Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-04435-265

Healthcare Inspection

Mental Health Service Concerns at the Knoxville VA Outpatient Clinic James H. Quillen VA Medical Center Mountain Home, Tennessee

June 7, 2016

Washington, DC 20420

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 privacy and confidentiality laws and regulations protecting veteran health or other private information in this report.

To Report Suspected Wrongdoing in VA Programs and Operations:
Telephone: 1-800-488-8244
E-Mail: vaoighotline@va.gov
Web site: www.va.gov/oig

Executive Summary

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection at the request of Senator Lamar Alexander, Senator Bob Corker, and Congressman John Duncan to assess allegations of mental health (MH) service concerns at the Knoxville VA Outpatient Clinic (Clinic), Knoxville, TN, which is part of the James H. Quillen VA Medical Center (facility), Mountain Home, TN. The specific allegations were:

- The facility failed to allow the Clinic to provide Peer Support Services (PSS).
  - The facility delayed hiring a full time PSS Specialist as required by Veterans Health Administration (VHA) policy.
  - The PSS Specialist position description included the provision of PSS related functions for groups hosted by the Council, and the hired PSS Specialist has not provided this function.
  - Patients were attending a non-evidence based Post Traumatic Stress Disorder (PTSD) group at the Clinic and were discharged without follow-up with PSS.
- The facility does not provide required Veterans Justice Outreach (VJO) services to incarcerated veterans.
  - The facility delayed hiring a VJO Specialist to service veterans in Knox County and surrounding counties.
  - It takes 3–5 days for confirmation of prescribed medications by the Clinic for veterans incarcerated at the Knox County Sheriff's Detention Facility (Detention Facility).
- The facility and Clinic managers violated agreements about meeting space, travel pay, and PSS facilitator training for members of the Council.

We substantiated the allegation that facility managers did not have PSS available to veterans at the Clinic for several years. We determined that facility managers failed to provide PSS between September 2008 and June 2013. The facility managers hired a full-time PSS Specialist for the Clinic in June 2013.

We did not substantiate the allegation that the PSS Specialist hired by the Clinic was expected to provide PSS related functions for groups hosted by the Knoxville Regional Mental Health Council (Council). The position description at issue did not include such an expectation.

We substantiated that patients were discharged from a non-evidence based PTSD, VA-provider led group without immediate PSS follow-up. The group was discontinued around September 2012, and PSS were not available at the Clinic until

September 2013. Although PSS were not immediately available, individual psychotherapy sessions with Clinic providers were offered to group members.

We substantiated the allegation that facility managers delayed hiring a VJO Specialist to service veterans in Knox County and surrounding counties. Although VHA policy mandated that VHA facilities designate a VJO Specialist to provide outreach to justice-involved veterans in the communities they serve beginning in 2009, facility managers told us that a VJO Specialist who could provide comprehensive VJO services was not hired until late August 2014. During the spring of 2013, facility managers requested VHA funding to hire a dedicated VJO Specialist for the Clinic. VHA funding was approved in December 2013, and the VJO Specialist position was announced in January 2014. For varying reasons, the position was not initially successfully filled and was announced three times prior to hiring a full-time VJO Specialist in late August 2014.

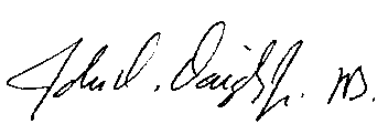
We did not substantiate the allegation that medication confirmation requests take 3–5 days for incarcerated veterans. We reviewed all 46 medication confirmation requests dated between June 3, 2014, and December 8, 2014, from non-VHA providers at the Knox County Sheriff's Detention Facility. We found that 45 requests were completed on the same day, and 1 was completed the following day. Also, Knox County Sheriff's Detention Facility staff affirmed that most requests are completed the same day.

We did not substantiate the allegation that facility and Clinic managers failed to uphold agreements with the Council regarding (1) providing meeting space for the group hosted by the Council, (2) sponsoring PSS facilitator training for members of the Council, and (3) providing travel pay for Council group members. Council members and facility and Clinic managers indicated that these agreements were verbal and had not been formalized.

We recommended that the Facility Director improve processes for communicating with community-based consumer-run groups that provide MH services to veterans enrolled at the Clinic. We also recommended the Facility Director ensure the Clinic's VJO Specialist provides comprehensive services including outreach for veterans in Knox County and surrounding counties in accordance with VHA policy.

Comments

The Veterans Integrated Service Network and Facility Director concurred with our recommendations and provided an acceptable action plan. (See Appendixes A and B, pages 8–10 for the Directors' comments.) We will follow up on the planned actions until they are completed.



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

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection at the request of Senator Lamar Alexander, Senator Bob Corker, and Congressman John Duncan to assess allegations of mental health (MH) service concerns at the Knoxville VA Outpatient Clinic (Clinic), Knoxville, TN, which is part of the James H. Quillen VA Medical Center (facility), Mountain Home, TN.

Background

The facility is a tertiary care facility offering primary care, inpatient care, domiciliary care, nursing home care, home health care, and outpatient specialty care. The facility includes a VA-staffed outpatient clinic in Knoxville, six VA-staffed community based outpatient clinics, and three rural outreach clinics. The facility, which serves approximately 54,000 veterans, is part of Veterans Integrated Service Network (VISN) 9.

Clinic. The Clinic provides health care services to over 15,000 veterans. Services provided include primary care, MH, radiology, laboratory, and clinical pharmacy consultative services.

Knoxville Regional Mental Health Council. The Knoxville Regional Mental Health Council (Council) was established in 2012 as a non-profit veteran advocacy group and is not a part of the Veterans Health Administration (VHA). The Council's mission is to be a "bridge" between veterans receiving MH services and their families, as well as between VA MH professionals and community support or Veterans Service Organizations. The Council's goal is to facilitate coordination among community MH services and provide a forum for addressing barriers or concerns veterans may have regarding their MH care.[1]

A VA provider had led a non-evidence based Post Traumatic Stress Disorder (PTSD) group at the Clinic for many years. The group included members who belonged to the Council. Around September 2012, the group at the Clinic was discontinued. With the Council's support, the group continued to meet at a non-VA facility. The VA provider initially attended the meetings at the non-VA facility to help with transitioning to a self-support group.

Peer Support Services. Peer Support Services (PSS) in VA are designed to offer hope for recovery and offer role models for successful management of mental illness. A PSS Specialist[2] helps veterans with the development of skills to manage their recovery, improve quality of life, support personal goals, and achieve independence. Since

[1] http://tnvhc.org/ site accessed on August 8, 2014.
[2] VHA policy refers to this position as a Peer Support Technician; however, the facility refers to this position as a Peer Support Specialist. Therefore, for this report, the term Specialist is used instead of Technician.
VHA Handbook 1163.05, *Psychosocial Rehabilitation and Recovery Services Peer Support*, July 1, 2011.

September 2008, VHA policy has required that all medical centers and very large community-based outpatient clinics provide individual or group counseling from PSS Specialists for seriously mentally ill[3] veterans when this service is recommended by the veteran's treatment plan.[4] According to a VHA policy issued in 2011, all veterans pursuing recovery from mental illness or substance use disorders will have access to PSS.[5]

Veterans Justice Outreach Program. In mid-2009, the Deputy Under Secretary for Health for Operations and Management issued a memorandum mandating that VHA facilities designate Veterans Justice Outreach (VJO) Specialists to provide outreach to justice-involved veterans in the communities they serve.[6] The purpose of the VJO Program is to avoid the unnecessary criminalization of mental illness and extended incarceration among veterans by ensuring that eligible justice-involved veterans have timely access to VHA services as clinically indicated. VJO Specialists are responsible for direct outreach, assessment, and case management for veterans in local courts and jails and act as liaisons with local justice system partners.

Allegations

On June 13, 2014, the OIG received allegations regarding MH service concerns at the Clinic. We subsequently interviewed the complainants who clarified the allegations as follows:

- The facility failed to allow the Clinic to provide PSS.
    - The facility delayed hiring a full time PSS Specialist as required by VHA policy.
    - The PSS Specialist position description included the provision of PSS related functions for groups hosted by the Council, and the hired PSS Specialist has not provided this function.
    - Patients were attending an non-evidence based PTSD group at the Clinic and were discharged without follow-up with PSS.

[3] Serious Mental Illness as defined by VHA refers to the American Psychiatric Association Diagnostic and Statistical Manual Axis I disorder resulting in significant functional impairment and/or disruption in major activities of daily living. This typically includes schizophrenia and other psychotic disorders, bipolar disorder, major depression, and severe Posttraumatic Stress Disorder. VHA Directive 2012-002, *Re-Engaging Veterans with Serious Mental Illness in Treatment*, January 10, 2012.
[4] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008. This Handbook was scheduled for recertification on or before the last working date of September 2013 but has not yet been recertified.
[5] VHA Handbook 1163.05, *Psychosocial Rehabilitation and Recovery Services Peer Support*, July 1, 2011.
[6] Deputy Under Secretary for Health for Operations and Management Memorandum. *Requirements for VA Medical Center and VISN Activity Focused on Justice-Involved Veterans; Announcement of Veterans Justice Outreach National Steering Committee*, May 27, 2009.

- The facility does not provide required VJO services to incarcerated veterans.
  - The facility delayed hiring a VJO Specialist to service veterans in Knox County and surrounding counties.
  - It takes 3–5 days for confirmation of prescribed medications by the Clinic for veterans incarcerated at the Knox County Sheriff's Detention Facility (Detention Facility).
- The facility and Clinic managers violated agreements about meeting space, travel pay, and PSS facilitator training for members of the Council.

Scope and Methodology

We conducted our review from August 2014 through July 2015. We conducted a site visit to the Clinic on March 26–27, 2015. We interviewed facility senior managers, Clinic managers, and clinical and administrative staff with knowledge about the specific services in question. We also interviewed the complainants and staff from the Detention Facility.

We reviewed relevant VHA and local policies and procedures related to MH services. We requested release of information documents for medication confirmations for all incarcerated veterans. We were provided and reviewed documentation for all 46 veterans for the time frame between June 3, 2014, and December 8, 2014. We reviewed documented correspondence between facility staff and Council members and Council meeting minutes from January 2014 through June 2014. We reviewed the electronic health records (EHRs) of 23 PTSD group veterans who received MH services at the Clinic through June 2015 to determine if they received MH follow-up. For the purposes of this report, we defined follow-up as the patient being seen by a MH provider at least once within 12 months from the time the group at issue was discontinued.

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

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

Inspection Results

Issue 1: Failure To Provide Peer Support Services

Delay in Hiring a PSS Specialist

We substantiated the allegation that facility managers did not have PSS available to veterans at the Clinic until June 2013. We determined that facility managers failed to provide PSS between September 2008 and June 2013.

The facility managers hired a full-time PSS Specialist for the Clinic in June 2013. Prior to June 2013, the Clinic did not have a PSS Specialist nor did the facility provide PSS through Non-VA Care.

Alleged Failure To Provide PSS in Accordance with Position Description

We did not substantiate the allegation that the PSS Specialist hired by the Clinic was expected to provide PSS related functions to groups hosted by the Council. The position description at issue did not include such an expectation. The PSS Specialist was hired in June 2013, and after completing orientation for the position, he initiated five PSS groups, as well as individual PSS, at the Clinic. The PSS Specialist attended the group hosted by the Council starting in January 2014 until the end of August 2014.

Discharged Without PSS Follow-Up

We substantiated that patients were discharged from a non-evidence based PTSD group that was led by a VA-provider without immediate PSS follow-up. The group was discontinued around September 2012. At that time, PSS were not available at the Clinic. In June 2013, a PSS Specialist was hired but did not complete orientation for many months. Facility managers informed us that all group members were offered to continue with individual psychotherapy sessions with Clinic providers. Our review of the EHRs of 23 patients who were discharged from the group indicated that 21 of the 23 patients received follow-up MH services at the Clinic. One of the remaining two patients cancelled two scheduled follow-up MH appointments; the other patient had not returned to the group after June 2012 and did not have any scheduled follow-up MH appointments.

Issue 2: Failure To Provide Services to Incarcerated Veterans

Delay in Hiring a Veterans Justice Outreach Specialist

We substantiated the allegation that facility managers delayed hiring a VJO Specialist to service veterans in Knox County and surrounding counties. Although VHA policy[7]

[7] Deputy Under Secretary for Health for Operations and Management Memorandum. *Requirements for VA Medical Center and VISN Activity Focused on Justice-Involved Veterans; Announcement of Veterans Justice Outreach National Steering Committee*, May 27, 2009.

mandated that VHA facilities designate a VJO Specialist to provide outreach to justice-involved veterans in the communities they serve beginning in 2009, facility managers told us that a VJO Specialist who could provide comprehensive VJO services was not hired until late August 2014.

A social worker, whose functional statement outlined both VJO Specialist and Homeless Outreach Social Worker duties, was hired in July 2012. However, the social worker was unable to completely perform all outlined duties, and facility managers advised the social worker to limit VJO outreach services.

During the spring of 2013, facility managers requested VHA funding to hire a dedicated VJO Specialist for the Clinic. VHA funding was approved in December 2013 and the VJO Specialist position was announced in January 2014. For varying reasons, the position was not initially successfully filled and was announced three times prior to hiring a full-time VJO Specialist in late August 2014. We reviewed Council meeting minutes, which confirmed the Council was aware of the announcements for the VJO position.

Alleged Delays in Medication Confirmations

We did not substantiate the allegation that medication confirmation requests take 3–5 days for incarcerated veterans. Medication confirmation requests are completed by incarcerated veterans to request the release of the veteran's medications list to the Detention Facility staff. Facility policy states that requests for copies of individually-identifiable information[8] must be answered within 20 workdays from the date of receipt, and requests received during non-business hours are processed by the facility's Administrative Officer of the Day.[9]

We reviewed all 46 medication confirmation requests dated between June 3, 2014, and December 8, 2014, from non-VHA providers at the Detention Facility. We identified that 45 requests were completed on the same day, and 1 was completed the following day. Also, Detention Facility staff affirmed that most requests are completed the same day.

On August 11, 2014, facility managers provided the Council with contact information that Detention Facility staff could use to make medication confirmation requests during business hours as well as non-business hours. We reviewed correspondence in December 2014 from the Council stating that no recent complaints about receiving timely medication confirmations were received from the Detention Facility staff.

Issue 3: Alleged Violations of Agreements with the Council

We did not substantiate the allegation that facility and Clinic managers failed to uphold agreements with the Council regarding (1) providing meeting space for the group hosted

[8] Individually-identifiable information is any information, including health information maintained by VHA, pertaining to an individual that also identifies the individual and, except for individually-identifiable health information, is retrieved by the individual's name or other unique identifier.
[9] Medical Center Memorandum 00P0-13-01, *Privacy and Release of Medical Information*, October 8, 2013.

by the Council, (2) sponsoring PSS facilitator training for members of the Council, and (3) providing travel pay for Council group members. Council members and facility and Clinic managers indicated that these agreements were verbal and had not been formalized.

VHA has outlined its policy on travel reimbursements in VHA Handbook 1601B.05. Veterans are eligible for travel pay when traveling to and from a VA facility or VA authorized health care facility in connection with treatment or care for a service connected disability.[10]

VHA was not required to provide services to the Council, as VHA had no formalized agreement to do so. Additionally, we found no consults for Non-VA Care and no authorizations for Non-VA Care for veterans attending groups hosted by the Council. Although we found no requirements to do so, Clinic managers authorized the Clinic's PSS Specialist to attend the Council's group meetings, and facility managers approved travel pay during that time period. Facility and Clinic managers could not approve beneficiary travel pay when the PSS Specialist no longer attended the group meetings.

Conclusions

We substantiated the allegation that facility managers did not have PSS available to veterans at the Clinic until June 2013. We determined that facility managers failed to provide PSS between September 2008 and June 2013. The facility managers hired a full-time PSS Specialist for the Clinic in June 2013. Prior to June 2013, the Clinic did not have a PSS Specialist nor did the facility provide PSS through Non-VA Care.

We did not substantiate the allegation that the PSS Specialist hired by the Clinic was expected to provide PSS related functions for groups hosted by the Council. The position description at issue did not include such an expectation.

We substantiated that patients were discharged from a non-evidence based PTSD group without immediate PSS follow-up. The workgroup was discontinued around September 2012, and PSS were not available at the Clinic until September 2013. Although PSS were not immediately available, individual psychotherapy sessions with Clinic providers were offered to group members.

We substantiated the allegation that facility managers delayed hiring a VJO Specialist to service veterans in Knox County and surrounding counties. Although VHA policy mandated that VHA facilities designate a VJO Specialist to provide outreach to justice-involved veterans in the communities they serve beginning in 2009, facility managers told us that a VJO Specialist who could provide comprehensive VJO services was not hired until late August 2014.

[10] VHA Handbook 1601B.05, *Beneficiary Travel*, July 23, 2010. This Handbook was scheduled for recertification on or before the last working day of July 2015 but has not yet been recertified.

We did not substantiate the allegation that medication confirmation requests take 3–5 days for incarcerated veterans. We reviewed all 46 medication confirmation requests dated between June 3, 2014, and December 8, 2014, from non-VHA providers at the Detention Facility. We identified that 45 requests were completed on the same day, and 1 was completed the following day. Also, Detention Facility staff affirmed that most requests are completed the same day.

We did not substantiate the allegation that facility and Clinic managers failed to uphold agreements with the Council regarding (1) providing meeting space for the group hosted by the Council, (2) sponsoring PSS facilitator training for members of the Council, and (3) providing travel pay for Council group members. Council members, facility, and Clinic managers indicated these agreements were verbal and had never been formalized.

Recommendations

1. We recommended that the Facility Director improve processes for communicating with community-based consumer-run groups that provide mental health services to veterans enrolled at the Knoxville VA Outpatient Clinic.

2. We recommended that the Facility Director ensure that the Clinic's Veterans Justice Outreach Specialist provides comprehensive services including outreach for veterans in the Knox and surrounding counties in accordance with Veterans Health Administration policy.

Appendix A

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: January 7, 2016

From: Director, VA Mid South Healthcare Network (10N09)

Subj: **Healthcare Inspection—Mental Health Service Concerns at the Knoxville VA Outpatient Clinic, James H. Quillen VA Medical Center, Mountain Home, Tennessee**

To: Director, Chicago Office of Healthcare Inspections (54CH)
Director, Management Review Service (VHA 10AR MRS OIG Hotline)

1. I concur with the findings and recommendations of this Office of Inspector General review of the mental health concerns at the Knoxville VA Outpatient Clinics, James H. Quillen VA Medical Center, Mountain Home, Tennessee, as well as the action plan developed by the facility.

2. If you have any questions or need additional information from the Network, please do not hesitate to contact Robert J. Campbell, Interim VISN 9 Mental Health Program Manager, at 423-926-1171, ext. 3379.

(original signed by and on file:)

John E. Patrick

Appendix B

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: January 4, 2016

From: Director, James H. Quillen VA Medical Center (621/00)

Subj: **Healthcare Inspection—Mental Health Service Concerns at the Knoxville VA Outpatient Clinic, James H. Quillen VA Medical Center, Mountain Home, Tennessee**

To: Director, VA Mid South Healthcare Network (10N09)

1. On behalf of the James H. Quillen VA Medical Center, Mountain Home, Tennessee, I concur with the findings and recommendations of this Office of Inspector General report. We had already been actively working to improve or enhance these areas and welcome the "fresh eyes" perspective provided by this report.

2. Included herein is an outline of improvement actions taken and in progress in response to these findings. We believe these changes will further enhance key systems and processes at our healthcare system.

(original signed by and on file:)

Daniel B. Synder, P.E., FACHE

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that the Facility Director improve processes for communicating with community-based consumer-run groups that provide mental health services to eligible veterans enrolled at the Knoxville VA Outpatient Clinic.

Concur

Target date for completion: June 2016

Facility response: The Mountain Home VA Healthcare System (MHVAHCS) Director attends the Knoxville Regional Mental Health Council Meetings on a quarterly basis. The Associate Chief of Staff for the Mental Health Service and the VISN 9 Mental Health leadership attends the meetings on a monthly basis. Minutes from this group are shared with the MHVAHCS Mental Health Leadership Team (MHLT) and the Executive Leadership Team (ELT).

Recommendation 2. We recommended that the Facility Director ensure that the Clinic's Veterans Justice Outreach Specialist provides comprehensive services including outreach for veterans in the Knox and surrounding counties in accordance with Veterans Health Administration policy.

Concur

Target date for completion: June 2016

Facility response: In August of 2014, a Veterans Justice Outreach (VJO) specialist was hired for the Knoxville area. The Knoxville VJO provides outreach to the Knox, Blount, Sevier and Anderson County jails and as time permits, to other county and city jails in the catchment area outlying counties. She provides telephone outreach to the counties beyond those named above and makes every effort to visit outlying areas when able. She is connected to the Knox County Veterans Treatment Court (VTC) and is working with the Blount County and Sevier County Courts. She is the point of contact for the Knox VTC Peer Specialist and this same Veteran serves as her point of contact for the Sevier County area. She is directly linked with the judge and other court personnel in the Blount County Court.

Appendix C

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Sheila Cooley, GNP, MSN Wachita Haywood, RN Alan Mallinger, MD Judy Brown, Management and Program Analyst

Appendix D

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, VA Mid South Healthcare Network (10N09)
Director, James H. Quillen VA Medical Center (621/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Lamar Alexander, Bob Corker
U.S. House of Representatives: Diane Black, Marsha Blackburn, Steve Cohen, Jim Cooper, John J. Duncan, Jr., Stephen Fincher, Charles J. "Chuck" Fleischmann, Scott DesJarlais, Phil Roe

This report is available on our web site at **www.va.gov/oig.**