clean and without holes or damage. The staff interviewed reported there had previously been problems getting enough linen; however, staff had not recently encountered these problems. During our interviews, staff reported that the facility uses the Alexandria VA Health Care System for laundry services. The facility's EMS delivers the linen to each unit daily, including weekends and holidays. Leadership stated that the facility had responded to a Watchdog.org report about the quantity and quality of facility linens. Four months prior to our site visit in September 2014, a facility review of resources had identified a problem with the linen quantity and quality. Since then, the new Chief of EMS reported that new pajamas have been purchased, an EMS staff member works on the weekends to re-stock the units, and an employee with a logistics background has been hired to manage linen processes. The facility does not have available resources to wash laundry onsite, and leadership reported the use of the Alexandria VA Health Care System linen services is cost effective when compared to alternative local resources.

Provision of Toiletries[11]

We substantiated the allegation that toiletries were provided by volunteer organizations and unit staff.

VHA does not provide personal care items (such as toiletries) to inpatients. During our onsite inspections of the units, staff interviewees reported that supplies were provided by volunteer organizations and were delivered Monday–Friday. When asked about availability of these supplies for after-hour or weekend admissions, we were shown limited toiletries stored on each of the units. Some staff reported purchasing toiletries for patients. While onsite, the Deputy Director of Patient Care Services spoke with Voluntary Service regarding the possibility of providing each unit with a limited stock of toiletries for patients admitted afterhours or on weekends. Voluntary Service agreed to provide each unit with a set stock level of combs, toothbrushes, toothpaste, razors, shampoo/body wash, lip balm, deodorant, denture adhesive and cleaning tablets, lotion, and shaving cream for after-hour and weekend admissions. After our initial site visit, we were notified that voluntary services purchased multiple cases of each of the toiletries to stock on each unit, that each unit had available items stocked, and that logistics would maintain each unit stock.

[11] A toiletry is any article or preparation used in personal cleaning or grooming such as soap, deodorant, toothbrush, toothpaste or a comb.

Nursing Attentiveness

We did not substantiate that there is a general lack of concern among nurses and nursing assistants for patients, that the nursing chain of command was not followed, or that patients did not receive personal hygiene assistance when needed.

We saw patients on each of the units wearing clean pajamas, with clean bed linens. When asked by inspectors, patients did not report complaints about nursing staff or availability of linens or toiletries.

When interviewed, nurse managers stated the unit standard was to check on patients at least hourly, and as needed. They did report that although occasional issues with nursing staff did occur, these issues were addressed as they arose using the chain of command. Nurse Managers reported they were not aware of complaints from patients needing assistance with personal hygiene or complaints that staff refused to help these patients. We saw staff actively interacting with patients on all units during our rounds. We spoke to staff and patients on all acute inpatient units and did not find any unkempt patients or smell foul odors in rooms or in hallways on the units.

We found 3,002 entries in the Patient Representative Program for FY 2014 through September 24, 2014. Of these, 24 were listed under the categories of "negligence/malpractice or hygiene, diet, feeding, or ambulation concerns." Six of these 24 were related to inpatient care. Of the six, three patient complaints came from the MH unit; one patient wanted hotter water, one complained of a shortage of pajamas in April 2014, and the other wanted special soap and deodorant. Two of the other three complaints were about food quality, and the remaining complaint was about the shower not being clean and the patient wanting ice. None of the complaints pertained to patient abuse or hygienic neglect, and some issues listed included compliments.

All of the 24 entries had appropriate responses documented and represented less than one percent of the total number of entries. Therefore, we did not find an indication of a systemic problem concerning care provided by nursing staff to patients.

Political Messages

We did not substantiate that public service messages on television screens throughout the facility at elevators and in waiting rooms were heavily slanted in any way.

During our site visits on September 24–25, 2014, and November 18–20, 2014, we observed television screens on various floors throughout the facility displaying public service messages. We found that the messages were health-related (for example, "time to get your flu shot"), and we were told by the leadership that the public relations department changes the messages weekly. We did not see any messages that appeared inappropriate during either of our site visits.

Death of a Patient on Telemetry

We substantiated that a patient died while on the telemetry unit.

The VA OIG Office of Investigations reviewed the events surrounding the patient's death, reviewed the findings from a facility-conducted AIB, and found no evidence to support any criminal activity occurred in this matter. The facility documented providing an institutional disclosure to the family because, although the patient was on a telemetry unit, the patient was not being actively monitored at the time of death. We also reviewed the findings and recommendations from the facility-conducted AIB and discussed the status of implementing the AIB's recommendations with facility leadership on February 5, 2015. Facility leadership delineated steps the facility has taken and continues to take to improve patient safety and quality of telemetry care, including:

- Reducing the number of units that provide telemetry monitoring from four units to two adjacent units.

- Reinforcing the expectation that nursing and telemetry staff respond immediately to any patient who appeared to be "off telemetry" (that is, not being monitored because telemetry equipment is no longer connected to the patient).

- Educating telemetry staff to contact the Nurse on Duty if unit staff do not respond within 5 minutes to a patient's apparent need.

- Providing dedicated cellular telephones to the units for timely communication between unit and telemetry staff.

- Providing telemetry monitors on the two telemetry units so that staff are able to observe patients' heart rhythms in real-time on the unit.

- Obligating funds needed for the purchase of new telemetry monitoring equipment.

Issue 2: Availability of MH Therapy

Dismantling of MH Group Therapy

We did not substantiate that MH group therapy programs are being dismantled or decimated.

MH leadership and direct care staff described several historical issues surrounding group therapy including the provision and chronic utilization of support groups versus evidence-based therapy groups, maintenance of therapy groups in excess of recommended group sizes, utilization of supportive group therapy for prolonged periods (in excess of 15 years) with unclear patient benefit, and misuse of the travel pay benefit.

Prior to our November 2014 site visit, the facility had conducted an internal fact-finding review for The Joint Commission in October 2014 in response to the same allegations received by Senator's Burr's office.

The facility's internal review detailed the events, which were thought to have possibly prompted some patients' perceptions that access to MH group therapy was being

reduced. The review documented conclusions made by the facility's Mental Health Quality Committee that had resulted in specific recommendations for changes to the structure, planning, objectives, and delivery of group therapy sessions in order to be in compliance with VHA requirements for the provision of EBP, including but not limited to:

- Limiting the size of group therapy sessions to 12 patients.
- Establishing mandatory admission and discharge plans for all recovery-oriented programs.
- Completing assessments and treatment plans on every patient at least every 90 days.
- Requiring a diagnosis of PTSD in order to attend PTSD-oriented group therapy sessions.
- Establishing and implementing group therapy guidelines.

These recommendations and their implementation reflected the facility's attempt to paradigmatically shift away from provision of some MH supportive therapy groups that were large, open-ended (in some cases patients had been attending specific groups for more than a decade), but had unclear group processes and treatment planning and ill-defined monitoring of patient goal and objective attainment. The facility was attempting to shift to provision of MH therapy groups emphasizing recovery-oriented programming; smaller group size; more defined group processes; evidence-based therapeutic principles; and active, ongoing treatment planning, with focus on objective attainment.

VSSC encounter data for FYs 2013 and 2014 reflect the actions implemented by MH leadership. We found that:

- Across all MH clinics, the overall number of unique patients seen and clinic encounters utilized increased (1.2 and 0.1 percent, respectively).
- For MH group therapy clinics, the number of unique patients and clinic encounters decreased (14.5 and 7.5 percent, respectively); however, the facility did continue to provide group therapies across MH clinics, and the number of encounters per unique outpatient increased overall by 8.1 percent.
- For MH individual therapy clinics, the number of unique patients and clinic encounters increased (4.4 and 4.9 percent, respectively). Overall, the number of MH individual therapy encounters per unique outpatient increased by 0.5 percent.
- For MH PTSD group therapy clinics, the number of unique patients and clinic encounters increased (6.2 and 5.1 percent, respectively).
- For MH PTSD individual therapy clinics, the number of unique patients and clinic encounters increased (16.7 and 61.5 percent, respectively).

Facility leadership asserted that the actions planned by MH leadership in response to the facility Mental Health Quality Committee's recommendations were prematurely shared with patients and presented in an inappropriately biased manner resulting in the perception among some patients that access to MH group therapy would be significantly reduced.

Although the facility was in the process of changing the structure and focus of its group therapy programming, the facility did not appear to have dismantled or decimated MH group therapy.

MH leadership maintained that for patients declining EBP and for those who have completed a course of EBP, ongoing support group alternatives and individual therapy options are available if both patient and provider believe the treatment would be beneficial and the provider considers the treatment clinically appropriate.

Tensions surrounding disparate views regarding the appropriate role, if any, of open-ended MH support groups within the continuum of general and PTSD related MH services during and after transition to recovery focused, evidence-based, programming and treatment planning is an issue we have encountered at various VAMCs in recent years. VHA resources or guidance to facilities on best practices for managing the transition process, potential conflicts, lessons learned from early adopters, and the role and nature of chronic supportive therapy groups post-transition (for example, policies, group process standards, treatment alternatives, group purpose, the role of supportive groups in achieving individual treatment plan objectives) are not clearly defined.

Large MH Support Group Size and Limited Access to Individual Therapy

We did not substantiate that MH staff have had to maintain large support groups in order to keep patients stable while waiting for individual treatment.

The complainant(s) alleged that patients with PTSD have been kept in non-EBT group therapy for years while waiting to receive one-on-one psychotherapy. From VSSC encounter data, we identified the universe of unique patients who had an encounter in a facility PTSD Clinic Team (PCT) individual therapy clinic during FY 2014. We selected and reviewed the EHRs of 32 of these patients (representing a 10 percent sample) who had an encounter with a clinical or counseling psychologist. We reviewed the EHRs to determine whether patients had been maintained in therapy groups for a prolonged duration prior to receiving individual therapy in a PCT clinic.

From the 32 patient EHRs reviewed:

- Five patients had only one encounter in the PCT individual therapy clinic stop code.[12] Documentation indicated these encounters did not involve an individual

[12] Stop codes, or Decision Support System identifiers, define workload associated with outpatient department structures.

therapy session (for example, one patient was experiencing active psychosis and was not felt to be a good therapy candidate at that time).

- Fourteen patient EHRs documented that patients had PCT individual therapy encounters in the absence of PTSD group therapy encounters.

- EHR documentation indicated that 10 patients had received individual psychotherapy in PCT clinic prior to or concurrent with group therapy.

- One patient was in group therapy prior to receiving individual therapy. The interval between the first group therapy session and the first session of individual therapy in PCT clinic was 6 days.

- One patient with a provisional PTSD diagnosis attended PCT group sessions without an indication for individual therapy.

- One patient began group therapy in 2006 and subsequently began receiving individual psychotherapy 8 months later in 2007.

MH Therapist Staffing

We did not substantiate that the facility is severely understaffed with MH therapists.

In August 2013, VHA committed to developing an outpatient MH-staffing model to ensure consistency for general outpatient MH staffing. In addition to staffing ratios per panel of patients, the BHIP model intended to incorporate a team-based treatment approach. VHA requires each health care system/medical center to implement at least one BHIP general MH outpatient team. Each BHIP team is to be responsible for the MH care of 1,000 patients and is to have 5.1–5.5 licensed independent provider (LIP) full time employee equivalents (FTE), 1 non-LIP FTE, and 0.5–1 FTE administrative clerical support.

VHA specifies LIPs always include psychiatrists, licensed clinical social workers, and advanced practice nurses and may include other professionals who practice autonomously including physician assistants, clinical nurse specialists, licensed marriage and family therapists, licensed professional MH counselors, and certain Doctors of Pharmacy (PharmDs) with residency and board certification in psychiatric pharmacy. Non-LIPs refer to registered nurses, addiction therapists, and peer specialist staff.

The following table displays the FTE composition and vacancies for each for the facility's two BHIP teams and for the PTSD clinic at the time of our site visit.

Table 1. Facility Staffing for BHIP and PTSD MH Clinics

Position Title	BHIP 1	BHIP 2	PTSD Clinic
	FTE		
Psychiatrist	0.5 Fee Basis	0.5	2.2
	0.2 Vacant	0.4	0.1 Fee Basis
Mid-level Provider (Nurse Practitioner)	1.0	0.4	1.0
		1.0 Vacant	
Psychologist	3.0	3.0	3.0
			1.0 Vacant
Neuropsychologist	1.0	1.0	—
Social Worker	1.0	2.0	1.0
Readjustment Counselor	—	—	1.0
Registered Nurse	2.0	1.0	1.0
Psychology Tech	1.0	1.0	—
Medical Support Assistant	1.0	1.0	1.0
Total LIP	6.5	7.3	8.3
Total Non-LIP	3.0	2.0	1.0
Total Admin Support	1.0	1.0	1.0

Source: OIG Analysis of Facility Data

As seen from Table 1, LIP, non-LIP, and administrative support staffing fall within the recommended staffing for the BHIP model. Although the PTSD clinic is not a general MH clinic, staffing for this clinic is also consistent with recommended BHIP staffing levels.

We reviewed the allocation of time between provision of therapy to patients, case management, and administrative duties for the psychologists and social workers for the BHIP teams and PTSD clinic.

Table 2. Allocation of Provider Time for BHIP and PTSD Clinic Therapist Providers[13]

Allocation of Provider FTE	BHIP 1		BHIP 2		PTSD Clinic	
	Therapy	Admin	Therapy	Admin	Therapy	Admin
Psychologists	3.6*	0.4	3.1*	0.9	3.45	0.2 Routine 0.25 MST Coordinator
Social Workers	0.9	0.1	0.75	1.0 Case Manager 0.25 EBP Coordinator	0.9	0.1
Licensed Professional Counselor	—	—	—	—	0.9	0.1

Source: OIG Analysis of Facility Data. *Reflects the total number reported at the time of our site visit.

Table 2 indicates most of the non-psychiatrist (psychologist, social worker, licensed professional counselor) LIP time is allocated to provision of therapy for these clinics.

A facility may employ LIP staff, and staff time may be largely allocated toward provision of direct patient care; however, if providers are not productive during the time allocated to direct patient care, access to services (for example, therapy) can be constrained. Therefore, we looked at the work relative value units (wRVU)[14] for facility psychologists and social workers using data from VSSC and internal facility data.

Specialty Productivity Access Report and Quadrant Tool data[15] from VHA's Office of Productivity, Efficiency & Staffing for FY 2015 through December 13, 2014, indicates psychiatry productivity at the facility is 0.31 standard deviations below the mean compared to other VHA Complexity Level 1c facilities.[16] Psychology productivity, which is more relevant to provision of psychotherapy, was 1.95 standard deviations above the mean compared to other VHA Complexity Level 1c facilities.

[13] For the neuropsychologists on BHIPs 1 and 2, allocation of clinical duties between provision of therapy and neuropsychology testing/evaluation can vary over time depending on clinic patient needs. Based on productivity data, the BHIP 1 neuropsychologist was allocated as 0.5 clinical and 0.5 administrative for purpose of this analysis.
[14] The Centers for Medicare and Medicaid Services RVU is a measure of the complexity and time required to perform a professional service. Several private sector healthcare entities use RVUs to determine reimbursement for services. In addition, many entities use RVUs to measure workload. Total RVUs consist of three components: work performed, practice expense, and malpractice expense. For measuring productivity, only the work component (wRVU) is used.
[15] VHA Office of Productivity, Efficiency & Staffing Specialty Productivity – Access Report and Quadrant Tool, http://opes.vssc.med.va.gov/Pages/Default.aspx, accessed January 29, 2015.
[16] VHA defines Complexity Level 1c facilities as those with large levels of volume, patient risk, teaching, and research, and four intensive care units.

VHA directive 116, *Productivity and Staffing in Outpatient Clinical Encounters for Mental Health Providers*, provides policy on outpatient provider productivity based on outpatient clinical encounters for psychiatrists, psychologists, as well as for advanced practice nurses, social workers, and physician assistants who work in MH settings.[17] The directive indicates that psychologists should strive for a yearly productivity target above 1,926 wRVU per outpatient core FTE [FTE (C)],[18] and productivity within 1,733–2,119 (+/-10%) is considered as meeting the standard "taking care not to compromise quality and patient access standards." The target for social workers is a yearly productivity target above 1,194 wRVU per outpatient FTE (C), and productivity within 1,075–1,313 is considered meeting the standard.

We reviewed internal facility wRVU per FTE (C) productivity data for BHIP and PTSD psychology and social work providers, VISN providers, and the VHA directive targets. The facility uses 1,671 wRVU per FTE (C) as the target for psychologists and 939 wRVU per FTE (C) as the target for social workers and 1,500 as the target for readjustment counselors based on VISN 16 averages.

Table 3. Annualized BHIP Team and PTSD Clinic Therapy Provider Productivity for FY 2014[19]

Productivity	Target (VHA)	Target (VISN)	Facility Actual
BHIP 1	7,154	6,116	9,461
BHIP 2	7,537	5,632	8,373
PTSD Clinic	5,671‡	5,097†	7,991

Source: OIG Analysis of Facility Data

On aggregate, BHIP and PTSD clinic psychologists and social workers who provide therapy appear to have met VISN and VHA wRVU productivity targets.

We conferred with the facility's Chief of Mental Health Services regarding the productivity data. He reported that during 2014, productivity data would have included the longstanding impact on wRVUs of having large 40 person therapy groups that met three times weekly each week. Additionally, during our on-site visit, the Chief of Mental Health Services had reported that after joining the facility from the private sector, he had determined that for these large therapy groups, the clinic profiles had been set up as if either of two MH providers were conducting the group. As a result, the wRVU for these groups were captured in the workload for both providers, essentially double counting the

[17] VHA Directive 1161, *Productivity and Staffing in Outpatient Clinical Encounters for Mental Health Providers*, June 7, 2013.
[18] Core FTE is FTE allocated to provision of direct patient care. If for example, 40 percent of a 1.0 FTE provider's time is allocated to administrative duties and 30 percent to research duties, then the provider would be 0.3 FTE (C).
[19] The 11-month actual data was annualized to reflect a 12-month period. †=Data for a provider who has left the facility was not included. ‡=VISN target used for inclusion of readjustment counselor in calculation of the VHA target.

wRVU for these groups. In addition to the changes in provision of group therapies discussed earlier in this report, the Chief of Mental Health Services subsequently had the profiles updated to eliminate the double counting.

Productivity data for the first two quarters of FY 2015 indicates above target productivity for psychologists and therapists even in the absence of the large, three times weekly groups and the associated workload double counting for these groups. Productivity is wRVU/FTE allocated to direct patient care. The Chief of Mental Health Services attributed part of the high productivity to facility MH providers being, in fact, fairly productive in addition to the circumstance that some MH providers, in practice perform more of their time in clinical activities than is allocated in their labor mapping. For example, a provider may have a small number of encounters in a month, but if the allocated time is 10 percent clinical and 90 percent administrative, the productivity (wRVU/FTE) allocated to direct patient care will be high. In a few circumstances, MH providers are picking up workload due to vacancies that are being recruited for; however, in the context of facility MH vacancy data, in the assessment of the Chief of Mental Health Services, the high productivity is not a product of significant understaffing.

We reviewed the current facility MH vacancies as of April 12, 2015 and found two registered nurses, two licensed practical nurses, and one nursing assistant vacancies, and no therapist vacancies for the inpatient unit. BHIP 1 team had a 0.2 psychiatrist vacancy. BHIP 2 team had no vacancies. The PTSD Program had two psychologist vacancies and a 0.4 psychiatrist vacancy. Throughout the other MH programs, the facility reported five social worker, a registered nurse, a readjustment counselor, an addiction therapist, two mid-level provider, and a MH compensation and pension psychologist vacancies.

The vacancy data in itself does not seem to support significant therapist understaffing or that the observed higher productivity is a result of severe understaffing.

Overall, this analysis of clinic staffing, allocation of FTE time between direct care and non-direct care, productivity, and vacancy data in conjunction with the mental health and PTSD clinic encounter data reviewed in issue 1, does not reflect severe understaffing of outpatient general MH and PTSD clinic therapists at the facility.

Issue 3: MH Patients Lost to Follow-Up and Continuity of Care

We substantiated that the facility had identified patients receiving MH care who were lost to follow-up. However, we did not substantiate that these patients had been placed on a secret wait list.

In early 2014, in order to plan and implement establishment of BHIP teams, MH and facility staff initially generated a Decision Support System report request to ascertain all patients who had been seen in MH in the prior 15 months to review. Patients were then to be assigned to one of the two BHIP teams. When possible, patients who were already assigned to a specific provider were assigned to the BHIP team that would

enable them to retain that same provider. Patients without a previously assigned provider were to be assigned to one of the two BHIP teams and a provider attached to that BHIP team.

During the BHIP development process, the facility found several patients who did not have providers actively assigned to them at that time because the patients' previous providers had retired, resigned, or left after temporary assignment (for example, locum tenens[20]). During the following months, these patients' EHRs were reviewed and, when appropriate, patients were contacted to determine if MH services were still desired/needed. During the review implementation process, the facility identified roughly 400 patients who had been lost to MH follow-up care. The facility identified 68 of these patients who had died. A facility psychiatrist reviewed all 68 EHRs and found none of the deaths to be related to an absence of MH care.

Additionally, we reviewed the 68 patients identified by the facility as being deceased at the time patients were assigned to BHIP teams. We found that 31 (46 percent) died while receiving end of life care; 24 (36 percent) died with serious medical conditions (non-mental health) contributing to or causing their death; 9 (13 percent) were receiving ongoing MH care with no indication that it related to their death; 1 died with multiple medical problems being managed by primary care, and was not on psychiatric medications, but was seeing a neuropsychologist on a periodic basis; 1 patient died of a heart attack believed to be related to sepsis; 1 patient died in an automobile accident; and 1 patient was murdered in his home. We found no lapse of mental health care access for any of the 68 patients prior to their death.

As part of the BHIP assignment and implementation process, the facility identified patients who had been lost to MH follow-up care. However, we did not substantiate that the patient list/report used to set up the BHIP teams represented a secret wait list.

We recommended that the Facility Director ensure patients are notified and re-assigned timely when their MH providers leave the facility.

Conclusions

We did not substantiate that patients did not have enough linen or that it was of insufficient or poor quality. We found linen available on all units in sufficient quality and quantity. The staff interviewed reported there had previously been problems getting enough linen; however, staff had not recently encountered these problems since changes were made by EMS.

Although the facility does not provide toiletries to patients, the facility's Voluntary Service took steps, as requested by facility leadership, to ensure an adequate supply of items on all units for both male and female patients during day, evening, night, and weekend hours.

[20] Locum tenens physicians may be used to provide health care services due to temporary staffing shortages.

We interviewed nurse managers, staff, and patients on all inpatient acute care units and did not find a general lack of concern among nurses and nursing assistants for patients, that the chain of nursing command was not followed, or that patients did not receive personal hygiene assistance when needed. In addition, we did not find any complaints reported in the patient advocate package regarding availability of linen, toiletries, or failure of nursing staff to provide assistance when needed.

We did not observe any inappropriate or overtly biased messages on public television screens throughout the facility at elevators and in waiting rooms during either of our site visits.

We found that a patient died while on a facility telemetry unit without telemetry monitoring in place as ordered. The VA OIG Office of Investigations reviewed the events surrounding the patient's death, reviewed the findings from a facility-conducted AIB, and found no evidence to support any criminal activity occurred in this matter. The facility documented providing an institutional disclosure to the family because, although the patient was on a telemetry unit, the patient was not being actively monitored at the time of death. We also reviewed the findings and recommendations from the facility-conducted AIB, discussed the status of the AIB's recommendations with facility leadership, and found that the facility had taken and continues to take steps to improve the safety and quality of telemetry care.

During our second site visit, we did not find that MH group therapy was being dismantled or decimated. The focus had shifted to a recovery-oriented paradigm emphasizing treatment planning, smaller groups, and greater provision of individual evidence-based therapies. We are not aware of VHA resources or guidance to facilities on best practices for managing the tensions that arise during transition from long-standing supportive therapy groups to recovery oriented, EBP groups and the role and nature, if any, of chronic supportive therapy groups post-transition.

We did not substantiate that patients did not have access to individual therapy for general MH issues or PTSD. We reviewed the EHRs of selected patients who had an encounter with a clinical or counseling psychologist in a facility PCT individual therapy clinic during FY 2014 and did not find patients who had been maintained in therapy groups for a prolonged duration prior to receiving individual therapy in a PCT clinic.

We did not substantiate that the facility is severely understaffed with MH therapists. We reviewed internal facility wRVU/FTE (C) productivity data for BHIP and PTSD psychology and social work providers, VISN providers, and the VHA directive targets. Our analysis of clinic staffing, allocation of FTE time between direct care and non-direct care, and productivity did not reflect severe understaffing of outpatient general MH and PTSD clinic therapists at the facility.

Additionally, we found that in early 2014, during the BHIP planning, development and implementation process, as part of the BHIP assignment process, a report had been generated of patients seen in MH in the prior 15-month period. We did not find evidence that this report/list constituted a secret wait list. During the process, the facility

had identified roughly 400 patients who had received MH care and were not receiving follow-up care at that time. Although the facility identified 68 of these patients who had died, a review of all 68 patients by both the OHI and facility clinicians, including psychiatrists did not find the deaths related to an absence of MH care.

Recommendation

1. We recommended that the Facility Director ensure patients are notified and re-assigned timely when their mental health providers leave the facility.

Appendix A

VISN Interim Director Comments

Department of Veterans Affairs

Memorandum

Date: May 29, 2015

From: Interim Director, South Central VA Health Care Network (10N16)

Subject: **Healthcare Inspection – Patient Care Deficiencies and Mental Health Therapy Availability, Overton Brooks VA Medical Center, Shreveport, Louisiana**

To: Director, Dallas Office of Healthcare Inspections (54DA)

Director, Management Review Service (VHA 10AR MRS OIG Hotline)

1. The South Central VA Health Care Network (VISN 16) has reviewed and concur with the findings and recommendation included in the draft report submitted by the Overton Brooks VA Medical Center, Shreveport, LA.

2. If you have any questions regarding the information submitted, please contact Reba T. Moore, VISN16 Accreditation Specialist at (601) 206-7022.

Susan Easter

Susan Easter, VISN 16 QMO
For and in absence of
Fernando Rivera, FACHE
Interim Network Director
South Central VA Health Care Network

Appendix B

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: May 28, 2015

From: Director, Overton Brooks VA Medical Center, Shreveport, LA (667)

Subject: **Healthcare Inspection – Patient Care Deficiencies and Mental Health Therapy Availability, Overton Brooks VA Medical Center, Shreveport, Louisiana**

To: Director, South Central VA Health Care Network (10N16)

1. This is Overton Brooks VA Medical Center's response to the draft report of the Office of Inspector General conducted on September 24-25, 2014 and November 18-20, 2014.

2. If you have any questions, regarding the information provided. Please contact Myrtle Tate, Team Leader, Quality, Safety & Value at (318) 990-5905.

Toby T. Matthew

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendation in the OIG report:

OIG Recommendation

Recommendation 1. We recommended that the Facility Director ensure patients are notified and re-assigned timely when their mental health providers leave the facility.

Concur

Target date for completion: Completed

Facility response: The processes now in place ensures that Veterans are notified of Mental Health follow-ups with the implementation of Behavioral Health Interdisciplinary Program (BHIP) teams. This process ensures that patients are properly managed when Mental Health providers leave the facility.

Since October 2014, 3 providers have left the facility. The table below shows the number of Veterans reassigned among the 4 other providers.

Departing Providers	Number of unique Veterans assigned to departing providers	Number of unique Veterans referred to another BHIP provider.
Provider 1 (.4 FTEE)*	264	264
Provider 2 (.1 FTEE)*	70	70
Provider 3 (.1 FTEE)*	16	16

*Full Time Equivalent Employee

Appendix C

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Cathleen King, MHA, CRRN, Team Leader Larry Ross, MS Michael Shepherd, MD Roneisha Charles, BS, Program Analyst

Appendix D

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