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Office of Healthcare Inspections

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Healthcare Inspection

Review of Complaints Regarding Mental Health Services Clinical and Administrative Processes VA St. Louis Health Care System St. Louis, Missouri

December 13, 2016

Washington, DC 20420

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Table of Contents

Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection pursuant to a June 2014 request from Senator Bernie Sanders, then Chairman of the Senate Veterans Affairs Committee, to assess allegations regarding deficiencies in Mental Health (MH) clinical processes, including productivity, data reporting, access, quality of assessments and care, and administrative processes at the VA St. Louis Health Care System (system), St. Louis, MO.

Of 19 allegations, 6 were substantiated and 13 were not substantiated, and we identified 8 additional findings.

Regarding productivity, our review focused on the system outpatient psychiatrists who provided primarily individual treatment. Our review of the allegations concerning productivity and data reporting substantiated that some outpatient psychiatrists completed fewer encounters per day in fiscal year (FY) 2013 than were available in their daily schedules or were typical in community MH settings. We found that the psychiatrists' scheduling grids were, in general, set up with fewer appointment slots than would be expected based on their assigned clinical time. We also substantiated that the system's productivity data were inconsistent with the number of daily patient encounters in FY 2013. Specifically, we found a low correlation between the number of psychiatry encounters and the productivity measure suggesting that the productivity metric does not reflect daily psychiatric patient care activity adequately. We found providers' errors in Current Procedural Terminology codes at a rate exceeding the Veterans Health Administration (VHA) minimum accuracy standard during the time frame May through August 2013. The system did not complete more frequent reviews and coding and documentation education for individual clinicians with high error rates in their coding, as required by VHA. We also found that two of 15 patients (12 patients who were identified by OIG Office of Audits and Evaluations during a concurrent review and an additional 3 patients who were identified by the complainant) had inadequate consult management follow-up with both of these patients referred for ancillary MH Clinic group treatment.

Concerning access and quality of assessments and care, we substantiated that in FY 2013, the system had average delays of 3 days for outpatient MH Clinic and Post Traumatic Stress Disorder (PTSD) treatment with significant variability amongst the psychiatrists' clinics. We found that the Chief of Staff[1] was aware of the wait times and supported the complainant's request for a system redesign to address the problem. We also found that a MH Clinic nurse did not adequately assess an unscheduled patient's treatment needs. We substantiated that the PTSD Clinic staff mismanaged treatment services for one of 14 patients. We also found that a former system staff member did not provide military sexual trauma treatment timely and that the PTSD Clinical Team 2 staff failed to provide timely care to a patient who presented to the clinic unscheduled.

[1] This Chief of Staff assumed the position in August 2012 and resigned effective August 2014. Currently, an interim Chief of Staff holds this position.

Additionally, we found that the "public" facsimile machine used for Veterans Benefits Administration Vocational Rehabilitation and Employment referrals was not reliable or attended to properly. Further, two Compensation and Pension evaluators entered erroneous information in a veteran's electronic health record. Finally, a PTSD Clinic patient was not included in treatment planning that included transfer to the MH Clinic.

Our review of the allegations concerning administrative processes substantiated insufficient investigation of two of three patient deaths. Specifically, we found these investigations were not inclusive of all relevant clinicians, were not consistently timely, and/or did not complete follow-up of two peer review processes and one management review.

We made nine recommendations. We recommended that the Acting VA St. Louis Health Care System Director ensure:

- MH Service staff reviews daily psychiatric patient care activity and determine if productivity is consistent with work relative value unit-based productivity and also meets reasonable expectations for number of patients treated.
- Staff psychiatrists' scheduling grids are consistent with expected patient care activity.
- Processes are strengthened to review and rectify staff psychiatrists' Current Procedural Terminology coding errors.
- Processes are strengthened for timely response to mental health clinic group treatment patient referrals.
- MH staff adequately assess and document treatment needs and follow-up arrangements for unscheduled (walk-in) patients.
- Facsimile machine numbers provided to referral sources are functional and appropriately located for timely response.
- Compensation and Pension evaluation documentation processes are strengthened to enhance accuracy of information.
- Processes are strengthened to include patients in treatment planning when transferred to another clinic.
- Management and peer reviews are inclusive of all relevant clinicians and timely and that managers take appropriate follow-up actions, if indicated.

We did not address allegations regarding retaliation, provision of Compensation and Pension benefits, Compensation and Pension benefits evaluator bias, patient satisfaction, and disinformation from management to some staff.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with our recommendations and provided an acceptable action plan. (See Appendixes H and I,

pages 72–77 for the Directors' comments.) We will follow up on the planned actions until they are completed.

OIG Update: Based on information provided to us in November 2016, we determined that planned actions have been completed for Recommendations 1, 2, 6, and 7; we will continue to monitor the remaining five recommendations.

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Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections (OHI) conducted an inspection pursuant to a June 2014 request from Senator Bernie Sanders, then Chairman of the Senate Veterans Affairs Committee, to assess allegations regarding deficiencies in Mental Health (MH) Services productivity, data reporting, access, quality of assessments and care, and administrative processes at the VA St. Louis Health Care System (system), St. Louis, MO.

Background

The System

The system is 1a complexity level[2] and includes two divisions that serve veterans in east-central Missouri and southwestern Illinois. The John Cochran Division (JC), located in midtown St. Louis, has 136 acute medical and surgical beds, and services include intensive care units, an emergency department (ED), primary care clinics, specialty care clinics, and laboratory and radiology services. The Jefferson Barracks Division (JB), located in south St. Louis County, has 102 acute, 50 domiciliary, and 71 community living center beds, and services include MH, spinal cord injury, nursing home care, geriatric health care, rehabilitation, and a domiciliary program. The system has four community based outpatient clinics and is part of Veterans Integrated Service Network (VISN) 15.

JC has one outpatient General MH Clinic (MHC). All other MH services are located at JB, including the MH specialty clinics, a 40-bed acute inpatient unit, and two residential programs. Specifically, JB outpatient MHCs include:

- General MHC - East
- General MHC - West
- Opioid Addiction Treatment Program
- Post-Traumatic Stress Disorder (PTSD) Clinical Team (PCT) 1 (Desert Storm and prior conflicts)
- PCT 2 (Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn)
- Senior Veterans Center[3]

[2] Veterans Health Administration facilities are categorized according to complexity level which is determined on the basis of the characteristics of the patient population, clinical services offered, educational and research missions and administrative complexity. Facilities are classified into three levels with Level 1 representing the most complex facilities, Level 2 moderately complex facilities, and Level 3 the least complex facilities. Level 1 is further subdivided into categories 1a - 1c. *2010 VHA Facility Quality and Safety Report.* Accessed December 2, 2014.
[3] This is a clinic that provides geropsychiatry, the psychiatric subspecialty of dealing with mental illness in the elderly.

Staffing

Generally, MH programs included nursing, psychiatry, psychology, program support, and social work. In July 2014, MH staffing included 5 outpatient advanced practice registered nurses (APRNs), 78 registered nurses, 12 licensed practical nurses, 20 nursing assistants, 9 psychiatric nursing assistants, 31 psychiatrists, 40 psychologists, 12 program support assistants (clinic clerks), 1 marriage and family therapist, and 39 social workers.

System MH Leadership

As of July 2014, the Medical Center Director position had been vacant since June 2013 with a series of Acting Directors during the following year. We were informed that the position had been posted four times with no candidate chosen. The physician who served as the Chief of Staff (COS) assumed the position in August 2012 and resigned effective August 2014. As of November 2016, an interim Chief of Staff holds this position.

System MH leadership includes the Associate Chief of Staff (ACOS) for MH to whom the Chief of Psychiatry and Chief of Psychology report directly. The ACOS reported directly to the COS. The ACOS' primary managerial responsibilities include providing overall leadership and direction for all programs, services, and activities within the MH Service. These programs include comprehensive inpatient (approximately 2,000 annual discharges) and outpatient (approximately 10,000 unique veterans) psychiatric, psychological, and substance abuse care. The ACOS has supervisory authority over 100 MH Service staff, including among others, approximately 30 Psychiatrists, 40 Psychologists, 6 Vocational Rehabilitation Specialists, and 10 Rehabilitation Technicians/Addiction Therapists. Additionally, the incumbent has programmatic responsibility for MH Service that includes approximately 150–200 clinical staff from various other services (for example, nursing, social work, occupational therapy, and recreational therapy).

The ACOS oversees Psychiatry Service and supervises the Chief of Psychiatry. The Chief of Psychiatry is responsible for overall service operations at both Divisions, including budget and fiscal management, human resource management (hiring, performance, and retention), strategic planning, program development, and other clinical psychiatry operations. From 2002 through 2012, the system has had a series of Acting Chiefs of Psychiatry, with the longest tenure having been 12–18 months in the role.

In January 2012, the system hired the complainant as a staff psychiatrist for the Opioid Addiction Treatment Program and selected him as Chief of Psychiatry in November 2012.[4] As Chief of Psychiatry, the complainant was responsible for 22 psychiatrists, including 16 full-time (6 inpatient and 10 outpatient) and 6 part-time

[4] On July 21, 2014, the complainant signed a Permission To Disclose Complaint Information form allowing OIG to release his name and written complaint to VA management.

outpatient psychiatrists. With COS approval, the complainant appointed three psychiatrists to lead the inpatient, outpatient, and substance abuse programs, respectively, and those psychiatrists reported directly to him. In addition to increased pay, these program leads had reduced clinical responsibilities to allot time for administrative duties, such as monitoring productivity.

The complainant served as Chief of Psychiatry until September 2013, when—pending an administrative review—he was detailed to compensation and pension (C&P) evaluation duties. Subsequently, the three psychiatry program leads were offered, but declined to serve as Acting Chief of Psychiatry, so the ACOS assumed the role; the ACOS continues in that role as of November 2016.

MH Productivity Measurement and Reporting

Veterans Health Administration MH Productivity Directive

In June 2013, the Veterans Health Administration (VHA) published Directive 1161, *Productivity and Staffing in Outpatient Clinic Encounters for Mental Health Providers.* This was the first directive that "…provided policy on outpatient provider productivity based on outpatient clinical encounters[5] for all psychiatrists and psychologists, as well as for those advanced practice nurses, social workers, and physician assistants who work in mental health settings."[6]

The Directive guidelines are based on the Centers for Medicare and Medicaid Services (CMS) Work Relative Value Unit (wRVU) model for measuring specialty provider productivity. CMS uses a physician reimbursement formula that factors in geographic location, current economic index, practice and malpractice insurance expenses, and wRVU. The wRVU accounts for approximately 50 percent of a Medicare provider's fees.[7] The wRVU is a measure of the complexity of and time required to provide a professional service.

Common Procedure Coding System

The American Medical Association defines the complexity and time of a service using a five-digit numerical code from the Level 1 Healthcare Common Procedure Coding System, which is more commonly referred to as the Current Procedural Terminology (CPT) code.[8] Each CPT code specifies procedure type, location, and (except for Evaluation and Management codes) the amount of service time. For each CPT code, a

[5] An encounter is a professional contact between a patient and a provider vested with responsibility for diagnosing, evaluating, and treating the patient's condition. VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures*, June 9, 2010. This Directive expired June 30, 2015; although the timeframe for scheduling appointments was revised in December 2015, the expiration date of the Directive was not modified.
[6] VHA Directive 1161, *Productivity and Staffing in Outpatient Clinic Encounters for Mental Health Providers*, June 7, 2013.
[7] Medicare and Medicaid Physician Fee Schedule, http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/MedcrephysFeeSchedfctsht.pdf . Accessed October 22, 2014.
[8] CPT codes and descriptions are copyright 2013 American Medical Association. All Rights Reserved. CPT is a registered trademark of the American Medical Association (AMA).

specific wRVU value is assigned based on the service complexity including the complexity of history, exam, and medical decision-making, as applicable. For example, assigned wRVUs for Psychiatric Diagnostic Evaluation with no medical services (CPT code 90791) is 2.80 while a Psychiatric Diagnostic Evaluation with medical services (90792) is 2.96. Similarly, an "Established Patient" with straightforward medical decision making (99213) is assigned 0.97 wRVUs while an "Established Patient" with moderate medical decision making (99214) is assigned 1.50 wRVUs.

CMS assigned a zero wRVU value to several MH CPT codes, such as care management and home-based care visits. Given that these patient care activities are core to some VHA clinical programs, VHA determined imputed wRVU values to be utilized for MH productivity.

As part of the close out of the appointment, the VHA provider enters the applicable CPT code on the Patient Care Encounter (PCE) form. Two types of errors can occur in provider coding—upcoding and downcoding. Upcoding is when the provider enters a CPT code assigned higher wRVUs than the "correct" CPT code, such as entering 90792 instead of 90791. Downcoding is when the provider enters a CPT code assigned lower wRVUs than the "correct" CPT code, such as entering 99213 instead of 99214.

A 2015 OIG Office of Audits and Evaluations (OAE) report, *Audit of VHA's Efforts To Improve Veterans' Access to Outpatient Psychiatrists,* identified national problems with CPT coding among VHA psychiatrists.[9] OIG recommended that the Under Secretary for Health develop a mechanism to monitor the variance in which psychiatrists code encounters and determine appropriate coding guidance and training to ensure consistency.

VHA MH Productivity Definition and Guidelines

The 2015 OIG report also identified that although VHA psychiatrists were exceeding productivity targets, they were not utilizing all their clinical time for patient care. The report recommended that the Under Secretary for Health reassess the appropriateness of VHA's productivity target for psychiatrists.[10]

VHA defines productivity as Workload (wRVUs)/Adjusted Clinical Full-Time Equivalent (FTE(c)) where the adjusted FTE(c) is the time spent in direct patient care activities. In VHA, the process of determining FTE(c) is called "labor mapping," and VHA has business rules to standardize physician labor mapping nationally in the Decision Support System (DSS).[11] All physician activities must be mapped to either Direct Patient Care or Indirect Administration, Education, or Research. Typically, the service chief, in consultation with the COS, assigns the amount of time that a provider is assigned to direct patient care and indirect duties.

[9] VA Office of Inspector General, *Audit of VHA's Efforts To Improve Veteran's Access to Outpatient Psychiatrists,* Report No. 13-03917-487, August 25, 2015.
[10] Ibid.
[11] VHA Directive 2011-009, *Physician and Dentist Labor Mapping,* February 28, 2011.

With the focus on wRVUs, the VHA productivity directive does not recommend a specified panel size (volume of assigned patients) for psychiatrists. Certain specialized programs are exceptions and specify panel size. For example, the Behavioral Health Integration Program has an interdisciplinary team panel size of 1000 patients,[12] and the Incentive Therapy Program has 40–50 patients per staff member.[13]

VHA defines direct patient care activities as the time to prepare, provide, and follow up on clinical care needs including providing care, reviewing and charting medical records, consulting about patients with colleagues, participating in clinically relevant trainings, and reviewing medical literature. Telephone contacts focused on patient care with patients, caregivers, or colleagues are included as well.[14] Indirect patient care administrative activities include management responsibilities atypical of a front line staff member such as chairing a facility or VISN administrative committee or serving in a collateral role such as a Clinical Team Leader or Military Sexual Trauma Coordinator.

VHA provides discipline specific guidelines for annual outpatient productivity targets which are within a range around the median observed wRVU per FTE(c). For psychiatry, VHA identified the FY 2011 median productivity per outpatient FTE(c) as 2574, and the current acceptable benchmark is -/+ 10 percent of the median (2317–2831).[15]

VHA MH leaders postulated that using patient encounters per day is a problematic measure of productivity due to the variability of practice expectations for different MH roles and therefore rendering it problematic to determine a benchmark. For example, Primary Care MH Integration (PC-MHI) providers are expected to keep their schedules relatively open to remain accessible and see patients for briefer appointments, while Home Based Health Care providers travel long distances to see a few people a day, and MH Outpatient Clinic providers see patients hour after hour.

Other than VHA Directive 1161, current professional literature does not offer guidelines for productivity or a benchmark for MH patient encounters per day. To identify a guideline of community practice, we consulted with an expert in public community MH administration who directs an outpatient MH clinical program in an urban University Medical Center located in a Midwestern city comparable in size to St. Louis. This consultant informed us that MH clinic psychiatrists in his program are expected to complete 14 patient visits (encounters) per day, which is accomplished by scheduling 21 appointments per day. Pharmacologic management appointments are scheduled for three returning patient visits per hour, which after missed appointments[16] yields on

[12] Weaver, Kendra. Behavioral Health Interdisciplinary Program (BHIP) Team Based-Care, http://www.avapl.org/conference/pubs/2014%20Conference%20Presentations/2%20-%20Weaver%20-%20BHIP-VAPL.pdf. Accessed March 2, 2015.
[13] VHA Handbook 1163.02, *Therapeutic and Supported Employment Services Program*, July 1, 2011.
[14] VHA Directive 1161, *Productivity and Staffing in Outpatient Clinic Encounters for Mental Health Providers*, June 7, 2013.
[15] Ibid. p. 3.
[16] Missed appointment includes a cancellation by patient after the appointment time and an appointment for which the patient does not present.

average 2.1 visits per hour (70 percent completed appointment rate). The consultant also stated that in his experience, the majority of public community MH settings schedule four patient visits per hour.

VHA Clinic Profiles and Scheduling Grids

VHA utilizes clinic profiles to outline expectations regarding clinicians' direct patient care duties. The profiles outline the days of the week, available appointment times and lengths, maximum number of regular appointments, maximum number of overbook appointments, and the overall number of maximum appointments (maximum number of regular appointments plus maximum number of overbook appointments). The profile includes information regarding times in which the provider is committed to indirect activities and not available for direct care, for example, during a reoccurring 60-minute monthly staff meeting. VHA requires that all clinic profiles be current at all times and subject to annual review.[17]

VHA staff schedule patient appointments using a scheduling grid software application in the Veterans Health Information Systems and Technology Architecture (also known as VistA) system. In the scheduling grid, appointment slots are set up based on time of day and appointment length, such as eight 30-minute appointment slots from 8:00 a.m. until noon every Monday. Providers' scheduling grids are set up to parallel their respective clinic profiles.

Data Management and Reporting

Since 1996, VHA facilities have been required to electronically report data concerning the provision of all billable and non-billable inpatient and outpatient services to the National Patient Care Database (NCPD) in Austin, TX.[18] Beginning in 2005, VHA required that all service information be recorded electronically via a Patient Care Encounter (PCE) form. The PCE ensures that every patient encounter has an associated provider, CPT code, and diagnostic code. The associated provider is responsible for "coding" the encounter, which means entering CPT and diagnostic codes into the electronic health record (EHR). This encounter information is entered electronically by the provider or a designee. VHA facilities utilize software packages to capture PCE data which is transferred to the NCPD. This data is then accessible to all VHA administrative levels including VA Central Office (VACO).

VHA adheres to the American Health Information Management Association's recommendation of maintaining a 95-percent coding accuracy rate as a minimum goal.[19] Quality indicators for measuring accuracy include accurate coding of all

[17] VHA Directive 2010-027, *Outpatient_Scheduling_Processes_and_Procedures*, June 9, 2010. This Directive was rescinded and replaced by VHA Directive 1230, *Outpatient Scheduling Processes and Procedures*, July 15, 2016 that contains the same or similar language regarding clinic profiles.
[18] VHA Directive 2009-002, *Patient_Care_Data_Capture*, January 23, 2009. This Directive expired January 31, 2014, and has not yet been updated.
[19] VHA Handbook 1907.03, *Health Information Management Clinical Coding Program Procedures*, September 26, 2012.

diagnoses and procedures, documentation to substantiate codes assigned, and correct sequencing according to coding guidelines.

To this end, VHA's workload quarterly close-out processes require each facility's Health Information Management (HIM) staff to code all inpatient discharges and monitor the accuracy of outpatient clinician coding using an "appropriate sample size as determined by the facility." System HIM staff audits (and corrects when necessary) all MH outpatient billable workload, which is approximately 20 percent of providers' workload. Billable workload is given priority to expedite the billing process. HIM staff are responsible for providing education on coding and documentation as needed. VHA requires "more frequent reviews" for clinicians who continue to have high error rates in their coding.[20]

Using the data reported to NCPD, VHA's Office of Productivity, Efficiency, and Staffing (OPES) and VHA Support Services Center (VSSC) provide platforms to generate productivity reports. Access to specialized software necessary to generate reports from this data is restricted to a maximum of 10 employees per facility, including the COS. These employees have read only rights and are unable to modify data in any way. Access is typically provided to administrative officers and health system specialists in program support roles.

Allegations. In June 2014, Senator Bernie Sanders, then Chairman of the Senate Veterans Affairs Committee, forwarded a complaint letter to the OIG. The complainant identified additional allegations in (i) a July 8 Complainant Statement, *Oversight Hearing on VA Whistleblowers: Exposing Inadequate Service Provided to Veterans and Ensuring Appropriate Accountability*, to the House Veterans Affairs Committee; (ii) a June 18 email to the Acting Secretary; and (iii) interviews and correspondence with OIG. In June 2014, a second complainant (Complainant 2) informed VA OIG auditors of inadequate administrative follow-up to a patient's completed suicide. The specific allegations included:

Issue 1. Psychiatrists' Productivity and Data Reporting

- System outpatient psychiatrists see a "dramatically low number of veterans per day."
- "Productivity data reported to VA Central Office was inconsistent with the number of veterans seen by psychiatrists per day."
- The system is in the "lowest tier of [psychiatrist] productivity."
- MH Leadership was manipulating the productivity measure data.
- The complainant's "…efforts to increase access to care were inexplicably thwarted" by his supervisors; "…bitterly resisted by all the specialties" providing clinical care;

[20] VHA Handbook 1907.03, *Health Information Management Clinical Coding*, page 5, September 26, 2012.

and, following his removal from his position, psychiatrists' performance reverted back to a low level by December 2013.

- "Fake" MH Service consult notes were entered into the patient record "to game the system" and make it appear that a doctor evaluated the veteran much sooner than what was happening.

Issue 2. Access and Quality of Assessments and Care

- "Veterans seeking treatment experience waits well in excess of the standard of care."

- "Many patients unnecessarily drop out of treatment" and there was "a very high no-show rate of 35 percent."

- Psychiatrists co-signed controlled substance (medications, such as narcotics, that are regulated at the federal level)[21] orders for APRNs without ever seeing the patient, which was a risk to the veteran's health and was both unlawful and unethical.

- Five credentialing and privileging evaluations were "substandard resulting in long delays to providing much needed benefits or in some circumstances serving as an absolute bar to the access to statutorily provided benefits."

- The specialized PTSD Clinic staff inappropriately refused veterans specialized PTSD treatment services.

- "Denial of care to a veteran in a minority group based on a very poor psychological evaluation." Further, the complainant alleged that the ACOS:

    - Had "very little concern for the veteran"
    - Had "special interest" in the psychologist evaluator
    - "Concluded that the VA could not provide a second opinion as it was too complex, instead he fee-based this veteran to a community psychologist," which was contradicted by the patient's receiving psychotherapy from a VHA psychology intern.

Issue 3. Administrative Processes

- A suicide attempt by an inpatient during a Joint Commission visit was covered up and not reported to the Joint Commission and corrective actions were deliberately delayed.

[21] The most harmful substances appear in Schedule I and the rest appear in descending order accordingly. http://www.dea.gov/druginfo/ds.shtml . Accessed October 1, 2014.

- Follow-up investigations of three patients' deaths were inadequate and the complainant's requests to investigate were turned down inappropriately.

- Bonuses were considered "automatic, irrespective of performance, based on erroneous 'productivity' data."

- There was a lack of reliable veteran feedback about their experiences with outpatient MH care.

Scope and Methodology

The scope of this review included system and employee practices related to productivity and data reporting, specific patient access and quality of care issues, and MH Services' administrative processes as related to two complainants' allegations. With respect to our review of productivity, we limited our focus to outpatient psychiatry staff who provided primarily individual treatment.

We conducted a site visit July 21 through July 25, 2014, and interviewed the complainants; select system leaders, managers, and outpatient MH staff; VHA MH leaders and facility leaders; and other individuals who may have been knowledgeable about matters related to the allegations. We reviewed documents that could address the allegations, including applicable regulations, policies, and guidance; incident reporting and adverse event follow-up procedures; coding audit reports; meeting minutes; peer review reports; psychiatrist performance pay and award records; productivity data and reports; root cause analyses (RCAs); scheduling grids; training records; veteran feedback mechanisms; pertinent email; applicable patient Veterans Benefits Administration (VBA) Vocational Rehabilitation and Employment records; VSSC reports; and applicable patient EHRs. We conducted basic statistical analyses on selected productivity data. We conducted some of the work through secure data exchange, email, and/or telephone.

For our review, we utilized the median[22] to reduce the impact of certain providers' variation of daily patient encounters. Since some providers had non-regular clinic days with low numbers of encounters, the use of the median (rather than the mean) was indicated so that we reduced the importance attached to atypical variability in the measurement. We consulted an independent expert to provide a perspective on non-VA MH provider productivity expectations.

The complainant's allegations of retaliation and leadership's "strategy to marginalize and remove" the complainant were beyond the scope of this healthcare inspection and therefore not reviewed. Specific allegations regarding the legality of prescribing controlled substances by APRNs and their collaborating psychiatrists were beyond the

[22] The median is the number separating the higher half of a data sample from the lower half. To find the median, we arrange the observations in order from smallest to largest value. If there is an odd number of observations, the median is the middle value. If there is an even number of observations, the median is the average of the two middle values.

scope of this inspection. Further, we did not address allegations regarding retaliation, provision of C&P benefits, C&P evaluator bias, patient satisfaction, and disinformation provided to the complainant by management. Specifically, the following allegations were beyond the scope of this inspection:

- C&P evaluations causing "…long delays to providing much needed benefits or in some circumstances serving as an absolute bar to the access to statutorily provided benefits."

- "Two veterans reportedly told the complainant that Dr. X's C&P examinations were prejudicial against the veteran and that another psychiatrist "declined to officially join my opinion" because of concerns of leadership retaliation.
- The Chief of Psychology misled the complainant regarding a psychologist's expertise and had led another psychiatrist to believe the complainant wanted that psychiatrist to be part of this complaint evaluation.

- The COS "…seemed either not to understand or care about the implications of such poor evaluations, specifically, this psychologist's important gate-keeping role and her evaluations have a serious impact on the veterans ability to get appropriate care at the VA."

We **substantiate** allegations when the facts and findings support that the alleged events or actions took place. We **do not substantiate** allegations when the facts show the allegations are unfounded. We **cannot substantiate** allegations when there is 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: Psychiatrists' Productivity and Data Reporting

Allegation: Outpatient psychiatrists see a "dramatically low number of veterans per day."

To determine if system outpatient psychiatrists treated a "dramatically low number of veterans per day," we evaluated how many patient encounters outpatient psychiatrists completed per day and then compared that data to encounters expected based on their daily schedules, FTE(c), and a non-VA MH outpatient clinic. Additionally, we compared the available appointments in their daily schedules as expected by FTE(c). Within these parameters, we substantiated that on average, the system outpatient psychiatrists treated a low number of patients per day. However, we found variability amongst the individual psychiatrists in the numbers of patient encounters completed per day.[23] We also found that psychiatrists' FY 2013 scheduling grids were, in general, set up with fewer appointment slots than would be expected based on their designated FTE(c).

In his computation of individual outpatient psychiatrists' workload, the complainant included only face-to-face patient encounters and excluded other VHA-defined direct patient care activities.[24] He reported finding six patient encounters per 8-hour workday. Using the same criterion, we similarly determined that the 12 outpatient psychiatrists completed the full-time equivalent[25] of an average of 6.8 patient encounters per 8-hour work day.[26]

However, VHA determines patient care workload based on defined direct patient care activities and not solely face-to-face patient encounters. Using VHA-defined criteria,[27] we found that the 12 outpatient psychiatrists completed an average of 8.4 patient encounters per day.[28] Thus, an outpatient psychiatrist completed a full-time equivalent

[23] Some outpatient psychiatrists underperformed while others completed the number of encounters closer to their scheduling grid assignments, especially when all direct care activities that meet VHA encounter criteria were included in workload calculations.
[24] Encounters of inpatient, telephone, and involving more than one clinician were not included.
[25] Part-time converted to full-time equivalent.
[26] Of the 12 outpatient psychiatrists, 7 were full-time non-administrative staff who completed an average of 6 patient encounters per 8-hour work day. One of these psychiatrists completed 10 patient encounters per day while the remainder of the group completed between 4 and 7 daily patient encounters. Using the face-to-face patient encounters only, the one full-time psychiatrist with administrative duties and the four part-time non-administrative psychiatrists completed an average of eight patient encounters per 8-hour workday.
[27] VHA Directive 2009-002, *Patient Care Data Capture*, January 23, 2009. Page 2 (5)(a-d). This Directive was in effect at the time of the events described in this report. Defined criteria include face-to-face, inpatient and outpatient encounters, telephone encounters, and encounters involving more than one psychiatrist. This Directive was rescinded and replaced by VHA Directive 1082, *Patient Care Data Capture* on March 24, 2015 which contains similar language regarding encounters and further clarifies the definition of secured messaging as an encounter.
[28] We found that the seven full-time, non-administrative psychiatrists completed an average of eight patient encounters per 8-hour workday (range 5-11). Although one full-time psychiatrist saw 11 patients per day, the remainder of the full-time psychiatrists saw 8 or fewer. The full time psychiatrist with .06 FTE administrative duties (that equates to 2.4 hours per workweek) completed an average of eight patient encounters per 8-hour workday. We found that the four part-time non-administrative psychiatrists completed the full-time equivalent of 10 patient encounters per average 8-hour workday.

of 34.4 patient encounters per week on average based on an expected 4.3 days of clinical effort per week.[29]

To perform a comparison of FTE(c) with completed encounters, we included only the eight full-time outpatient psychiatrists.[30] We found that the median number of available 30-minute appointment slots was 49 per week, yet the psychiatrists completed an average of 35 encounters weekly.[31] Thus, the median number of completed patient encounters for the full-time psychiatrists comprised 71 percent of the available appointment slots[32] although there was variability among the psychiatrists.[33]

We found that psychiatrists' FY 2013 scheduling grids were, in general, set up with fewer appointment slots than would be expected based on their designated FTE(c). Specifically, we expected 68 weekly appointment slots of 30-minute duration based on the 0.86 average FTE(c). The seven full-time non-administrative outpatient psychiatrists' week with most available appointments had an average of 9.9 available appointments per day, which is substantially less than the number cited by our consultant (21 appointments scheduled per day to complete 14 encounters per day after patient cancellations and failure to present). Thus, the average of 6.8 patient encounters per day for the full-time psychiatrists was less than the 14 patient encounters per day expected based on both FTE(c) and a comparable non-VA MH clinic.

Psychiatric staff described working full days including double booking appointments and working after hours on EHR charting. They attributed lower numbers to patients who cancel or do not present for appointments (patient-driven missed opportunities) rather than a lack of scheduled appointments. The staff psychiatrists estimated a higher number of patients seen per day than OIG's calculation that included all types of direct patient care encounters. For example, one psychiatrist estimated seeing 15–20 patients a day; whereas, we calculated the average as 8 encounters per day. The full-time psychiatrist with 11 encounters per day estimated seeing an average of 13–15 patients a day. One possible explanation for this discrepancy is that the psychiatrists are spending time in VHA defined direct patient care activities other than provision of care, such as reviewing and charting medical records, completing paperwork for patients, and consulting with colleagues about patients. Although VHA includes these activities in the definition of direct patient care and as such are a component of FTE(c), they are not captured in encounters.

[29] The FTE(c) for the eight full-time psychiatrists ranged from 0.78 to 0.91 with an average of 0.86 which equates to 4.3 days or 34 hours of weekly clinical effort[29]

[30] Given that there is no proportional equivalence of part-time to full-time data for FTE(c), we omitted part-time psychiatrists.

[31] The full-time non-administrative psychiatrists' available appointment slots ranged from 25 to 55 per week with a median of 40 per week.

[32] This 13 percent is less than the System's MHC and PCT Clinics psychiatry FY 2013 missed opportunities rate of 20 percent, suggesting that generally the psychiatrists are completing appointments per their scheduling grids.

[33] Four of the 8 full-time psychiatrists on average completed within 5 patient encounters of their grid availability while 3 psychiatrists were at least 15 encounters less than their grid availability. (See Table 1.)

Allegation: "Productivity data reported to VA Central Office was inconsistent with the number of veterans seen by psychiatrists per day."

We substantiated that the productivity data reported to VACO was inconsistent with the number of daily patient encounters. We found that the system's CPT coding error rate exceeded VHA's minimum accuracy standard thereby compromising the VHA productivity metric.[34] We found that the system did not conduct VHA-required reviews and coding/documentation education of individual clinicians with high error rates.

We determined that there was a very low correlation[35] between the VHA-defined[36] median daily encounters and the productivity data. (See Table 1.) When we applied a model assuming that the value of the productivity measure changed in a simple linear way with corresponding changes in VHA-defined median daily encounters, our analysis found that less than eight percent of the variability was explained. In other words, the changing values of the number of patient encounters completed were not reflected accurately by the VHA productivity metric.

Table 1. System Psychiatrists' FY 2013[37] Encounters Per Day and Productivity

Psychiatrist*	Median Daily Encounters#		Productivity Measure^
	Face-to Face Only	VHA-Defined	
A	10	11	2210
B	4	6	2855
C	5	5	2351
D	4	8	2791
E	7	8	2228
F	7	7	2509
G	5	8	5595
H	10	10	4268
I	5	10	3732
J	8	8	2294
K	8	12	3711
L	8	8	3302
AVERAGE	**7**	**8**	**3154**

Sources: #FY2013 Psychiatry Encounters Per Day, VA St. Louis HCS, +OIG data analysis, ^OPES FY2013 Physician Productivity Cube, VHA

*Full-time A–G; Part-time H–K - Adjusted to Full-Time Equivalent; and Full-time Administrative L.

We found that system psychiatrists' CPT miscoding may have contributed to the inconsistency between patient encounters and the VHA productivity measure. Given that the VHA productivity measure is derived principally from coding of outpatient

[34] VHA Handbook 1907.03, *Health Information Management Clinical Coding Program Procedures,* September 26, 2012.
[35] Pearson product-moment correlation coefficient (r) is a measure of the linear correlation between two variables X and Y, giving a value between +1 and -1 inclusive, where 1 is total positive correlation, 0 is no correlation, and -1 is total negative correlation. For this analysis, we determined that r = 0.281.
[36] VHA Directive 2009-002, *Patient Care Data Capture*, January 23, 2009. VHA-Defined Encounters include all face-to-face patient encounters including inpatient and those with additional staff present or by telephone.
[37] Use of FY 2013 data when available to address the time period of complainant's allegations.

encounters,[38,39] we reviewed the system's audit of the CPT coding for the 20 percent of MH encounters that were billable for May through August 2013. We reviewed the audits of 10 of the 12 outpatient psychiatrists who submitted more than 10 total billable encounters for this 4-month period. The 10 psychiatrists miscoded (upcoded or downcoded) an average of 87 percent of the encounters.[40] Assuming that this 20 percent sample is representative of the psychiatrists' coding practices, the 13 percent coding accuracy rate was markedly below VHA's minimum target of 95 percent accuracy.

On average, 53 percent of the encounters we reviewed were upcoded, and the individual psychiatrists' upcoding ranged from zero to 89 percent of the total billable encounters. Thirty-five percent of the encounters were downcoded with the individual psychiatrists' downcoding ranged from zero to 99 percent. These coding errors likely impacted the productivity metric.[41]

We also reviewed psychiatrist FY 2013 wRVUs per encounter across same level complexity facilities. Consistent with our finding of psychiatrist upcoding, the system averaged 1.63 wRVUs per psychiatrist encounter, which was above 1.46, the national average for 1a complexity level facilities. The 1a facilities ranged from 1.08 (Richmond, VA) to 2.18 (San Juan, PR). Six of 31 other 1a complexity level facilities ranked higher than the system. We did not look at upcoding at these other facilities as part of this inspection.

HIM staff offered four "CPT Code Update" training sessions with two sessions in December 2012, one session in November 2013, and one in December 2013, to address the 2013 CPT coding changes.[42] We did not find evidence that HIM staff completed additional reviews for clinicians who had ongoing high error rates in their coding, as required by VHA.[43] Managers informed us that, due to HIM staffing vacancies, individual clinician reviews were not completed for approximately 2 years prior to our site visit in July 2014.

[38] The complainant informed OHI that a month after he became Chief of Psychiatry, he learned that some psychiatrists were upcoding (entering higher complexity CPT codes than were appropriate for services rendered). However, we found no evidence that the complainant took actions at that time related to this concern.
[39] The week before the OHI site visit, the ACOS requested HIM staff conduct a coding audit of psychiatrists on staff who were below 75 percent or 200 percent higher than the of the productivity wRVU target. Four of the 12 outpatient psychiatrists included in this audit (Psychiatrists F, G, I, and J) had accuracy rates that ranged from 5 to 89 percent with a median accuracy rate of 77 percent and an average of 62 percent.
[40] Psychiatrists F and I did not have coding data available and were therefore excluded from the coding analysis.
[41] Psychiatrist A with the most daily median encounters of the full-time psychiatrists, downcoded 97 percent of the time and had a productivity metric below the VHA range suggesting that the productivity metric was deflated by coding error. Psychiatrist G with average number of daily encounters and the highest productivity had an upcoding rate of 89 percent suggesting that the productivity metric was inflated by this error. Psychiatrists B and C with below average median daily encounters upcoded 81 and 53 percent of the time, respectively, and had above benchmark productivity that was likely inflated by the coding error.
[42] Two psychiatrists (Psychiatrists A and B) attended all four sessions, four (Psychiatrists C, E, G, and J) attended three sessions, five (Psychiatrists D, F, H, K, and L) attended two sessions, and one (Psychiatrist I) attended one session.
[43] VHA Handbook 1907.03, *Health Information Management Clinical Coding Program Procedures,* September 26, 2012.

Allegation: The system is in the lowest tier of [psychiatrist] productivity.

We did not substantiate that the system ranked in the "lowest tier of productivity." We found the system's average psychiatric output was above the VHA specified benchmark for FY 2013.

We examined FY 2013 outpatient psychiatrist productivity data compiled by OPES.[44] We found that the productivity for the 12 outpatient psychiatrists ranged from 2210 to 5595 with an average of 3154, which is 23 percent above the VHA specified productivity benchmark of 2574.[45] (See Table 1.)

For further consideration of the complaint that the system ranked in the lowest tier of productivity, we compared the system's FY 2013 overall (inpatient and outpatient) psychiatry productivity with the 31 other same complexity level facilities. The national FY 2013 productivity average was 2648 with a range of 1609 (Richmond, VA) to 4366 (San Juan, PR). The system's inpatient and outpatient psychiatry staff productivity was 3129. The system ranked in the top 10 percent of productivity with only 3 of 31 other same complexity level facilities ranked higher than the system.

Allegation: MH Leadership was manipulating the productivity measure data.

Specifically, the complainant alleged that the ACOS manipulated the labor mapping factor of the productivity equation denominator to improve productivity data reviewed by VACO. We did not substantiate the allegation.

In order to manipulate productivity data via labor mapping, the ACOS would have to artificially reduce providers' FTE(c), in other words, report that the percentage of time dedicated to direct patient care activities was less than the actual time. However, national data reflected that the system had the highest MH psychiatric FTE(c)[46] compared to other 1a complexity level facilities. This data contradicts the assertion that the ACOS was reducing the providers' FTE(c). In fact, it suggests that system psychiatrists have the highest direct patient care assignment of any other same complexity level facility.

As a matter of procedure, VHA provided specialized productivity-related software access only to the COS and appointed administrative support staff including the system's MH Data Analyst (not the ACOS). This access only permitted generation of reports and not data entry or modification. We found no evidence that system personnel manipulated data related to psychiatric productivity.

[44] We found that of the 12 system outpatient psychiatrists with primarily individual psychiatric care duties, 4 were under and 6 were above the VHA specified productivity target range of 2317 to 2831.
[45] The psychiatrist with the lowest productivity was 11 percent below the lower limit of VHA specified productivity range. The psychiatrist with the highest productivity was 98 percent above the higher limit of the VHA specified productivity range.
[46] The system's psychiatrists' FTE(c) was 92.6 percent, with the lowest 1a complexity level facility at 69.9 percent (San Diego, CA) and a national average of 82.3 percent. Office of Productivity and Efficiency 2013 data, received on December 2, 2014.

Allegation: The complainant's "…efforts to increase access to care were inexplicably thwarted" by his supervisors; "…bitterly resisted by all the specialties" providing clinical care; and, following his removal from his position, psychiatrists' performance reverted back to a low level by December 2013.

We did not substantiate that the complainant's efforts to improve access to care "were inexplicably thwarted" by his supervisors. We found evidence of COS support for the complainant's proposed initiative to address psychiatry access and productivity. We did substantiate negative feedback from some of the clinicians. We found that shortly after the implementation of this initiative, there were serious accusations of wrongdoing by multiple staff psychiatrists resulting in an administrative review. We did not substantiate that psychiatrists' patient encounters per day reverted back to a lower level subsequent to the complainant being relieved from his duties.

Both the complainant and recently appointed outpatient psychiatry lead reported concerns to the COS about the system's outpatient productivity. In January 2013, the COS encouraged Lean Thinking[47] training and a formal performance improvement (PI) project. The complainant and outpatient psychiatry program lead participated in Lean Thinking training. The outpatient lead served as the PI project leader, and a staff ophthalmologist (with success in optimizing his service) served as the facilitator. In addition, the team included the Chief of Psychiatry, two staff psychiatrists, a MH registered nurse, a social worker, and a Health Administration Services[48] staff member. The team met the first week in March and determined an outcome solution to improve outpatient psychiatrist productivity by reducing psychiatric appointment times from 30 minutes to 15 minutes.

In addition to the approved training and PI project described above, we found other examples of support provided to the complainant in his role as Chief of Psychiatry. The COS agreed to the complainant's organizational restructuring request that included assigning three psychiatrists as leads, which involved promotions to a higher salary tier and reassignment of the psychiatrists' clinical and administrative time/tasks.

The complainant had minimal previous managerial experience. In an effort to foster development in this area, the COS and ACOS arranged and supported multiple sources of physician leader mentoring. Atypical for a Service Chief, the complainant received mentoring from the COS at least twice monthly. Additionally, the COS arranged for the Chief of Medicine, a physician with experience in improving physician productivity, to meet with the complainant for weekly mentoring. Further support came from bi-weekly telephone mentoring with another VISN 15 physician leader, weekly meetings with the former ACOS, and an additional meeting that included this former ACOS and the Chief of Psychology. The complainant also pursued "informal mentorship" from four psychiatrists who worked in academia and private practice.

[47] Lean Thinking is a method to think about how to organize human activities to deliver more benefits to society and value to individuals while eliminating waste. http://www.lean.org/whatslean/. Accessed December 5, 2014.
[48] Health Administration Service (HAS) includes administrative functions essential to the effective overall benefit management, impacting inpatient and outpatient care such as facilitating enrollment and determining eligibility.

Despite being generally aware of the PI initiative, the psychiatrists and acting MH outpatient clinic program manager were not informed of or prepared for the shortened appointments set up during June through July. Psychiatry leadership changed four psychiatrists' scheduling grid appointments' duration from 30-minute to either 15- or 20-minute appointments. Subsequently, staff raised several concerns. For example, the staff psychiatrists asserted that the reduced appointment times led to overcrowded waiting room conditions, which contributed to an unprovoked assault event. Additionally, staff had concerns about managing an increased volume of patients, including the impact on nursing and other non-psychiatry staff involved in patient care.

In July 2013, the complainant and psychiatry staff had a meeting, during which some psychiatrists complained to the COS and ACOS. In an August 2013 follow-up meeting with the ACOS, psychiatrists described the complainant as disrespectful and threatening and, in particular, expressed feeling intimidated and concerned for their jobs.[49] Subsequent to receiving the ACOS' report on this meeting, the COS recommended that an Administrative Investigative Board be conducted. Consistent with VA standard operating procedures, the complainant was relieved from his Chief of Psychiatry duties and assigned clinical responsibilities during the investigation. Additionally, the four psychiatrists' scheduling grids were restored to the prior 30-minute per patient schedule.

To evaluate whether psychiatrists' performance reverted to a low level by December 2013, we reviewed the August and December patient encounters per day data for the four outpatient psychiatrists whose schedules were changed in June and July.[50] This limited analysis indicated that there was not a meaningful change of median patient encounters per day with reversion of the scheduling grids. The August and December patient encounters per day were similar. (See Table 2.)

Table 2. Encounters Comparison During and Following Grid Change

Four Outpatient Psychiatrists with Schedule Grid Changes	Encounters Per Day[51]	
	August 2013	December 2013
B	8	7
D	6	7
G	9	8
K*	8	6
Mean	**7.75**	**7**

*Source: FY2013 Psychiatry Encounters and Grid Data, VA St. Louis HCS data; *Part-time staff*

[49] In Handbook 0700, Administrative Investigation Board, http://www.va.gov/ogc/investigations.asp, VA authorizes convening of an Administrative Investigative Board in cases where there are allegations of suspected threats, abuse, or deliberate injury to employees.
[50] We reviewed August data as that data would reflect the changes made in June and July.
[51] VHA-defined median encounters.

Allegation: "Fake" MH Service "…consult notes are being entered into patient record to game the system to make it appear that the veteran was evaluated by a doctor much sooner than what is happening."

In June 2014, the complainant, then Chief of Psychiatry, wrote the VA Acting Secretary that consults were being inappropriately closed with the intent of appearing as though an appointment with a provider was completed sooner than when it actually took place. Complainant 2 identified the same concern about inappropriately completed consults to the OIG OAE when interviewed regarding other allegations. OAE conducted an inspection of the above allegation and determined that some consults were improperly closed due to a performance issue of a staff member.

OAE determined that a system staff member closed 12 of 20 sampled consults inappropriately during the period of October 2013 through April 2014. According to OAE, this staff member reportedly lacked knowledge and training on consult management and inadvertently documented the 12 appointments as "completed" prior to the patient actually being seen by a provider.[52]

OHI focused on a review of a total of 15 patient EHRs to determine if the inappropriate consult management process resulted in adverse outcomes. Our review included the 12 patients identified by OAE and an additional 3 patients provided by the complainant.

We found that of the 15 improperly closed consults we reviewed, staff had not followed up with two patients from the OAE identified group who were referred by their psychiatric provider for ancillary MHC group treatment. In both of these patients' cases, the treating psychiatric provider submitted consult requests for group treatment. For the first patient, 2 days after the staff member entered a consult note that stated the information would be forwarded to the group leader, the group leader documented that the patient was placed on the group wait list. We found no evidence that a staff member informed the patient of this information, and at the next psychiatric appointment that the patient attended (3 months later), the patient expressed interest in counseling. The psychiatrist provided information about MH services at the Vet Center and referred the patient to a system psychologist with whom the patient engaged in treatment the following month. The second patient received treatment from a psychologist and an APRN. The APRN submitted a request for stress management group treatment and when contacted, the patient was unable to begin the group and requested "…to be called about attending the group" the following month. We found no evidence of any follow-up to the patient's requested start date for group treatment.

In the three cases provided to OHI that the complainant considered examples of medical record falsification (Patients 1–3 in Appendix A), we found that although the staff member had prematurely "completed" consults with a note, MHC psychiatry appointments were scheduled appropriately. The identified inappropriate

[52] VA Office of Inspector General, *Review of Allegations of Inappropriately Completed Consults and Inappropriate Bonuses at the St. Louis VA Health Care System,* Report No. 14-03434-530, September 29, 2015.

documentation practice did not appear to be a barrier to care for these three patients, and there were no delays or adverse events.

In summary, although a MHC staff member "closed" consults by virtue of documentation, we found no adverse outcomes related to this erroneous consult management process in the 15 patient cases reviewed. We found poor follow-up to two consults submitted for ancillary group treatment.

Issue 2: Access and Quality of Assessments and Care

Allegation: "Veterans seeking treatment experience waits well in excess of the standard of care."

The complainant alleged that the wait time for a new appointment in FY 2013 was 25 days, and for a follow-up appointment, the wait time was 30 days from the desired follow-up date.

We substantiated the allegation of delays for new patients and established patients seeking MHC and PTSD outpatient treatment in FY 2013. We found that the new patient appointment delay amounted to 3 days longer than the 14-day VHA requirement in place at the time, not 25 days. The delay for established patients was 1.7 days longer than the desired appointment date. We found, however, that the COS was aware of the wait times and had supported the complainant's request for a system redesign to address the problem. During our review, we found that a MHC nurse failed to assess a patient's treatment needs adequately, which contributed to a delay in care and a missed opportunity for optimum clinical intervention.

MHC All Services Wait Times Data

An OIG report, *Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System,* identified concerns regarding the accuracy of VHA nation-wide wait time data.[53] As one component of its response, VHA revised the definition of wait time goals to be "…not more than 30 days from either the date that an appointment is deemed clinically appropriate by a VA health care provider, or…the date a Veteran prefers to be seen for hospital care or medical services."[54] Given that these events occurred during the inspection period, we also reviewed FY 2015 wait time data.

Using VSSC data, we found that the FY 2013 average wait time for system MHC new patients (not solely psychiatrist appointments) was 16.6 days while nationally it was 13.8 days. VHA FY 2014 data indicated that the system MHC average wait time for

[53] VA Office of Inspector General. *Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System*, Report No. 14-02603-267, August 26, 2014.
[54] *Report to Congress on the Veterans Choice Program Authorized by Section 101 of the Veterans Access, Choice, and Accountability Act of 2014*, (Pub. L. 113-146), http://www.va.gov/HEALTH/docs/VA_Report_Section101-PL_113-146-Final.pdf, October 3, 2014.

new patients decreased to 13.4 days, and the national average was 13.7 days.[55] VHA FY 2015 data indicated a system MHC wait time of 13.8 days and a 12.8 day national wait time.

In FY 2013, FY 2014, and FY 2015, established MHC system patients had average wait times from desired appointment date of 1.7, 2, and 1.8 days, respectively. The national average wait times were 1.2, 1.2, and 0.5 days, respectively.

Another perspective on appointment availability is the third next available appointment.[56] Per VHA data, the system MHC FY 2013 third next available appointment was 20 days, which was higher than the national average of 15.4 days. In FY 2014, the system MHC average third next available appointment reduced to 16.1 days although the national average (14.9 days) showed minimal change from FY 2013. FY 2015 data indicated that the system MHC third next available appointment time reduced to 13.3 days while national appointment time increased to 15.9 days.

PTSD Clinic Wait Times Data

Using VSSC data, we found that the FY 2013 median wait time for system PTSD new patients (not solely psychiatrist appointments) was 11.5 days comparable to the national 11.4 days. VHA FY 2014 data indicated that system PTSD median wait time for new patients decreased to 9.3 days, and the national average was 12.6 days.[57] VHA FY 2015 data indicated a continued trend of reduced wait times with the system PTSD Clinic wait time of 8.4 days, which was less than the 11.2 day national wait time.

FY 2013, FY 2014, and FY 2015 established PTSD patients had median wait times from desired appointment date of 1.1, 1.4, and 1.8 days, respectively. These wait times are longer than the respective national median wait times for 0.4, 0.4, and 1.8 days, respectively.

Per VHA data, the system PTSD FY 2013 third next available appointment was 34.3 days, which was higher than the national median of 12.2 days. In FY 2014, the system PTSD average third next available appointment reduced to 26.9 days although the national average (12.9 days) showed minimal change from FY 2013. FY 2015 data indicated that the system PTSD third next available appointment time decreased to 20.6 while national time decreased to 12.2 days.

[55] This national data is consistent with FY 2014 system data in which the median average new patient wait time decreased to 12 days with a range of zero to 33 days and included 8 clinics with less than 14 day access.
[56] Third next available appointment is defined as the average length of time in days between the day a patient makes a request for an appointment with a physician and the third available appointment for a new patient physical, routine exam, or return visit exam. The "third next available" appointment is used rather than the "next available" appointment since it is a more sensitive reflection of true appointment availability. http://www.ihi.org/resources/Pages/Measures/ThirdNextAvailableAppointment.aspx. Accessed March 9, 2015.
[57] This national data is consistent with FY 2014 system data in which the median average new patient wait time decreased to 12 days with a range of zero to 33 days and included 8 clinics with less than 14 day access.

MHC and PTSD Clinics Psychiatry Only Wait Times

We found that wait times for new and established patients seeking MH treatment exceeded VHA's 14-day and 30-day requirements applicable in FY 2013.[58] Using available FY 2013 system data, we tabulated average new patient wait times for the outpatient MHC and PTSD Clinic psychiatrists. We found that the range of wait times for new MHC or PTSD Clinic patients in FY 2013 was zero to 70 days with a median of 17 days. Of the 14 outpatient psychiatry individual clinics, 6 clinics were below 14 days average new patient wait time.

For MHC and PTSD Clinic psychiatrists, the FY 2014,[59] average established patient wait times from desired appointment date had a median value of 3 days, with a range from 0.83 to 10.2 days.

Leadership Response to Wait Times

As previously discussed, in early 2013, the ACOS and COS supported a PI project to address wait times, which the complainant and the outpatient psychiatric lead had proposed. In March 2013, the PI committee recommended decreasing psychiatric follow-up appointment duration from 30 minutes to 20 minutes. Given problems with the implementation of the project, the ACOS, in April 2014, charged the Acting MH Program Manager with a system redesign project to address scheduling and access problems. Efforts to implement the accepted system redesign initiatives have been ongoing and included the April 2014 establishment of a PC-MH Service Agreement. The multidisciplinary redesign team's June 2014 final proposal focused on implementation of an electronic consult system to streamline the referral process and standardization of a missed appointment procedure. Facility-provided access data for FY 2015 indicated that the facility generally exceeds national benchmarks.

Delay of MHC Treatment (Patient 4)

The complainant provided a patient example of what he considered to be a prolonged delay of treatment in the MHC. Specifically, he alleged that a patient, "…who was suffering a deterioration of his illness and needing medications refilled, was turned away and given an appointment for months later, after the patient rode with a 'buddy' a long distance to the MHC." The complainant reported, "I found it difficult to believe that no one could spare 15 minutes to address this veteran's urgent medical needs." The complainant provided OHI with an email he sent to MHC staff regarding his concerns about the patient's care needs and access.[60] (See Appendix B for patient 4 case details.)

[58] 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. Although an amendment related to appointment time frames was made in December 2015, the recertification date of the Handbook was not modified.
[59] FY 13 established patient wait times data was not available when requested.
[60] Staff provided this unscheduled patient with an appointment 7 weeks later.

We substantiated that an appointment was not provided within VHA-required timeframes. Based on our EHR review, we did not substantiate that the patient's MH condition had deteriorated, that his needs were urgent, or that a provider refused to see the patient. However, the nurse's failure to bring a provider into the decision making process while the patient was in the clinic resulted in a deficiency of care.

Allegation: "Many patients unnecessarily drop out of treatment" and there was "a very high no-show rate of 35 percent."

We did not substantiate that "many patients unnecessarily drop out of treatment" or that the system had a "very high no-show rate of 35 percent."

The complainant described the basis for this allegation as, "In the settings I know, most people see their patients at least four times a year." He asserted that the system "…had a 30 percent drop from one visit to second…then another 30 percent drop from second to third." From this, he concluded "…60% of the patients were dropping out of care after one or two visits with their psychiatrist." The complainant explained, "If I ask who is coming at least three times a year, I lose another 30 percent. In the settings I know, most people see their patients at least four times a year. Forty percent are coming three times or more." As such, the complainant alleged that the system psychiatrists were performing at a lower level as compared to "…not-for-profit psychiatric clinics in the St. Louis area."

Treatment dropout is defined in various ways in the psychiatric literature depending upon population, treatment setting, and other factors. Examples of MH treatment dropout definitions include a 12-month gap in treatment[61] or quitting treatment before the provider recommended.[62] The complainant's definition of treatment dropout was uniquely based on a cumulative percentage of appointments attended in a 12-month period. This standard for treatment retention has not been used by VHA or non-VHA settings. Therefore, we cannot compare the complainant's dropout rates with other VA or non-VA settings to determine whether system psychiatrists were performing at a lower level as alleged.

Aside from premature termination of treatment, there are other viable explanations for a patient not returning for care more than one to three times per year. For example, the psychiatrist treatment plan may prescribe twice yearly visits for patients stable in maintenance treatment and/or receiving interdisciplinary treatment; patients may be managed in other treatment settings, such as primary care; patients may have relocated; patients may have chosen alternative treatment; and/or psychiatrists may not have recommended further treatment. Therefore, the complainant's cumulative

[61] McCarthy, John F, Blow, Frederic C, Valenstein, Marcia, Fischer, Ellen P, Owen, Richard R, Barry, Kristen L; Hudson, Teresa J, Ignacio, Rosalinda V, *Veterans Affairs Health System and Mental Health Treatment Retention among Patients with Serious Mental Illness: Evaluating Accessibility and Availability Barriers,* Health Services Research, 2007 June, 42(3 Pt 1): 1042–1060.
[62] Offson, Mark, Mojtabal, Ramin, Sampson, Nancy A., Hwang, Irving, Kessler, Ronald C, *Dropout from Outpatient Mental Health Care in the United States,* Psychiatric Services, 2009 July, 60(7); 898–907.

percentage methodology was not designed to determine whether patients were dropping out of treatment prematurely.

We did not substantiate that the system MHC or PTSD Clinics (PCT 1 and 2) had no-show rates of 35 percent. VHA's target for missed opportunities (which includes no-shows)[63] is 10 percent although the FY 2013 national averages for individual treatment in the MHC and PCT were 18.18 and 18.06 percent, respectively. VHA FY 2013 data indicated that the missed opportunity rate for individual treatment in the system MHC was 19.25 percent, which was approximately 6 percent higher than the national average. The system PCT individual FY 2013 missed opportunity rate was 13.54 percent, which was 25 percent lower than the national average. In FY 2014, the system reduced its missed opportunity rates such that the MHC was equivalent to the national rate while the PCT rate continued to be lower than the national rate. (See Table 3 below.)

Table 3. System and National MHC and PTSD Clinics (PCT 1 & 2) Missed Opportunity Percentage Rates FY 2013 and 2014

Fiscal Year	Clinic (Individual Treatment Only)	System	National
FY 2013	MHC	19.25	18.18
	PCT 1 & 2	13.54	18.06
FY 2014	MHC	18.91	18.95
	PCT 1 & 2	12.51	18.66

Source: VSSC Wait Time Cube, VA St. Louis HCS

We also reviewed a subset of the missed opportunity data provided by the system that included missed opportunity rates specifically for MHC and PTSD psychiatrists. The psychiatrists had an FY 2013 average missed opportunities rate of 20.1 and 16.1 percent, respectively. FY 2014 psychiatry MHC and PCT average missed opportunity rates remained approximately the same.

The system data also included no-show specific rates for individual psychiatry appointments in the MHC and PCT clinics. The average no-show rates were 15.2 and 12.4 percent, respectively. FY 2014 psychiatry MHC and PCT average no-show rates remained approximately the same.

[63] A missed opportunity is an unused appointment slot including patients' "no-shows" and cancellations after the appointment time.

Allegation: Psychiatrists co-signed controlled substance orders for APRNs without ever seeing the patient, which was a risk to the veteran's health and was unethical.

We substantiated that psychiatrists were co-signing controlled substance orders for APRNs without seeing the patient. However, we did not substantiate that this practice was a risk to the patient's health or unethical. We found that the APRNs' and collaborating psychiatrists' management of patients prescribed controlled substances fell within the usual scope of professional practice as defined by VA with no requirement for collaborating psychiatrists to see patients who were evaluated by APRNs. Further, we found that APRNs are expected to inform patients of their role and VA does not require additional disclosure.

APRN Scope of Practice

VA requires that APRNs comply with the state of licensure's authorization to prescribe controlled substances.[64] APRNs are required to practice under the rules of whatever state issued their license, independent of the State in which they practice.

The system's five outpatient MH Services APRNs were licensed in Missouri. Consistent with VA's requirement, the system had scope of practice documentation that included identification of a collaborating physician.[65] Missouri is one of nine states in which practice and licensure regulations do not allow APRNs to prescribe Schedule II controlled substances.[66,67,68] However, in Missouri the collaborating physician may delegate to the APRN the authority to administer, dispense, or prescribe controlled substances listed in Schedules III, IV, and V; the APRN's Schedule III prescriptive authority is limited to a 5-day supply with no refill.[69] More restrictive than Missouri's regulations, the system 2006 Standard Operating Procedure specified that APRNs could not prescribe controlled substances.[70] Consistent with the local Standard Operating Procedure, the system MH APRN scope of practice specified the APRN's routine duty to prescribe medication excluding narcotics and controlled medications.

In an OHI interview, the complainant highlighted two major concerns regarding APRN practice that involved lack of (1) direct contact with the patient by the physician and

[64] VHA Directive 2008-049, *Establishing Medication Prescribing Authority for Advanced Nurses*, August 22, 2008. This Directive expired August 31, 2013 and has not yet been updated.
[65] VHA Directive 2008-049, *Establishing Medication Prescribing Authority for Advanced Nurses*, August 22, 2008.
[66] American Association of Nurse Practitioners, http://www.aanp.org/images/documents/federal-regulation/PrescriptiveAuthorityMap06-12.pdf,. Accessed December 3, 2014.
[67] Substances are placed in their respective schedules based on whether they have a currently accepted medical use in treatment in the United States, their relative abuse potential, and likelihood of causing dependence when abused. http://www.deadiversion.usdoj.gov/schedules/#define. Accessed September 21, 2015.
[68] Schedule II medications include stimulants, for example methylphenidate. http://www.deadiversion.usdoj.gov/schedules/#define. Accessed September 21, 2015.
[69] Missouri State Board of Nursing, Nursing Practice Act and Rules, http://prmo.gov/boards/nursing/npa.pdf, accessed December 11, 2014.
[70] Chief of Staff Standard Operating Procedure Nol. 66, *Advanced Practice Nurse Practice Arrangements*, February 8, 2006. This Standard Operating Procedure expired February 8, 2009.

(2) "informed consent." The complainant questioned the appropriateness and safety of APRNs ordering controlled substances for patients, and psychiatrists subsequently signing the medication orders but not meeting with the patient. The complainant expressed particular concern about the safety of this practice since he was familiar with a tragic situation involving a Missouri VHA patient (not of the system) who was treated by an APRN.[71] The complainant also expressed concern about APRNs and psychiatrists having "two different levels of expertise" and the situation of not obtaining the patient's informed consent to see an APRN rather than a psychiatrist.

Each of the five system MH outpatient APRNs was assigned a collaborating psychiatrist, and the APRNs' scopes of practice included both APRN and collaborating physician signatures. One of the five APRNs had a primarily managerial role and did not perform medication management although the APRN provided supportive counselling. One of the collaborating psychiatrists did not agree to have the assigned APRN managing patients who were prescribed controlled substances, and therefore the psychiatrist saw those patients. Three APRNs and their collaborating psychiatrists acknowledged that the psychiatrists sometimes prescribed controlled substances, such as benzodiazepines, for patients who were seen only by the APRNs. This was done by means of the APRN setting up the electronic order for the psychiatrist and the psychiatrist signing the order. Although the APRN did not technically prescribe the controlled substance, the need for the controlled substance was based upon his/her assessment and consultation. According to the Federal Drug Enforcement Administration and Missouri Bureau of Narcotics and Dangerous Drugs, there is no absolute requirement for the physician to meet face-to-face with the patient before ordering controlled substances under these circumstances. Our review of FY 2013 adverse events found none related to MH APRN medication management.

The complainant acknowledged that the collaborating psychiatrist is given an hour per week for meeting with the APRN to discuss patients. Collaborating psychiatrists and MH APRNs told us of regular formal meetings and accessibility as needed to discuss patients for whom the APRN was providing care.

Regarding informed consent, nursing leadership reported that it is standard practice for APRNs to identify themselves as APRNs to patients, there is MHC signage denoting the APRN title, and three of the four[72] APRNs have their degree/certification displayed on their lab jackets. The system APRNs did not routinely inform patients about their collaborating physician although nursing leadership stated that any patient could see the psychiatrist as requested or needed.

[71] We did not review the particular Missouri case cited by the complainant since it was beyond the scope of this inspection.
[72] One of the APRNs retired prior to our inquiry with leadership regarding the lab jackets.

Allegation: Five C&P evaluations were "substandard resulting in long delays to providing much needed benefits or in some circumstances serving as an absolute bar to the access to statutorily provided benefits."

We did not substantiate that five C&P evaluations identified by the complainant were clinically substandard. The determination of whether delays occurred in benefits or barriers to accessing benefits was beyond the scope of this healthcare inspection and therefore not addressed in this report. We reviewed the C&P documentation and determined only whether the C&P evaluations were clinically substandard. Appendix C includes OHI review of the five complainant-provided patient cases that included specific allegations of "substandard" C&P evaluations.

C&P Process

Veterans submit claims to VBA for military service related disability compensation or non-service-connected pension benefits. Service-connected disability benefits are provided if the veteran's claimed disability is a result of an event, injury, or disease incurred or aggravated in military service.[73] To determine if the claimed disability is related to military service, VBA requests a C&P disability examination. Typically, these examinations are conducted by VA medical staff or VA contract providers. The evaluator provides diagnoses and clinical opinions regarding the claimed disability's relationship to the veteran's military service as well as the functional impact of the disability on the veteran. VBA makes a rating decision on the veteran's disability compensation based on the medical disability evaluation report and other relevant information.

In 2012, VHA issued a directive that required C&P examiners be competent to:

- Diagnose all mental disorders.
- Provide an assessment of each veteran using the multi-axial system as set forth in American Psychiatric Association's Diagnostic and Statistical Manual - IV Edition (DSM-IV).
- Determine when clinician-administered psychometric testing is necessary and integrate the results of such testing into the examination reports.
- Assess the need for, and effectiveness of, pharmacological and non-pharmacological treatment.
- Provide a prognosis with respect to each mental disorder or condition.
- When necessary, comment on the significance of the veteran's prior MH assessments (as reported) with respect to symptoms, occupational history, social history, and global assessment of functioning.

[73] Veterans Benefits Administration, Compensation, http://www.benefits.va.gov/compensation/index.asp. Accessed January 13, 2015.

- Identify veterans presenting with complex diagnostic questions or other issues that are beyond the examiner's expertise, and refer those veterans identified to a board-certified, or board-eligible, psychiatrist or a licensed doctorate-level psychologist who has the expertise necessary to complete the C&P mental disorder examination.[74]

In 2010, VA implemented the use of Disability Benefit Questionnaires (DBQs) with the goal of speeding up the process of C&P claims. For MH, VA has three DBQs—Eating Disorders, Mental Disorders (other than PTSD), and PTSD.[75]

VHA specifies that an initial MH C&P evaluation must be conducted by either a:

(1) Board-certified psychiatrist;

(2) Psychiatrist who completed an accredited psychiatry residency and who is appropriately credentialed and privileged;

(3) Licensed doctoral-level psychologist;

(4) Non-licensed doctoral-level psychologist working toward licensure under close supervision by a board-certified, or board-eligible, psychiatrist or a licensed doctoral-level psychologist; or

(5) Psychiatry resident under close supervision by a board-certified, or board-eligible, psychiatrist or a licensed doctoral-level psychologist.[76]

A MH C&P evaluation for a review or increase can be conducted by the above mentioned professionals as well as other MH professionals such as licensed social workers or physician assistants under close supervision of a board-certified psychiatrist or licensed doctoral-level psychologist. In compliance with The Joint Commission's requirement for evaluation of practitioners' professional performance on an ongoing basis, VHA conducts discipline-specific Ongoing Professional Practice Evaluation (OPPE). The OPPE is conducted to monitor professional competency, identify areas for possible performance improvement by individual practitioners, and use objective data in decisions regarding continuance of practice privileges. To meet the OPPE requirement, the system Psychology Credentialing Council consists of senior psychologists who review two EHRs quarterly, including those who complete C&P exams. For C&P evaluations, the reviewing psychologist determines if documentation includes patient history, severity and functional impact of symptoms, appropriate assessment procedures, diagnosis and data congruency, as well as any ethical violations. The system psychiatrists have a similar oversight process.

[74] VHA Directive 2012-021, *Compensation and Pension Qualifications*, August 27, 2012.
[75] VBA Compensation, http://www.benefits.va.gov/COMPENSATION/dbq_ListByDBQFormName.asp. Accessed January 15, 2015.
[76] VHA Directive 2012-021, *Compensation and Pension Qualifications*, August 27, 2012.

Allegation: The "specialized PTSD Clinic staff" inappropriately refused veterans specialized PTSD treatment services.

The complainant reported that he had informed the Office of Special Counsel that the PTSD Clinic staff inappropriately refused six patients (Patients 10–15) specialized PTSD treatment services. Later, in emails to OHI, the complainant identified an additional four patients (Patients 16–19) whom he alleged were inappropriately not provided access to the PTSD Clinic. Further, one system APRN provided OHI four patient examples (Patients 20–23) in which staff member referrals to the PTSD Clinic were declined.

Although we did not substantiate that the "specialized PTSD Clinic staff" refused veterans treatment, we found that the PCT 2 staff mismanaged specialized PTSD treatment services resulting in a missed opportunity for one of the 14 identified patients[77] (Patient 18). We also found that a former system staff member failed to provide timely military sexual trauma (MST) treatment (Patient 13), the referral process from VBA Vocational Rehabilitation and Employment to the system was not reliable (Patient 19a)[78], and that a patient was not included in treatment planning and never received group treatment (Patient 22). In one patient's EHR, we found that a C&P evaluator referred to the veteran by two erroneous last names, and a second evaluator entered another veteran's report in that EHR (Patient 10).

Appendix D includes our review of the above 14 patient cases (Patients 10–23) that also includes specific allegations of inappropriate refusal of PTSD treatment services.

Allegation: "Denial of care to a veteran in a minority group based on a very poor psychological evaluation." Further, the complainant alleged that the ACOS:

- Had "very little concern for the veteran"
- Had "special interest" in the psychologist evaluator
- "Concluded that the VA could not provide a second opinion as it was too complex, instead he fee-based this veteran to a community psychologist," which was contradicted by the patient's receiving psychotherapy from a VHA psychology intern.

We did not substantiate the complainant's allegations that a patient (Patient 24) was denied hormonal treatment based on a "grossly inadequate" and "very poor" psychological evaluation by a staff psychologist. We determined that a second evaluation was completed by a community clinician, and the patient received the care

[77] A PCT 2 Clinic nurse did not document contact with a walk-in patient, and staff's follow-up contact attempts were unsuccessful.

[78] On multiple occasions and from two different locations, we tried the pre-programmed facsimile machine that the vocational counselor routinely used for referrals. We got recurrent no answer/failure to deliver messages. The system Quality Manager informed us that the facsimile machine number was an active "public posted fax number" to the system executive office that received one or fewer clinical facsimiles received per day.

requested, thus ultimately there was no denial of hormone treatment. (See Appendix E for patient case details.)

We did not substantiate the complainant's allegations that the then Chief of Psychology had "very little concern for the veteran," "special interest" in the psychologist evaluator, and did not want to understand the complainant's goal of wanting a "decent evaluation" for this patient. Nor did we substantiate the complainant's allegation that the then Chief of Psychology's conclusion that VA could not provide a second opinion due to complexity and instead referred the patient through Non-VA Care to a community psychologist was contradicted by the patient's receiving psychotherapy from a VHA psychology intern.

We did not find any statements or evidence that the Chief of Psychology had "very little concern for the veteran," "special interest" in the psychologist evaluator, or that he did not want to understand the complainant's goal of wanting a "decent evaluation" for this patient. Email evidence indicates that the Chief of Psychology communicated agreement with some aspects of the complainant's criticism of the evaluation report and supported getting a second opinion.

We found no evidence to support the allegation that the Chief of Psychology asserted that VA could not provide a second opinion due to complexity and instead referred the patient to a community psychologist even though the patient was receiving psychotherapy from a psychology intern. We found no explicit discussion in the VA EHR of the reasons for obtaining a second opinion as a Non-VA Care referral but note that the argument of connecting the second opinion evaluation to the patient's psychotherapy care by a psychology intern assumes false equivalence of evaluation and psychotherapy in spite of the different goals.

In their email string, the ACOS and the complainant both commented about the professional ability of the VA psychologist who had conducted the review. These comments addressed different issues and were not mutually exclusive. Overall, they appeared to be expressing differing opinions of the expertise of a colleague. A review of the psychologist's 2012–2014 OPPEs did not identify professional ability concerns. While the complainant may disagree with the ACOS' opinion, resolution of this difference of opinion was beyond the scope of this review.

The complainant also alleged that the COS had initially responded to the complainant that he would consider a review of the psychologist's evaluations (as the evaluation in question was extremely poor) and her hiring, but then he stated that the ACOS' assurance that the psychologist was doing an adequate job was sufficient for him (the COS). We did not conclude that the psychologist's report would be characterized as "extremely poor." We found that the COS used accepted administrative practice in relying on the judgment of the Chief of Psychology to assess the professional competence of a staff psychologist. Further, the provider's OPPEs contained no evidence of problematic performance.

The complainant also informed OHI that this psychologist "had another veteran complaint in July 2014" and that the complainant was deliberately not included in this

complaint evaluation. We could not substantiate this allegation. We found no patient advocate report regarding the psychologist.

Issue 3: Administrative Processes

Allegation: A suicide attempt by an inpatient veteran during a Joint Commission visit was covered up and not reported to The Joint Commission, and corrective actions were deliberately delayed.

We did not substantiate that a suicide attempt by a MH unit inpatient during a Joint Commission visit was covered up. (See Patient 25, Appendix F.) After review of the pertinent records, we concluded that the incident in question did not qualify as a suicide attempt. In terms of reporting requirements, VA requires all facilities to conduct root cause analyses on all inpatient suicides and report all suicides and serious suicide attempts to the National Center for Patient Safety.

Given that this was neither a completed suicide nor a serious suicide attempt,[79] the system was not required to report to The Joint Commission. Further, system staff followed local procedures to address clinical concerns and identified environmental concerns. We found that staff managed the clinical issues appropriately and informed relevant managers for follow-up to the environmental concerns. Our interviews and email review did not support the allegation that corrective actions to the events were deliberately delayed.

Allegation: Follow-up investigations of three patients' deaths were inadequate, and the complainant's requests to investigate were turned down inappropriately.

We substantiated that there was an insufficient follow-up investigation in two of the three complainant-provided[80] patient cases. (See Patients 26 and 28 summaries, Appendix G.) Specifically, we identified deficiencies in the peer review process including a failure to include a relevant provider(s), timeliness issues, and inadequate administrative follow-up [Redacted pursuant to 38 U.S.C. § 5705]. We found that two of 13 FY 2013 peer reviews exceeded both the required initial and final review timeframes.[81] Only one FY 2014 peer review did not meet timeline requirements.

We did not substantiate that the complainant's requests to investigate the "…avoidable death of a young combat veteran" (Patient 26) and "…an elderly veteran" (Patient 27) to improve quality of care at the VA were turned down inappropriately.

[79] The Centers for Disease Control and Prevention (CDC) defines a suicide attempt as non-fatal self-directed potentially injurious behavior with any intent to die as a result of the behavior.[79] A suicide attempt may or may not result in injury. http://www.cdc.gov/violenceprevention/suicide/definitions.html. Accessed January 6, 2015.
[80] Complainant 2 provided Patient 28 information.
[81] VHA Directive 2010-025, *Peer Review for Quality Management,* June 3, 2010. Initial and final reviews are to be completed within 45 and 120 calendar days of determination of the need for the review. This Directive expired June 30, 2015, and has not yet been updated.

Allegation: "Bonuses are considered automatic, irrespective of performance, based on erroneous 'productivity' data."

We did not substantiate that bonuses were considered automatic and irrespective of performance but rather that the ACOS used five specific performance objectives to determine performance pay. Further, we could not substantiate that the productivity data were erroneous. We found that the May through August 2013 CPT coding data underlying the productivity measure were unreliable; however, the effect on the productivity measure was beyond the scope of this inspection.

VHA physician and dentist pay consists of base pay,[82] market pay,[83] and performance pay. Performance pay is the third required component of physician pay. The purpose of performance pay is "to improve the quality of care and health care outcomes through the achievement of specific goals and objectives related to the clinical, academic and research missions of VA."[84] In other words, physician performance pay is an incentive to achieve goals of the organization. Typically the service chief defines the goals and performance objectives (benchmarks) with ACOS and ultimately COS approval. Per the American Federation of Government Employees March 2011 Master Agreement, an appropriate "Department official" should communicate the goals, objectives, and the maximum amount of performance pay awarded with achievement of the specified goals and objectives to the physicians by July 3, which is 90 days prior to the beginning of the fiscal year.[85]

Each physician is eligible for performance pay contingent upon his/her individual achievement towards the goals. The goals need to be met in full or are considered as not met and the pay is prorated accordingly. In one fiscal year, any individual physician's performance pay may not exceed the lower of $15,000 or 7.5 percent of that physician's annual pay.

In addition to performance pay, employees may be eligible for a performance award (bonus). The US Office of Personnel Management requires that performance awards (bonuses) may be given only to career executives (managers) and are for performance during the previous appraisal period.[86] The amount of an award must be between 5 percent and 20 percent of the manager's rate of basic pay as of the end of the performance appraisal period. Generally, total award payments in an agency are limited to 10 percent of the aggregate amount of a manager's basic pay.

[82] Base pay is determined by the physician's assigned table and tier.
[83] Market pay is a component of the base pay intended to reflect the recruitment and retention needs for the specialty or assignment of a particular physician.
[84] VA Directive 5007, *Pay Administration*, April 15, 2002.
[85] American Federation of Government Employees, Master Agreement, http://www.va.gov/LMR/docs/Agreements/AFGE/Master_Agreement_between_DVA_and_AFGE-fin_March_2011.pdf, Article 55, Paragraph O-P, March 2011.
[86] Office of Personnel Management, https://www.opm.gov/policy-data-oversight/senior-executive-service/compensation/#awards. Accessed March 11, 2015.

For FY 2011–2014, the Office of Personnel Management and the Office of Management and Budget issued guidance limiting the overall spending on performance awards. Performance awards were limited to 5 percent of the aggregate salary of career members instead of the usual 10 percent. The limitations on individual awards (5–20 percent) remained the same.

According to the ACOS and COS, the complainant, in his role as Chief of Psychiatry, did not set up the required psychiatry performance pay goals and objectives for FY 2013. According to the American Federation of Government Employees Master Agreement, the pay goals and objectives should be set up within 90 days of the beginning of the fiscal year (July 2012 in this instance). The complainant was not yet appointed as Chief of Psychiatry at that time; however, April 2013 emails indicated that the ACOS had directed him to address this requirement with psychiatry staff. The May 2013 psychiatry staff meeting minutes, authored by the complainant, noted that performance pay was reviewed and "briefly touched upon the elements of this for the next fiscal year that we will develop and discuss over the next months." After the complainant was detailed to another position (September 2013), the COS directed the ACOS to develop the five performance objectives that included productivity (100 percent or greater of 2011 national median of psychiatry productivity), completed EHR encounter documentation, follow-up on depression and PTSD clinical reminders and inpatient discharges, and two or fewer valid patient complaints.

The ACOS rated each psychiatrist on the goals and objectives above and, based on the rating, recommended a percentage of performance pay. Productivity had to be at least 100 percent of the 2011 national psychiatry wRVU median (2574) and was worth 20 percent of the total rating. Of the 13 outpatient psychiatrists, 9 received ratings that supported full performance pay. Based on insufficient productivity but sufficient performance on the four other objectives, two psychiatrists (Psychiatrists E and J) received 80 percent of their full performance pay. Psychiatrist H received 70 percent of full performance pay due to inadequate clinical reminders follow-up.

The complainant alleged that the productivity data used in this process was "erroneous." We determined that the MH Data Analyst compiled the data quarterly based on reported wRVUs and the FTE adjusted for leave and dedicated clinical time per labor mapping for that quarter. The Data Analyst then obtained the wRVU data from the VISN 15 Data Warehouse, and for each psychiatrist, entered the specific CPT code frequency, total wRVUs, and wRVU target, which was calculated from the 2011 median wRVU value and the adjusted FTE. We reviewed the spreadsheet used in the performance pay productivity calculation and did not find evidence of an erroneous methodology.

The other FY 2013 "bonuses" were $1,350 performance awards given to each of the three psychiatrist program leads for "outstanding" performance appraisal ratings and were consistent with Office of Personnel Management guidance.

Use of VHA's productivity metric benchmark as one criterion for performance pay was a reasonable decision given that this is the required VHA standard for productivity. Given the required performance and supportive data compiled to determine eligibility, we did not find that the awarding of performance pay was automatic or irrespective of

performance. Although our review identified erroneous CPT coding that contributed to the productivity metric, productivity accounted for 20 percent of the total potentially awarded performance pay while the remaining 80 percent was based on factors other than productivity.

Allegation: There was a lack of reliable veteran feedback about their experience of outpatient MH care.

We did not substantiate a lack of reliable feedback about patients' outpatient MH care experiences. The system was compliant with VHA's requirements for obtaining stakeholder feedback.

We found that the system had several mechanisms to obtain feedback from patients receiving outpatient MH care including the Survey of Healthcare Experiences of Patients (SHEP), 2013 LEAD class project, Patient Advocacy Program, Office of MH Operations satisfaction survey, MH Consumer–Advocate Liaison Council, and local feedback surveys.

VHA requires all facilities to participate in SHEP, a standardized survey of patient experiences that includes inpatient and outpatient MH care.[87] The system participates in this required survey.

The system 2013 leadership program (LEAD)[88] class members identified a gap between the administration of the SHEP and the obtained limited local applicability results as their required interdisciplinary class project. The LEAD class conducted a comprehensive analysis of current point of care survey tools utilized in VHA and the applicability for the needs of the system. In February 2014, the end of the 12-month program, the LEAD class members presented their point of care survey recommendations to the Medical Executive Board. Due to changes in interim system leadership, the implementation process was not initiated until August 2014.

Another source of stakeholder feedback required by VHA is obtained through the system's Patient Advocacy Program.[89] The patient advocacy program ensures that patients can meet with a patient advocate to disclose any complaints and concerns.

In 2013, the Office of MH Operations conducted an initial MH Veterans Satisfaction Survey of randomly selected patients who had received outpatient MH services at each VHA facility. Each facility received a report that included results at the facility, VISN, and national levels. The system's report stated that the overall results were "overwhelmingly positive" with many areas of strength identified.

[87] VHA Office of Analytics and Business Intelligence, Patient Experiences, http://vaww.car.rtp.med.va.gov/programs/shep/shepReporting.aspx. Accessed March 17, 2015 and November 21, 2016.
[88] LEAD is a 12-month developmental leadership program for competitively selected high performance VHA employees with goals of leadership positions.
[89] VHA Handbook 1003.4, *Patient Advocacy Program*, September 2, 2005. This VHA Handbook was scheduled for recertification on or before the last working day of September 2010 but has not yet been recertified.

Another MH-specific mechanism for feedback is the local MH Consumer-Advocate Liaison Council that is composed of MH treatment consumers, family members of consumers, and other stakeholders such as Veteran Service Organizations.[90] Strongly encouraged by VHA, the goal of this council is to facilitate input from stakeholders and therefore is another source of consumer satisfaction information. The system MH Services has established a Veteran Advisory Council that reports directly to MH leadership.

The system MH Services programs collected patient satisfaction data intermittently. We reviewed two examples of FY 2013 program anonymous "point of care"[91] surveys from the PCT 1 Clinic and MHC–West. The PCT 1 Clinic Patient Satisfaction Survey included 188 patient respondents and inquired about treatment quality, accessibility, and overall experiences. The survey provided patients an opportunity to offer comments of dissatisfaction and suggestions for change. The MHC–West survey had 372 patient respondents and included ratings of satisfaction with each staff member, cleanliness, phone accessibility, and appointment scheduling ease in addition to comments.

The complainant pursued the development of another MH point of care survey in the spring of 2013. The MH quality improvement specialist was engaged in supporting the complainant's efforts. The complainant suspended this project when he was detailed from the Chief of Psychiatry position.

Conclusions

Regarding Psychiatrists' Productivity and Data Reporting:

We substantiated:

- Some system outpatient psychiatrists completed fewer encounters per day in FY 2013 than were available in their daily schedules or typical in community MH settings. System outpatient psychiatrists with primarily individual treatment responsibilities completed an average of 8 VHA-defined patient encounters per day with a range of 5 to 12. We also found that psychiatrists' scheduling grids were, in general, set up with fewer appointment slots than would be expected based on their dedicated clinical time (FTE(c)).

- The productivity data provided to VACO were inconsistent with the number of daily patient encounters in FY 2013. We found a low correlation between the number of psychiatry encounters and the VHA wRVU-based productivity measure.

[90] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.
[91] Point of care survey occurs at the time of the health care service provision.

We did not substantiate:

- The system ranked in the "lowest tier of productivity" when compared to other same-level complexity facilities although we did find significant variability in productivity amongst psychiatrists.

- MH Leadership manipulated the data provided to VACO.

- The complainant's "…efforts to increase access to care were inexplicably thwarted" by his supervisors; "…bitterly resisted by all the specialties" providing clinical care; and, following his removal from his position, psychiatrists' performance reverted back to a low level by December 2013.

- Adverse outcomes from inappropriately closed consults.

We also found:

- The system's CPT coding error rate exceeded VHA's minimum accuracy standard during the time frame of May through August 2013, and the system did not complete VHA-required education for individual clinicians with high coding error rater.

- Inadequate follow-up for two patients referred for ancillary MHC group treatment.

Regarding Access and Quality of Assessments and Care:

We substantiated:

- In FY 2013, the system had an average delay of 3 days for outpatient MHC and PTSD treatment with significant variability amongst the psychiatrists' clinics.

We did not substantiate:

- Many patients drop out of treatment prematurely or a missed opportunity rate of 35 percent.

- APRNs and collaborating psychiatrists engaged in unethical behavior with regard to prescribed controlled substances or informed consent.

- Five C&P evaluations were substandard and lacked critical information.

- PCT staff inappropriately refused PTSD treatment services to 14 patients (10 identified by the complainant and 4 patients identified by a system APRN).

- "Denial of care to a veteran in a minority group based on a very poor psychological evaluation," or that the ACOS:

    - Had "very little concern for the veteran"
    - Had "special interest" in the psychologist evaluator

- "Concluded that the VA could not provide a second opinion as it was too complex, instead he fee-based this veteran to a community psychologist" which was contradicted by the patient's receiving psychotherapy from a VHA psychology intern

During our 2014 review, we also found:

- An unscheduled (walk-in) MHC patient was given an appointment approximately 7 weeks later.
- The MST Coordinator, no longer with the system, was not timely in MST treatment or follow-up.
- A PCT 2 Clinic nurse did not document contact with a walk-in patient, and staff's follow-up contact attempts were unsuccessful.
- The "public" facsimile machine used by VBA Vocational Rehabilitation and Employment (and located in the system's executive suite) was not reliable.
- A PTSD Clinic patient was not included in treatment planning that included transfer to the MHC.
- Two C&P evaluators entered erroneous information in a veteran's EHR.

Regarding Administrative Processes:

We substantiated:

- System managers insufficiently investigated two of three patient deaths that occurred 2013–2014. Specifically, we found deficiencies in the inclusion of all relevant clinicians, timeliness and follow-up to two peer review processes and one management review.

We did not substantiate:

- A suicide attempt by a MH unit inpatient during a Joint Commission visit was covered up or that related corrective environmental actions were deliberately delayed.
- The complainant's requests to investigate the deaths of two veterans were turned down inappropriately.
- Bonuses were considered automatic, irrespective of performance.
- The system had lack of reliable feedback about patients' outpatient MH care experience.

Recommendations

1. We recommended that the Acting System Director ensure that Mental Health Service reviews daily psychiatric patient care activity and determine if productivity is consistent

with work relative value unit-based productivity and meets reasonable expectations for number of patients treated.

2. We recommended that the Acting System Director ensure that staff psychiatrists' scheduling grids are consistent with expected patient care activity.

3. We recommended that the Acting System Director ensure that processes be strengthened to review and rectify psychiatry staff's Current Procedural Terminology coding errors.

4. We recommended that the Acting System Director ensure that processes be strengthened for timely response to mental health clinic group treatment patient referrals.

5. We recommended that the Acting System Director ensure that mental health staff adequately assess and document treatment needs and follow-up arrangements for unscheduled (walk-in) patients.

6. We recommended that the Acting System Director ensure that facsimile machine numbers provided to referral sources are functional and appropriately located for timely response.

7. We recommended that the Acting System Director strengthen the Compensation and Pension evaluation documentation processes to enhance accuracy of information.

8. We recommended that the Acting System Director ensure that processes be strengthened to include patients in treatment planning when they are transferred to another clinic.

9. We recommended that the Acting System Director ensure that peer reviews are inclusive of all relevant clinicians and timely and that managers take appropriate follow-up actions, if indicated.

Appendix A

Consult Management – Patients 1–3

Patient 1

In 2014, MH Residential Rehabilitation Treatment Program staff entered a MHC consult upon the patient's discharge directly from the rehabilitation program into a domiciliary program. That same day, the MHC nurse scheduled the appointment for approximately 6 weeks later and prematurely marked the consult as "completed." The patient attended the MHC psychiatry appointment and requested reduction in sleep medication, which was the only change the psychiatrist made to the medication protocol. We found no adverse outcomes.

Patient 2

In 2014, after approximately 4 years of providing three to five psychiatric visits a year, the PC-MHI psychiatrist referred the patient to the MHC. Approximately a week later the MHC nurse prematurely marked the consult as "completed" and scheduled a psychiatric appointment 6 weeks later, which the patient attended. We noted no lapse in care.

Patient 3

In 2014, during a primary care visit, this patient was referred to a PC-MHI psychologist to address depression and anxiety secondary to a medical condition. When he declined short-term psychotherapy and requested psychotropic medication, the PC-MHI psychologist submitted a MHC consult for psychotropic medication management. Five days later, the MHC nurse called the patient and sent a letter requesting a call back for scheduling. The next day, the nurse prematurely marked the consult as "completed" and added a note that the patient's wife stated they will call after the patient's C&P evaluation, which was scheduled three weeks later "…if they want him seen." On the day of the scheduled C&P evaluation, the evaluator noted that the patient and his ex-wife had the MHC contact information and added a consult comment that the patient was requesting "the earliest available appointment." Approximately 2 weeks later, a social worker notified the patient of a MHC psychiatry appointment scheduled for the following month. The patient was evaluated during the subsequent appointment. We found no lapse in care or adverse outcome.

Appendix B

MHC Access – Patient 4

This patient had a long history of MHC treatment at the system. In calendar year 2012, the patient presented for 3 medical appointments but did not present (no-showed) for the 14 scheduled MH appointments. MH staff cancelled an additional five appointments.

In 2013, this patient walked in, without an appointment, to the MHC and expressed frustration about not being able to reach staff by phone. He told the nurse that he had a friend drive him to the MHC so he could get medication refills and schedule appointments with his therapist and prescribing provider. The patient denied MH "issues" including alcohol or other substance abuse and suicidal or homicidal ideation. The nurse provided the patient with her contact information and sent a request to the prescribing provider for medication refills. The nurse also notified the clerk that the patient needed an appointment; the clerk scheduled the patient for an appointment in 2 months.

Later the same day, the prescribing provider documented that the patient had not been seen since 2011, and his prescriptions had not been filled since 2012; therefore, it was not safe to prescribe without an evaluation. The prescriber tried unsuccessfully to contact the patient by phone and wrote "Undersigned to write letter to veteran askig [sic] him to call anc [sic] clarify when he last took requested meds." However, there is no documentation that a letter was sent.

The nurse also documented that management would be informed of clerks' "inaccessibility" and that MHC voicemail should be "reinstated." Approximately 2 weeks after the walk-in contact, a MH Quality Improvement Specialist forwarded the documentation to MH leadership, including the complainant. The complainant electronically mailed the prescribing provider to contact the patient and noted that, "…we MUST improve access urgently" and informed the outpatient psychiatrist lead of the situation.

The patient did not show for the 2013 appointment that had been scheduled 2 months after the day of the walk in or two subsequent appointments and staff were unsuccessful in contacting the patient.

Appendix C

C&P Evaluation – Patients 5–9

Patient 5

The complainant alleged that a psychologist did not determine an appropriate diagnosis of PTSD at the time of a C&P evaluation.

A Vietnam veteran and Purple Heart recipient, who was 70 percent service connected, received PTSD treatment in the community. He enrolled in VHA for the first time in 2011. At that time, a system psychologist diagnosed him with Adjustment Disorder. Approximately 13 months later in 2012, a psychologist (Dr. Z) conducted a C&P exam to evaluate the patient for an increase in his 70 percent service connection for PTSD. As required, Dr. Z reviewed the EHR and claims folder and completed the Initial PTSD DBQ that includes an inquiry regarding PTSD symptom clusters. Dr. Z concluded that the veteran did not exhibit the avoidance symptoms and, therefore, did not meet the full criteria for a PTSD diagnosis. Dr. Z diagnosed the veteran with anxiety disorder and depressive disorder and noted that "his symptoms were as likely as not related to his military service experiences." On the DBQ, Dr. Z noted that the "veteran perseverated on his physical condition throughout the interview" and that this "…may have superseded his report of behavioral problems."

Four months after Dr. Z's evaluation, VBA returned the C&P examination to the system for "reconciliation of conflicting medical evidence" in response to the submitted opinion of a private psychiatrist who concluded that the veteran demonstrated avoidance symptoms of PTSD and was "totally socially and occupationally impaired by his PTSD." Dr. Z provided two reasons why the VA examination should stand: (1) unlike the private psychiatrist, Dr. Z was specifically trained to conduct C&P evaluations, and (2) the veteran's avoidance symptoms were not specific to trauma and thus did not fulfill criteria warranting a diagnosis of PTSD (per 2011 and 2012 evaluations).

In 2014, the complainant conducted a C&P evaluation to determine if the veteran's requested increase in service connection for generalized anxiety disorder was warranted. The complainant documented the veteran's complaint that the 2012 evaluation "did not give him an appropriate chance to explain his symptoms, instead, that it disproportionately focused on his pain and physical condition." Further, the complainant wrote that the veteran stated that the 2012 evaluation was "frequently interrupted by telephone calls…" and that he "did not feel heard." The complainant documented that he focused his 2014 evaluation on the veteran's "claim of having PTSD in order to reconcile the differing [professional] opinions" and "to satisfy [the veteran's] request to be heard." The complainant "confirmed the background history" documented by Dr. Z. He also explained that the veteran stated he did not readily speak about his "…traumatic experiences unless he has to [if asked by his doctors] and that could also be one of the reasons why he may not have reported the full spectrum of PTSD symptoms" in the initial 2011 VHA evaluation**.**

We did not find Dr. Z's evaluation clinically substandard. Our review concluded that Dr. Z and the complainant documented similar background information although the veteran provided significantly more detailed trauma-related information in the complainant's interview than in previous evaluations. In part, this may be attributed to the veteran's expressed complaint about "feeling rushed" by Dr. Z and that the complainant was, therefore, able to interview with additional knowledge about the veteran that enhanced the likelihood of disclosure. It appears that Dr. Z and the complainant both cited distinct and partial information from the 2011 VHA psychological evaluation. Although Dr. Z reviewed the veteran's injuries and related experience, we did not find evidence of "disproportionate" focus on physical problems. Dr. Z specifically identified the veteran's perseveration of physical pain symptoms as an issue during the evaluation. The veteran's reported dissatisfaction with Dr. Z's evaluation was beyond the scope of this report. It is noted, however, that no related complaint was filed with the patient advocate's office at the time.

Patient 6

The complainant alleged that a psychology "Resident[92] under supervision did NOT do a reasonable review of his records and offered a speculative opinion that was not supported by evidence that was available in 2007." We did not substantiate the allegation.

In 2007, a psychology resident conducted a C&P examination on a middle-aged non-combat veteran to determine service connection for "severe depression." The resident reviewed the claims file, service medical records, and VHA EHR and included all VBA-required elements (pre-military and military history, a mental status exam, and current symptomatology) in the evaluation. The resident did not conduct psychological testing due to the veteran's cognitive limitations discovered upon the mental status exam. The resident concluded that the veteran was of borderline intelligence, had a history of mood-related disturbance beginning during his military service, and that a developmental history may have affected the veteran's psychological adjustment and coping skills. Specifically, the veteran reported that in childhood he spent a "considerable amount of time alone" due to "…being verbally abused by his father and 'bullied' and 'picked on' by all the other children at school and in the neighborhood." The resident concluded that "it is equally likely as not that the veteran's psychological symptoms predated the service." As required, the report was co-signed by a supervisory psychologist.

In 2014, the complainant evaluated the veteran in response to a subsequently submitted claim for depression. The complainant focused his interview on the veteran's experiences prior to joining the Air Force to clarify the conclusion from the

[92] There are two types of psychology trainees, interns and residents. Psychology interns are pre-doctoral candidates who must fulfill the internship requirement towards their doctorate degree. Psychology residents are trainees who have obtained a doctoral degree and are fulfilling the supervised experience requirement for licensure or other continuing education objectives.

2007 evaluation. In his evaluation, the complainant confirmed that the information regarding the veteran's childhood in the 2007 evaluation was accurate. A difference, however, was that in the 2014 evaluation, the veteran asserted that he did not consider himself abused since he was not the only child in his class who was bullied and his father's physical punishments did not cause serious injury. As such, the complainant concluded that the veteran's pre-military service history did not contribute to depression.

Based on our review of the C&P evaluations, both the resident's and the complainant's evaluations contained relevant and generally similar history and symptomatology with some notable differences of information and opinion. Although the reports included differences in information garnered from the records, we found evidence in the 2007 report that the resident reviewed the records. For example, the resident wrote that the record did not specify the veteran's type of discharge from the military and contained no evidence of a reason for his discharge. The complainant documented that the veteran's personnel records and letter of notification identified that the veteran received an honorable discharge as a result of being diagnosed with a personality disorder. Although the resident's account of the records differs from that of the complainant, this information would not likely impact the diagnostic formulation.

The resident's report reflected review of the record in statements such as, "Additionally, both notes from Psychiatry and Psychology in the service did not see evidence of depressive symptomatology. The veteran was, in fact, regarded as 'fit for duty.'" However, the complainant noted that the veteran met criteria for Major Depressive Disorder during his military service and that "…his account is corroborated by his Personnel Records…"

[Paragraph redacted pursuant to 38 U.S.C. § 7332]

The major difference of clinical opinion between the two evaluations is that the resident viewed the veteran's pre-military history "as likely as not" in contributing to his depression disorder; while the complainant emphasized that the disorder was incurred during the service. It is noted that the resident does not say the veteran's depressive disorder was caused by childhood experiences but rather that it is as likely a contributor as is military experience. There is, however, no way to be certain either way, and it appeared that each MH professional formed their clinical opinions based on the information deemed salient at the time of evaluation.

Our review concluded that the resident did not form opinions without supportive evidence as alleged. There are multiple reasons for the possible difference of clinical opinion including that the complainant's focus on the veteran's childhood in the evaluation that may have elicited the veteran's more complex cognitive perspectives regarding his early history. However, one cannot with certainty conclude that a childhood that admittedly includes bullying and physical punishment has had no impact on a person's coping and emotional management. Additionally, given the span of almost 7 years between evaluations, which included ongoing MH treatment, it is also possible that the veteran presented a different perspective of his personal history in 2014.

Patient 7

We did not substantiate that a C&P evaluation conducted in 2010 by a psychologist (Dr. X) was "…dismissive, prejudicial and incompetent…" and "grossly sub-standard."

The complainant was "particularly bothered by" one of Dr. X's statement in the veteran's 2010 C&P evaluation that the complainant considered "wrong and unconscionable." Our review concluded that in the context of the entire evaluation, Dr. X's statement in the 2010 C&P report regarding the relationship of inactivity and mood disturbance, although poorly constructed, was intended to reflect the veteran's own statements regarding the impact of inactivity (unemployment) on her mood and not be dismissive of her emotional challenges.

In 2010, a female veteran submitted a service-connection claim for PTSD due to MST. A contract C&P psychologist, Dr. X, completed the evaluation and documented detailed information regarding behavioral observations, developmental history, sexual trauma experiences, MH and physical conditions (including multiple sclerosis and diabetes mellitus) and symptoms, a mental status exam, and results of select psychological tests. Dr. X documented that the veteran exhibited "…only one clear symptom in cluster C for PTSD and indicates relatively good success in managing it." Based on the veteran's presentation, Dr. X concluded that depressive disorder, not otherwise specified (NOS) was "the best diagnostic approach" and that "It can at least as likely as not, be attributed to numerous events that occurred during her time in the service." In an integrative summary, Dr. X noted that the veteran described "…some irritability, but clearly says that the irritability may be due to her lack of employment and a lack of a general direction for her life. She does report some mild claustrophobic and somewhat vigilant behaviors, but they appear to be controllable through her own cognitive interventions" and that "...significant components of her depression include her unemployment, her multiple sclerosis, her general pain complaints, et cetera, and most of these have some connection to conditions for which she is already service-connected."

The complainant considered Dr. X's following statement, "…WRONG and unconscionable." At the end of the report, Dr. X wrote: "It is worth observing; however, that were she able to reduce the amount of time that she has to sit around being dysphoric about her physical and social conditions, she would almost certainly functionally improve. The only real alternatives that she seems able to generate are employment and she reports that vocational rehabilitation has not been particularly supportive." Following Dr. X's C&P evaluation, the veteran was awarded service connection for depression.

Four years later, the complainant was asked to address the veteran's new claim of memory loss secondary to multiple sclerosis. The complainant conducted a PTSD diagnostic evaluation and documented the patient's specific traumatic memories. The complainant concluded that memory loss was secondary to PTSD-related concentration difficulties. It is possible that the patient's report of the impact of military experiences was different in the second evaluation thereby providing the complainant a different perspective of the veteran's MH issues. These differences might be at least partially

attributable to the veteran's engagement in intensive psychiatric treatment for the 4 years between evaluations.

[Paragraph redacted pursuant to 38 U.S.C. § 5705]

We found Dr. X's evaluation to include relevant and detailed history and psychosocial functioning information as well as reasoning for diagnostic conclusions. We did find the one statement noted by the complainant to be misinterpreted if taken out of context of the information presented earlier in the report. However, we found no evidence that the evaluation was dismissive, prejudicial, incompetent, or grossly substandard.

Patient 8

We did not find the C&P evaluation to be clinically substandard.

The complainant alleged that Dr. X's C&P evaluation of a veteran was "just absurd and dismissive of the veteran."

In 2013, Dr. X completed the DBQ and documented veteran history, military history, current symptomatology, and a review of PTSD symptom clusters. Dr. X noted that the veteran was "unable to give a specific incident of trauma" and that he was traumatized by fear of imminent death. He diagnosed PTSD while noting that not all symptom clusters were strongly endorsed. Approximately 1 month later, VBA requested that Dr. X review the examination and "…state whether the veteran has a diagnosis that meets the…" criteria in the DSM-IV or Fifth Edition. Specifically, they asked Dr. X to reconcile the assigned PTSD diagnosis and statement that the veteran's disability is related to his fear of hostile military service with his statements "that symptoms are incomplete by DSM-IV standards" and that "PTSD is as unlikely as not a tenable diagnosis." Dr. X responded, "I do not consider this to be a strong case" for PTSD, and "the most credible possible trauma is fear being in a war zone, although that criterion is only recognized by CO and not by the APA."

VBA sent a request for a medical opinion from document review and specified that "two psychiatrist specialist[s]" (not Dr. X) be assigned. The complainant reviewed the case and highlighted information in a 2012 psychiatric evaluation in which the patient reported that his convoy frequently came under small arms fire without any injuries to self or others reported.

A key issue in VBA's request for an evaluation review is related to the difference in the definition of stressor between DSM-IV and VBA. DSM-IV PTSD diagnosis required that the individual had been exposed to a traumatic event in which the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others. For PTSD service connection claims, VBA accepts reports of a "…stressor that is …related to fear of hostile military or terrorist activity, if a VA psychiatrist or psychologist confirms the

claimed stressor is adequate to support a diagnosis of PTSD, and the veteran's symptoms are related to the claimed stressor."[93] The difference between these two criteria is subtle but clear—DSM-IV required an event; whereas VBA requires fear of hostile military or terrorist activity.

As an additional source of information, we requested that the system Psychology Credentialing Council conduct a de-identified review of Dr. X's initial report using the OPPE process. The Chair of the committee and two senior psychologists reviewed the C&P report and determined that there were no remarkable concerns with the basic assessment and diagnosis information (including review of relevant history, assessment of severity and functional impact of symptoms, and diagnosis congruent with data reported).

We concluded that although Dr. X's initial report and follow-up response were indecisive and therefore ineffective for the intent purposes of a C&P rating, we would not characterize them as absurd or dismissive. We did not find the C&P evaluation to be clinically substandard.

Patient 9

We did not find the evaluation to be clinically substandard.

The complainant alleged that Dr. X "comes to the absurd conclusion that getting struck by lightning that nearly killed the veteran would not qualify as a traumatic event."

In the 1970s, this veteran was struck by lightning. He was service-connected for chronic ear infections, tinnitus,[94] and impaired hearing since 2007, labyrinthitis[95] since 2008, and limited motion of arm since 2009.

In 2012, Dr. X conducted the C&P evaluation related to the veteran's claim for PTSD related to the lightning event. At the time of the evaluation, the DSM-IV, Text Revision, specifically defined a trauma as "direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity… The person's response to the event must involve intense fear, helplessness, or horror." Dr. X reviewed the available military records, EHR, and completed the DBQ. Dr. X documented that the patient reported that he was immediately unconscious and "Even considering waking up in the hospital to have been traumatic to this hospital [sic, veteran] could not tell me what his emotional reaction was." Therefore Dr. X reasoned that although the veteran experienced an event that involved threatened death or serious injury, his response did not involve intense fear, helplessness, or horror.

[93] M21-1MR Compensation and Pension Manual, Web Automated Reference Material System, Part IV, Subpart ii, Chapter 1, Section D, http://www.benefits.va.gov/warms/M21_1MR.asp. Accessed March 14, 2015.
[94] Tinnitus is noise or ringing in the ears. Mayo Clinic, http://www.mayoclinic.org/diseases-conditions/tinnitus/basics/definition/con-20021487. Accessed February 12, 2015.
[95] Labyrinthitis is an ailment of the inner ear and a form of unilateral vestibular (balance) dysfunction. Medline Plus Medical Encyclopedia, http://www.nlm.nih.gov/medlineplus/ency/article/001054.htm. Accessed February 12, 2015.

Additionally, Dr. X assessed the veteran as meeting criterion for two of the required three avoidance symptoms. Dr. X, therefore, concluded that the veteran did not meet full criteria for PTSD. He did, however, diagnose simple phobia related to the lightning event, and as a result, the veteran was granted service-connection for this disorder.

Our review of the EHR found that in 2011, a neurologist referred the patient to a psychologist to address depression. The psychologist diagnosed depressive disorder, NOS. Three months later, following Dr. X's C&P evaluation, a VHA psychiatrist completed an initial evaluation and diagnosed the patient with specific phobia (lightning) and noted that the patient's "…depressive symptoms are more likely related to obstructive sleep apnea and cognitive disorder than a primary depression." As such, the same symptoms that the complainant attributed to PTSD, another psychiatrist attributed to other non-psychiatric medical conditions. Additionally, the facility had administered two PTSD screenings, in 2007 and 2012, and both were negative (scores of zero and two respectively). Also noteworthy is that in a 2014 C&P evaluation, a cardiologist referring to the lightning event documented that the patient "…did not have a syncopal episode from this event. STRs [service treatment records] don't show that he had a cardiac arrest and/or was resuscitated from any such event contrary to the history (brief clinical) appended to the Holter monitoring, chemical stress tests, cardiac catheterization or ECHO cardiogram performed 2008 and 2010 two of which appear below under remarks. His cath was negative for ischemic heart disease and there is no proven histoory [sic] of MI [myocardial infarction] or significant arrhythmias on the Holter monitoring."

Although it is uncertain whether Dr. X was aware of the absence of documented evidence of resuscitation at the time of the event, it provides a challenge to the assertion that lightning "nearly killed" the veteran. In contrast to the complainant's allegation, it is noted that Dr. X documented that the lightning event was traumatic, but that the absence of the emotional response the event disqualified it as meeting criterion for the development of PTSD at that time. Based on Dr. X's evaluation, as well as the additional information in other available VHA MH and C&P evaluations, Dr. X's conclusions do not meet the definition of "absurd," that is, wildly unreasonable, illogical, or inappropriate. We did not find Dr. X's evaluation to be clinically substandard.

Appendix D

PTSD Clinic – Patients 10–23

Patient 10

The complainant alleged that this patient was referred to the PTSD clinic after two psychologists diagnosed PTSD, and Dr. Y, the PTSD Clinic psychologist, "…determined that this veteran did not have PTSD and that he did not need to get specialized services, in essence overriding two independent evaluations." We substantiated that Dr. Y did not diagnose this patient with PTSD but did not substantiate that he overrode two evaluations.

An EHR review indicated that the patient had only one brief MH evaluation contact prior to Dr. Y's assessment. Dr. Y, a PTSD specialist, conducted an in-depth diagnostic assessment. Dr. Y recommended psychotherapy and medication management appropriate for the patient's presenting symptoms and diagnosis at that time. A psychiatrist who evaluated the patient approximately a week after Dr. Y's assessment also did not diagnose PTSD. The patient later acknowledged withholding PTSD-relevant information from Dr. Y, lending further support that the patient was not presenting a diagnostic profile consistent with PTSD at the time of Dr. Y's evaluation.

At the patient's 2010 initial PC evaluation, a physician's assistant referred the patient, a non-service connected returning OIF veteran, to the medical psychologist. The psychologist diagnosed the patient with PTSD after a 30-minute evaluation, consulted with the physician's assistant regarding medication, and submitted a consult to PCT 2. Five days later, Dr. Y, a PCT 2 Clinic psychologist, conducted a comprehensive evaluation including pre-military and military history and administration of the PTSD Checklist – Military (PCL-M).[96] Given that the PCL-M is a self-report inventory and therefore does not confirm a diagnosis, Dr. Y reviewed the patient's endorsed PTSD symptoms in detail. Based on the patient's history and absence of specific symptom criteria for PTSD, Dr. Y diagnosed major depressive disorder and noted that "…the veteran's needs are not best met by the OEF/OIF PTSD Clinic." He consulted with a psychologist in the MHC who agreed to coordinate psychotherapy services and submitted a MHC consult request for ongoing medication management. Eight days later, a MHC psychiatrist evaluated the patient and diagnosed mood disorder, NOS and anxiety disorder, NOS. That same day, a social worker met with the patient and developed a treatment plan to include psychotherapy sessions. The patient initially reported improvement and then did not show for individual psychotherapy or group appointments.

Five months later, the patient met with the medical psychologist who had previously evaluated him and reported that he had not been "forthright in his descriptions of his

[96]The PCL is a 17-item self-report checklist of PTSD symptoms based closely on the DSM-IV criteria. Respondents rate each item from 1 ("not at all") to 5 ("extremely") to indicate the degree to which they have been bothered by that particular symptom over the past month. International Society for Traumatic Stress Studies, http://www.istss.org/PosttraumaticStressDisorderChecklist.htm. Accessed March 12, 2015.

PTSD symptoms…(with Dr. Y)" due to concerns about his military career. The medical psychologist listed five patient-reported symptoms, including "describes noticeable anhedonia" and "avoids talking about war-time experiences." The medical psychologist suggested, "At the current time the veteran appears to be experiencing the full spectrum [sic] of combat related PTSD." That same day the patient had a C&P exam, and the psychologist evaluator concluded that the patient met the PTSD criteria and cited the medical psychologist's note from earlier that day as evidence that the patient met the criteria. The patient received PTSD service connection following a 2011 C&P examination.

We found that one C&P evaluator entered two other last names in addition to this veteran's name in the report and a second evaluator entered a report of an entirely different veteran in this veteran's EHR. We informed system leadership and the C&P Medical Director informed us that actions were taken to address the errors and a review of procedures would be pursued.

Patient 11

The complainant alleged that (1) this PTSD service-connected patient had a "thorough" evaluation, and then a PCT 2 Clinic psychology intern[97] determined diagnoses other than PTSD under the supervision of Dr. Y, and (2) the patient was referred to MHC with the "…earlier evaluations being disregarded by a person with less training and full support … of Dr. Y."

We did not substantiate that the patient had a "thorough" evaluation prior to the PCT 2 Clinic psychology intern assessment or that the psychology intern disregarded the prior evaluation. We did substantiate that the patient was referred to the MHC for treatment of patient-identified non-PTSD concerns; however, we found this was an appropriate treatment decision.

At the patient's 2010 PC evaluation, the physician referred the patient, a non-service connected OIF veteran, to the medical psychologist. During this 30-minute "brief clinical interview," the patient endorsed multiple PTSD symptoms, and the medical psychologist concluded the patient "appears to meet criteria for PTSD." The patient requested a referral to the PCT 2 for "further evaluation and appropriate treatment," and the medical psychologist submitted the consult. Six days later, a psychology intern conducted a comprehensive evaluation including consideration of an earlier life event and the impact on his family relationships. In consultation with Dr. Y, the supervising psychologist, the intern diagnosed generalized anxiety disorder and referred the patient to the MH Clinic for medication management and individual therapy. A week later, the C&P examiner diagnosed PTSD and depressive disorder, NOS. Three days after the C&P examination, a MH Clinic APRN prescribed psychotropic medication and noted that the patient was receiving counseling at the Vet Center.

[97] A psychology intern is a doctoral level trainee who has completed all but dissertation and is enrolled in an approved formal psychology internship program.

We found that the patient, then non-service connected, had one brief evaluation prior to the assessment by the psychology intern that did not definitively diagnose PTSD. By professional standards, a 30-minute brief clinical interview by a non-PTSD specialist would not be considered a "thorough evaluation" compared to the psychology intern's supervised specialized diagnostic assessment. We did not substantiate that the intern disregarded the prior evaluation. We noted that the psychology intern, with a supervisor's approval, referred the patient to the MHC to address the patient's concerns regarding an earlier life event and the impact on family relationships.

Patient 12

The complainant alleged that Dr. Y's evaluation of this patient "read like a transcript from an interrogation" and that "…sadly that this veteran's needs could not be addressed at the PTSD clinic." We did not substantiate the characterization of the evaluation being like an interrogation; we did substantiate that Dr. Y concluded that the patient's needs would be better met at the MHC than the PCT 2 Clinic.

In 2009, a psychology resident conducted a brief clinical interview with a non-service connected patient in the PC setting. The psychology resident administered the PCL-M and reviewed PTSD symptoms and "…deferred to follow-up" by the PCT 2 Clinic. The patient canceled two appointments, and in a phone call with Dr. Y, the patient "expressed interest in who would be meeting with him; it is noted that he expressed interest in meeting with a female assessor and hoped to seek treatment for lability, sex addiction, and anxiety and depression." Dr. Y conducted an in-depth PTSD symptom assessment and included quotes of the patient's responses in the report. Dr. Y concluded that the patient was suffering from personality disorder and other mental health issues and as such, submitted a MHC consult. Subsequently, the patient cancelled several scheduled MHC appointments. The patient had six inpatient psychiatric admissions between 2010 and 2012, and the discharge diagnoses (determined by six different MH clinicians) included depression and personality disorder. These diagnoses aligned with those of Dr. Y.

A clinical interview is a dialogue between a MH clinician and patient with the main purpose of diagnosis and treatment recommendations. In a diagnostic interview, the clinician asks specific questions about symptoms.[98] An interrogation consists of a monologue of statements designed to persuade a person to tell the truth, typically about a crime.[99] Based on these definitions, we did not find evidence that Dr. Y offered a persuasive monologue of statements but rather asked specific questions to elicit details about the patient's symptoms to determine an accurate diagnosis and included the patient's own words in the write-up. We found that Dr. Y's treatment recommendations were consistent with the diagnostic profile that he and six other inpatient MH clinicians subsequently determined.

[98] http://www.psychotherapy.net/data/uploads/52d99900de254.pdf. Accessed March 12, 2015.
[99] http://policetraining.net/blog/2012/04/18/interviewing-interrogation/. Accessed March 12, 2015.

Patient 13

The complainant alleged that an OEF/OIF veteran who was a "victim of military sexual trauma and resultant PTSD" was referred to the MHC rather than the PTSD clinic.

We substantiated that Dr. Y, of PCT 2 Clinic, referred a "victim of military sexual trauma and resultant PTSD" to the MHC. However, we determined that this referral for specialized MST treatment was appropriate. We also substantiated that Dr. Y erroneously documented that the patient was not an OEF/OIF veteran; although this had no apparent implications for treatment. We found that the MST Coordinator did not respond to the initial referral that was placed at the time of an ED visit, and MST care was not initiated until 2 months later.

The PCT 2 Clinic provided treatment for OEF/OIF patients with combat-related PTSD. The system's MST specialists provided treatment in both the MHC and Women's Clinic (not in PCT 1 or 2). The reason for Dr. Y's documentation of "not an OEF/OIF veteran" is unclear; however, this entry did not impact the process especially since MST treatment is available to veterans of all eras independent of combat status. Based on our review, we found Dr. Y's actions appropriate. The MST Coordinator involved in this patient's case is no longer working at the system.

In 2009, the patient presented to the system ED with "troubles beginning after a sexual assault while on duty..." An ED psychiatrist diagnosed PTSD and submitted a consult for treatment to the PCT 2 Clinic. Within an hour of receiving the consult, Dr. Y forwarded the consult to the MST Social Worker/Coordinator. The next EHR entry, approximately three months later, is Dr. Y's consult submission to the MHC that stated the consult was sent to the PCT Clinic in error "…(veteran c/o MST, is not OEF/OIF veteran) over 2 months ago, and was forwarded to MST Coordinator; still awaiting resolution. Veteran is seeking psychiatry services, please assess." A MHC psychiatrist assessed the patient the next day, and 4 days later, the MST social worker evaluated the patient. The patient did not show for the follow-up appointment 3 weeks later, and we found no documentation of follow-up. The final EHR entry, approximately 5 months later, is a 2010 closure of the consult with a note that the patient had not made appointments for therapy.

Patient 14

The complainant alleged that the care of a patient receiving treatment at the PTSD specialty clinic was interrupted when the patient was transferred from the PCT 2 clinic to a MHC inappropriately.

We did not substantiate that the patient receiving treatment at the PCT 2 Clinic "…had an interruption in his care." We did substantiate that this patient was referred to the MHC; however; we found this transfer of care was accomplished at the explicit recommendation of the treating psychiatrist.

This patient was diagnosed with non-combat related PTSD, panic disorder, and a history of major depression, recurrent with psychotic features. In 2009, after 2 years of

care with a PCT 2 Clinic psychiatrist, the patient was transferred to another PCT 2 Clinic psychiatrist. Of the patient's eight scheduled appointments with the PCT 2 psychiatrist during the following 14 months between p 2009–2010, the patient completed four visits, the patient canceled three times (twice due to physical illness), and the clinic canceled one appointment. During the last 3 months of treatment in 2010, the patient participated in a MHC time-limited anxiety management group. At the beginning of the patient's enrollment in the MHC group, the PCT 2 psychiatrist provided a prescription refill for a non-controlled substance [drug A] in response to the patient's phone request. At that time, the psychiatrist documented that the patient was attending MHC anxiety management groups, should be seen for a prescribing provider appointment soon, that the patient "…is being treated for psychosis and depressive symptoms" and "medication management needs would likely be better addressed in MH Clinic." The patient canceled an appointment one month after the MHC group ended. One month later, the patient again phoned in a request for prescription refills including a request for a controlled substance. The PCT 2 psychiatrist wrote, "unable to lawfully refill medication for controlled substance [drug B] at this time without further assessment…Needs appear to be better met at MH Clinic," and added Dr. Y as an additional signer. Dr. Y entered a consult to the MHC for psychiatry. Approximately a month later, a MHC psychiatrist and psychologist met the patient for medication management and treatment planning, respectively.

Given the patient's engagement in treatment in the MHC and refilled prescriptions, we found no interruptions in treatment beyond the patient's cancellation of a medication management appointment in the PCT 2 Clinic. Our review clarified that the treating psychiatrist documented the recommendation for the patient's referral to the MHC and clarified that treatment was focused on psychosis and depressive symptoms, not PTSD. Psychologist Dr. Y's consult submission was an administrative follow-up to the psychiatrist's clinical recommendations.

Patient 15

The complainant alleged that a psychologist (Dr. Y) determined that a patient's symptoms "…only had 'superficial resemblance' to PTSD" and "Therefore, he does not belong in the specialized PTSD clinic" in spite of psychiatrists [Redacted pursuant to 38 U.S.C. § 7332] having diagnosed PTSD during an inpatient admission.

We substantiated that three system psychiatrists documented a PTSD diagnosis during an episode of care. However, we did not substantiate that one of those psychiatrists was the patient's "psychiatrist at the [Redacted pursuant to 38 U.S.C. § 7332] …." We did not substantiate that Dr. Y concluded that the patient's symptoms only had "superficial resemblance" to PTSD and "Therefore he does not belong in the specialized PTSD clinic."

In 2011, a Central Texas Health Care System psychologist completed a C&P Initial PTSD evaluation for this patient and documented that "A diagnosis of PTSD appears in his medical record in 2006 note – prior to any deployment," suggesting that the patient

had a preexisting condition. Subsequently, per the EHR, the patient was 30 percent service connected for major depression disorder.[100]

In 2013, the patient presented to the system ED with suicidal ideation, "bad panic attacks, anxiety and nightmares." A psychiatrist diagnosed him with PTSD, major affective disorder, depression, panic disorder without agoraphobia, and [Redacted pursuant to 38 U.S.C. § 7332]. The patient was admitted to the inpatient MH unit, and during his 6-day admission, two psychiatrists met with him, the admitting psychiatrist and a psychiatrist the complainant identified as the patient's "psychiatrist at the [Redacted pursuant to 38 U.S.C. § 7332] program." The admitting psychiatrist documented the same diagnoses as the ED psychiatrist and noted that the patient had multiple PTSD symptoms since military discharge in 2012, "classic" panic symptoms, depressed mood, and [Redacted pursuant to 38 U.S.C. § 7332].. On Day 4 of the patient's inpatient admission, the second psychiatrist documented the patient's progress including "…he slept well last night…He had no complaints or concerns" as well as the same diagnoses. This is the only EHR entry from that psychiatrist. The inpatient staff submitted a consult to PCT 2 Clinic.

Dr. Y completed the consult and documented details of the patient's abusive childhood and noted that the patient "… was able to describe several distressing events that occurred in the military." However, based on an in-depth review of the patient's PCL-M responses, Dr. Y determined that the patient did not endorse the symptoms needed for a PTSD diagnosis. Dr. Y wrote, "Nonetheless, for comprehensiveness, the veteran was also queried about other PTSD Sx [symptoms] to determine if he may benefit from treatment in the PCT if he meets criteria for an Anxiety NOS Dx [diagnosis]" but did not find that this was the case. Dr. Y concluded that the patient's symptoms "bear superficial resemblance to PTSD" and are more consistent with his service connected depression and therefore referred the patient to the MHC for treatment.

We found that Dr. Y documented that the patient's symptoms "bear superficial resemblance to PTSD." Given the definition of superficial as "apparent rather than actual or substantial,"[101] use of the word in this context is fitting since Dr. Y concluded that the patient's symptoms although similar on the surface to PTSD were more consistent with a long-standing depressive disorder than military-related PTSD. As indicated in the EHR, Dr. Y explicitly evaluated the patient for symptoms to determine if specialized PTSD treatment would be beneficial. This documentation does not support the allegation that Dr. Y's intention was to refuse this patient access to PCT 2 Clinic.

Patient 16

The complainant alleged that: (1) he submitted a consult to the PTSD clinic that was initially "discontinued but then resurrected"; (2) a psychology intern determined the

[100] It is noted that the patient received 100 percent service connection for PTSD within the period of this review and is no longer service connected for major depression disorder.
[101] http://www.thefreedictionary.com/superficial. Accessed March 12, 2015.

patient did not meet criteria for PTSD although he did in the complainant's C&P exam the month prior; (3) the psychology intern's notes indicate that he changed his diagnosis one time to PTSD "…before reverting back to his non-PTSD diagnosis"; and, (4) the patient missed his last appointment and did not respond to the clinic trying to contact him for follow up.

In 2014, the complainant conducted an initial C&P evaluation and diagnosed combat-related PTSD. On the same day, another outpatient psychiatrist submitted two consult requests for this patient, one consult for a PC provider, and one for JC outpatient psychology (general MH) and documented that the patient asked the complainant "…to assist patient get set up for mental health, patient stating he would like counseling for depression." The Chief of Psychology responded that no PC provider was assigned and alerted PC staff.[102]

The JC MHC staff discontinued the outpatient psychology consult since the complainant referred the patient to the PCT 2 Clinic the next day (a third consult). In response to the complainant's PCT 2 Clinic consult, Dr. Y commented that the patient was not yet established at the VA, and a few days later, a psychology resident added that there was no phone number in the EHR and that a letter was sent requesting the patient contact the clinic to be scheduled. Two weeks later, the PCT-2 Clinic consult was discontinued since the patient did not contact the clinic. The complainant then added an addendum to the EHR patient letter with a telephone number from the Veteran Benefits Management System[103] records to which he had access as a C&P evaluator.

The psychology resident contacted the patient the next day, offered "multiple appointment times," and although the patient reported that scheduling was difficult due to his work schedule and distance from JB, an appointment was scheduled for the following month. On the day of the evaluation, Dr. Y resubmitted the complainant's original PCT 2 Clinic consult request and added the scheduled evaluation appointment information "for administrative tracking purposes."

During the evaluation, the psychology resident diagnosed other specified trauma and stressor-related disorder and panic disorder and noted, "Veteran's presentation during today's evaluation appears somewhat different from his presentation and report of symptoms during C&P evaluation." The patient said that although the PCT 2 Clinic (at JB) was 1.5–2 hours distance, he was dissatisfied with services closer and wished to come to this particular clinic. The patient also stated that he did not wish to pursue psychotropic medication and was referred to PCT 2 Clinic for psychotherapy. A psychology intern conducted six sessions over 2 months and documented PTSD as the diagnosis in the third progress note although listed other specified trauma and stressor-related disorder and panic disorder in the remainder of the notes. The patient

[102] Per the VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, All veterans receiving mental health care need to be enrolled in a VA primary care clinic to receive primary care.
[103] Veterans Benefits Management System is a web-based electronic claims processing portal. http://www.blogs.va.gov/VAntage/8736/the-benefits-of-a-paperless-claim/. Accessed March 13, 2015.

responded positively to the treatment at JB but did not return for a seventh scheduled appointment. The intern attempted phone contacts unsuccessfully and sent the patient a letter. Later that month, the patient informed a psychiatrist at a neighboring VISN facility that he wished to transfer his care to neighboring facility and that he was receiving twice weekly therapy at JC and seeing a therapist at a Vet Center. The psychiatrist at the neighboring facility prescribed medication. Three days after that visit, the complainant met with the patient[104] and documented that the patient "… had not kept up with his treatment at JB as it was too far off and inconvenient for him. He stated that it is easier for him to come to JC." The complainant prescribed additional medication and requested the patient return in 1 month although no future appointments were scheduled. We found no documentation of JC Clinic follow-up contact attempts. The patient subsequently moved out of state and received therapy at another VA facility.

We substantiated that:

(1) The initial 2014 consult was discontinued; at that time, the patient was not yet enrolled at the system. Approximately 3 weeks later, Dr. Y resubmitted the PCT 2 Clinic consult for administrative purposes since the patient was then enrolled at the facility and contacted the clinic. The EHR contains documentation of the process and appropriate actions taken to contact the patient and address the consult.

(2) In the EHR, the psychology resident[105] (who was supervised by a VA staff psychologist) noted a difference in presentation at the subsequent evaluation as compared to the initial C&P evaluation and diagnosed other specified trauma and stressor-related disorder and panic disorder.

(3) A psychology intern (who was supervised by a VA staff psychologist) provided treatment and in one of his six treatment notes listed PTSD as diagnosis while the other notes listed other specified trauma and stressor-related disorder and panic disorder. It is noted that this had no implications for the treatment provided in that session.

(4) This patient received care from multiple providers and offered reasons for discontinuing treatment, such as distance and expense. The EHR contains documentation of attempts by PCT 2 Clinic staff to contact the patient when he missed an appointment although there is no evidence of JC MHC follow-up after the patient's first psychiatric appointment. It is noted that this patient was engaged in psychiatric treatment at another VA facility prior to and after the JC psychiatric appointment.

[104] The EHR does not explain how or why this appointment was scheduled.
[105] We assumed that the complainant is referring to the psychology resident although he stated psychology intern in the allegation.

Patient 17

The complainant alleged this patient was "bounced" to the MHC with differing opinions about a PTSD diagnosis that resulted in his not pursuing follow-up at the VA.

We could not substantiate that the inpatient psychiatrist diagnosed PTSD because two discharge documents contained different diagnoses.[106] We substantiated that the inpatient provider referred the patient to the PCT 2 Clinic for post-discharge care where a psychology intern (who was supervised by a system staff psychologist) concluded at the time that the patient did not have PTSD. We did not substantiate that the intern did not offer PTSD treatment and "bounced" the patient to the MHC. Given that we found no documentation to suggest that the patient was "…very disappointed that he was being bounced around…" we did not substantiate this allegation. We substantiated that the patient "did not follow-up with the VA."

This patient's first contact was with the system via inpatient MH admission in 2013. An APRN initially diagnosed unspecified schizophrenia spectrum/other psychotic disorder, rule out substance induced psychotic disorder, [Redacted pursuant to 38 U.S.C. § 7332]. The next day, a resident physician spoke with the patient's parents and suggested that the patient was exhibiting"…symptoms consistent with PTSD, likely exacerbated by activating Wellbutrin[107], [Redacted pursuant to 38 U.S.C. § 7332]. The inpatient psychiatrist wrote two progress notes that included a "Rule Out PTSD" diagnosis although included education about PTSD in the treatment plan. This same inpatient psychiatrist documented two discharge diagnoses, PTSD and [Redacted pursuant to 38 U.S.C. § 7332], on the discharge summary and "Rule Out PTSD" on the discharge note. Further, the psychiatrist documented a meeting with the patient and his parents in which [Redacted pursuant to 38 U.S.C. § 7332] and ongoing care were emphasized, and although the patient declined [Redacted pursuant to 38 U.S.C. § 7332], he agreed to a PTSD evaluation and follow-up.

Eight days following discharge, a PCT 2 Clinic psychology intern (who was supervised by a system psychologist) conducted a brief evaluation due to the patient's late arrival and, in agreement with the patient, scheduled a second session within 2 weeks to complete the evaluation. The psychology intern administered the PCL-M on which the patient scored substantially below the accepted cut off typically associated with clinically significant PTSD symptoms. The intern inquired about the patient's PCL-M responses. In this interview, the patient disclosed military related stressors and denied distress related to events during his deployment. Specifically, he denied any re-experiencing or avoidance symptoms and, hence, did not meet PTSD criteria. The intern diagnosed [Redacted pursuant to 38 U.S.C. § 7332] psychotic disorder [Redacted pursuant to 38 U.S.C. § 7332]. The patient declined interest in or need for trauma-focused psychotherapy and expressed interest only in medication management. The patient

[106] The same psychiatrist listed a diagnosis of "Rule Out PTSD" in a discharge note and a diagnosis of "PTSD" in the discharge summary.
[107] Wellbutrin is an anti-depressant medication.

again declined [Redacted pursuant to 38 U.S.C. § 7332] and "accepted a referral" to the MHC for medication management for which the supervising psychologist submitted a consult that same day. The intern wrote, "He was invited to contact PCT 2 should his treatment needs change in the future; he expressed understanding and willingness to do so."

Approximately a month later, the complainant completed a C&P evaluation in which the patient disclosed additional traumatic stressors, and based on this information, the complainant diagnosed PTSD. Following the C&P evaluation, the PCT 2 Clinic and MHC teams consulted and the PTSD supervising psychologist attempted to reach the patient by phone and sent a letter to offer an appointment for a psychiatric consultation in PCT. We found no evidence in the EHR that the patient responded to this effort.

Based on our EHR review, we found that the inpatient psychiatrist did not definitively diagnose PTSD and specifically requested a PCT Clinic evaluation. The PCT 2 Clinic evaluation preceded a C&P evaluation for PTSD; therefore, the intern did not have the complainant's C&P evaluation report to consider. However, the patient provided different information regarding symptoms and stressors in the PCT Clinic evaluation as compared to the C&P evaluation. As such, the two clinicians formulated different diagnostic opinions although both agreed that the patient would benefit from treatment.

We found that the PCT 2 Clinic psychology intern offered the patient multiple treatment options including trauma-focused psychotherapy at the PCT 2 clinic which the patient declined; and medication management at the MHC which the patient accepted but did not follow up. Additionally, the PCT 2 Clinic staff encouraged the patient to contact the PCT clinic for treatment as desired both before and after the C&P evaluation. Given these circumstances, we did not consider the patient "bounced" to the MHC by the PCT 2 Clinic. There was no clinician documentation or patient advocate report to suggest that the patient was dissatisfied with the treatment plan.

Patient 18

The complainant alleged that system staff did not document a patient's PCT 2 Clinic visit during which he requested information on getting care and did not pursue contacting the patient by email despite congressional interest in this patient's situation. Subsequently, the patient was lost to follow-up.

We substantiated that a patient made a special effort to go to JB seeking help for PTSD, and a nurse took his information (although we found no documentation of this contact). We found that approximately 2 weeks later, a PCT 2 Clinic psychologist documented, "This provider was made aware of the veteran's recent request for psychotherapy services at the PCT Team 2 meeting," but PCT 2 staff documented that they were unable to reach the patient. The patient reported to us that he did not receive phone messages or letters offering MH services. At that time, VHA required that all new patients requesting or referred for MH services must receive an initial evaluation within

24 hours and a more comprehensive diagnostic and treatment planning evaluation within 14 days.[108] Given the contradictory information regarding contact attempts, we could not substantiate that the PCT 2 Clinic staff did not follow up on the patient's request for services. However, based on the patient's report and timeline provided, we found that the nurse did not document an evaluation, and the patient was not set up with an appointment for a more comprehensive diagnostic and treatment planning evaluation timely.

We also substantiated that PCT 2 staff responded to the complainant's instructions that the patient wanted to be contacted via e-mail "…with a generic response that VA does not allow e-mail contact." VHA policy states, "A request to receive communications via email is considered unreasonable and therefore will be denied."[109] Therefore, Dr. Y's response regarding use of email (see below) was consistent with policy.

We did not substantiate that "…another spurt of effort to contact…" the patient in 2014 was related to congressional intervention. We did not find evidence of congressional intervention. The time frame of a Congressman's visit to the system coincided with the patient's leaving a voicemail at the PCT 2 Clinic; however, we found that the attempt to contact the patient was likely to be related to the voicemail message that the patient left for the PCT 2 team. EHR documentation indicated that the PCT 2 team responded to the voicemail message. It is the system's procedure to establish records of on any and all congressional requests. The system did not have any record of congressional inquiry related to this patient.

This patient underwent a C&P evaluation in 2012 and was deemed to be 50 percent service connected related to PTSD. In late 2014, a PCT2 Clinic psychologist at the system entered the first EHR document that noted awareness of the patient's request for PCT 2 Clinic psychotherapy services but did not specify how this information became available. This psychologist called the patient and left a phone message with her direct phone number as well as the clinic number. Per the PCT 2 staff's request, the OEF/OIF Care Management team also phoned the patient and mailed a letter but did not make contact with the patient. We spoke with the patient who told us that he never received a call back nor a letter except related to "re-evaluation" for his pension.

Over a month later, the complainant conducted a C&P evaluation and noted that the patient's PTSD symptoms had worsened over a period of 2 years. The patient told him that he had recently visited the system to inquire about getting care and "…never got a call back" from the system's PCT Clinic. The patient denied psychotic symptoms, suicidal or homicidal ideation, and high risk behaviors. The complainant submitted a PCT 2 Clinic consult with a response requested "within 24 hours" and added that the patient requested that he be contacted by email or after his work hours. Dr. Y

[108] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.
[109] VHA Handbook 1605.1, §10c, *Privacy and Release of Information, Confidential Communications*, May 17, 2006. This VHA Handbook was due to be recertified May 2011, but has not been recertified.

responded to the consult indicating that "VA Policy prohibits contacting veterans by email given that email is not a secure medium" and that Dr. Y would attempt to contact the patient to discuss treatment options given his availability. The patient did not respond to voicemails, and the consult was closed 9 days later. The following month the patient left a message expressing interest in an appointment, but the PCT 2 Clinic staff failed to reach the patient by phone and sent a letter.

The EHR does not contain documentation of the patient's reported walk-in visit to the PTSD Clinic or documentation of how the PCT 2 Clinic staff became aware of the patient's request for treatment services. The PCT 2 staff told us that walk-ins are seen by a nurse for an assessment and that this information is entered in the EHR. The patient told us that he met with a nurse who asked some questions; however, we found no progress note. Further, he said that the nurse had to generate a folder to be given to staff and that staff would contact him. Using the complainant's timeline information, the PTSD Clinic psychologist tried to reach the patient approximately 2 weeks after the patient's reported visit to the facility. Staff could not recall how they learned of this patient's interest in treatment but suggested that it is most likely that the patient called for an appointment and a Health Administrative Services staff member provided PCT 2 Clinic staff with the name and number. Documentation indicated multiple unsuccessful attempts at reaching the patient including letters. However, we found no conclusive evidence of the time at which the PCT 2 Clinic staff called the patient or that the letters were sent. The veteran denied receiving calls, phone messages, or letters. The PCT 2 Clinic had hours until 6:30 pm 1 day a week and as required by VHA, the MHC had evening availability for PTSD treatment.[110] However, this information was not provided to the patient, and the PCT 2 staff did not reach the patient to discuss evening appointment options.

Patients 19a and 19b

The complainant alleged that this patient (Patient 19a) "…did not get a call back from the VA after he and [and then] his Vocational Rehab Counselor had contacted the VA in [Redacted pursuant to 38 U.S.C. § 5701] 3013 [sic]" and that the complainant initiated a subsequent consult "…that was discontinued as the veteran could only come to the clinic between 3:30 PM and 4:00 PM due to his work." The complainant also specifically alleged that this patient's friend (Patient 19b) "… also with PTSD had committed suicide last year while he was awaiting the phone call for his appointment from the PTSD clinic."

i. Patient 19a

We substantiated that the patient did not receive a call from system staff after he left voice messages and after his VBA Vocational Rehabilitation and Employment Counselor faxed a referral requesting MH services; however, we could not determine if

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

system staff received the facsimile. We also substantiated that a PCT 2 Clinic consult was discontinued, but due to contradictory statements we did not establish that the patient was not offered an appointment after hours.

This patient is a PTSD service-connected veteran who informed the complainant that in 2013, he called the PCT 2 clinic and left a voicemail requesting help but never heard back from the clinic. The EHR does not contain clinical progress notes or scheduled appointments for about 3 months after the time he reported calling the PCT 2 clinic other than a few entries related to a non-MH C&P examination. We spoke to the patient who told us that he never received a call back to his voicemails.

The patient also said that his Vocational Rehabilitation and Employment Counselor had put in PTSD treatment referral "a couple of times" as well. We requested and obtained the patient's pertinent Vocational Rehabilitation documentation which contained a 2013 prepared referral form and a scanned copy emailed to the patient. The vocational counselor told us that he routinely sent referrals to a specific pre-programmed facsimile machine number and also made sure that the patient had a copy of the referral so that they could follow up. We tried the facsimile machine number on multiple occasions and from two different locations and got recurrent no answer/failure to deliver messages. The system Quality Manager informed us that the facsimile machine number was an active "public posted fax number" to the system executive office that received one or fewer clinical facsimiles received per day.

We cannot determine with certainty that system staff received the facsimile from the Vocational Rehabilitation counselor and, therefore, cannot assign responsibility for this failed effort. We found that the referral process was ineffective in this case.

In 2014, the complainant conducted a C&P evaluation and submitted a consult request to the PCT 2 Clinic. Dr. Y contacted the patient the same day, and the patient declined available appointments due to his work schedule. Dr. Y called back the next day with treatment options at JB and Vet Center, but the patient declined pursuing at that time and said he would call PCT 2 Clinic if his needs change. Dr. Y discontinued the consult.

Dr. Y informed us that the clinic is open until 6:30 pm on Mondays, and in general if the patient had " been agreeable to an appointment at 4 or 5 on Monday, he would have been offered one." Dr. Y did not document if/what appointment times had been offered; Dr. Y told us that he "should have documented that better." Further, we did not substantiate that the consult was discontinued due to the patient's work schedule. The accounts of the specific conversation that took place between the patient and Dr. Y differ between the two parties, and we found no further evidence to support either version of the story.

ii. Patient 19b

This patient's EHR includes only Department of Defense Carl R. Darnall Army Medical Center (Fort Hood) appointment information and system PC progress notes. Appointments reflected a history of treatment for [Redacted pursuant to 38 U.S.C.

§ 7332] beginning in 2013; two months later, behavioral health staff provided the patient and his family with psychotherapy sessions for PTSD with the last session 5 months later. The available progress note one month before termination of treatment showed that the PC provider submitted a consult for a VA Central Texas Health Care System Sleep Disorder Clinic and documented "undiagnosed PTSD, with depression and anxiety" and noted that the patient had a PTSD evaluation scheduled (Fort Hood Behavioral Health) for the next day. The patient had a VA Central Texas Health Care System appointment in 1 month following termination of treatment and a follow-up a month later at the Sleep Disorders Clinic. We found no mention of MH symptoms or consults submitted.

We did not substantiate that Patient 19b (a friend of Patient 19a) committed suicide while waiting for a phone call for an appointment with the system PCT Clinic at the time of the suicide. The only note in the veteran's system EHR was entered by a PC Nurse Manager 6 days before the veteran's death. The veteran had come to PC as a walk-in complaining of head congestion. The Nurse Manager instructed him take over the counter medication, use a humidifier, and to return at the end of the week if needed. The EHR note does not contain complaints of MH symptoms.

A psychologist completed a C&P evaluation posthumously, and based on the Department of Defense information, concluded that this veteran's death was more likely than not related to combat-related MH issues. Although it appeared that the veteran was in Fort Hood MH treatment for PTSD, we found no evidence that this veteran contacted the system PCT Clinic or another VHA facility for MH treatment.

A third complainant (Complainant 3) alleged that referrals to PTSD clinic for patients 20–23 had been declined.

Patient 20

We did not substantiate that this patient was "refused" treatment in the PCT 2 Clinic.

This non-service connected patient first interacted with the system ED in 2014 when he sought assistance for [Redacted pursuant to 38 U.S.C. § 7332] and was admitted to the inpatient MH unit. The inpatient MH psychiatrist diagnosed [Redacted pursuant to 38 U.S.C. § 7332] mood disorder, and rule out PTSD. The patient declined referral to the [Redacted pursuant to 38 U.S.C. § 7332] and was referred to the MHC. Within the first week of discharge, the patient attended a MHC discharge group. The following month, a MH APRN diagnosed PTSD, adjusted the medication protocol, requested an appointment in 8 weeks, and submitted a PCT 2 consult.

The PCT 2 Clinic psychology resident (who was supervised by a VA staff psychologist) completed the consult within 2 weeks of submission. The psychology resident diagnosed [Redacted pursuant to 38 U.S.C. § 7332] in partial remission and other specified depressive disorder with anxious distress and noted that although the patient was exposed to stressors, he denied critical PTSD symptoms, such as physiological

response to reminders and avoidance of cues. The psychology resident explained the PTSD Clinic services available to the patient and the patient declined due to "cost." The patient also refused to consider accessing treatment at the Vet Center (no cost). Over the following 5 months, the MHC cancelled the next two APRN appointments and the patient did not present (did not call to cancel and did not come) for two appointments. During a MHC evaluation 8 months after his initial visit, the patient complained that the PTSD Clinic Staff "…were useless, they didn't do anything for me." The APRN provider noted that the patient had been offered treatment, but the patient reiterated that cost was an issue.

We found that the patient had been referred to and was evaluated by a psychology resident (under the supervision of a VA staff psychologist) in the PCT 2 Clinic. The psychology resident did not diagnose PTSD because the diagnostic criteria were not fully met as well as symptoms potentially better explained by other factors. The psychology resident offered treatment in the PTSD 2 Clinic to address the patient's exposure to combat-related stressful conditions; however, the patient declined PTSD treatment at that time due to financial concerns.

Patient 21

We did not substantiate that this patient was "refused" treatment in the PCT 2 Clinic.

In 2010, the PC provider referred this Vietnam veteran to the PC-MHI psychologist for evaluation of rule out PTSD. At the time, this patient's medical history was remarkable for diabetes mellitus, epilepsy and seizure-related sleep problems, and no psychiatric diagnosis or treatment by history. The PC-MHI psychologist diagnosed anxiety disorder, NOS and depressive disorder, NOS, and a psychiatrist offered medication management which the patient declined at that time stating that he preferred psychotherapy only. Consistent with the PC-MHI model, the psychologist utilized a short-term structured treatment plan and met with the patient for an additional five sessions with some progress noted, and then the patient canceled the final sixth session twice. In the last session, the patient agreed to one more session with the psychologist and then a transfer to a new provider for longer term treatment with the goal of identifying if military experiences were related to anger. When the scheduled final session did not occur, the psychologist submitted a consult to the MHC requesting ongoing treatment for depression and anger.

At the MHC, the patient's wife joined the patient and APRN and expressed "upset and frustration that they were referred to the MHC" rather than the PTSD Clinic. The APRN referred the patient to the PTSD 1 Clinic, and the psychologist diagnosed rule out depression and the patient agreed to a referral to a MHC anger group but declined medication management. A MHC nurse added a note to the consult saying, "will forward to the clinician who runs group for completion." A few weeks later, the MHC nurse contacted the patient to offer treatment for depression with the APRN. We found no further information about the anger group. The patient canceled his next appointment, the MHC canceled an appointment the following month, and the patient

did not come to a third appointment a few weeks later. At the next APRN appointment in 2011, the patient agreed to a medication protocol and referral to a stress management group, which the patient joined in two months later. The patient attended the groups and reported medication compliance. Additionally, the patient was meeting with a social worker for individual psychotherapy. The APRN noted improvement in affect and presentation with decreased depression. In 2013, the APRN recommended a transfer to the Senior Veterans Center given the patient's age and memory problems. The Senior Veterans Center APRN diagnosed the patient with anxiety disorder, NOS and persistent depressive disorder.

We found that the patient had been referred to and was evaluated by a psychologist in the JB PCT Clinic. Multiple providers, including the treating MHC APRN, diagnosed anxiety disorder, NOS and persistent depressive disorder. As such, there would be no clinical indication to offer PTSD treatment.

Patient 22

Complainant 3 alleged that "this patient was "previously treated in PTSD [PCT 2 Clinic], then [inappropriately] sent to MHC."

We substantiated that the patient was previously treated in PCT 2 Clinic, but we concluded that the transfer to the MHC was clinically appropriate. We found that the PCT 2 Clinic staff did not document the discussion that informed the patient of the recommendation for transfer to the MHC. Additionally, we found that the MHC APRN documented that the patient would receive only medication management which was inconsistent with the MHC psychologist's treatment plan from the same day in which the patient agreed to two group treatments. Further, MHC staff did not follow up on a referral to group treatment.

From 2009 to 2011, a PCT Clinic 2 psychiatrist prescribed medication to address this patient's reported depression and sleep disturbance. The patient was service connected for a neurosis-phobia. The psychiatrist diagnosed PTSD related to Desert Storm military service. In 2011, the psychiatrist requested a diagnostic evaluation in response to the patient's increased [Redacted pursuant to 38 U.S.C. § 7332] and deteriorating functioning. A psychology intern determined that the patient, although not in combat, suffered from panic attacks and pre-military traumatic experiences. The intern diagnosed panic disorder; rule out PTSD, non-combat; and rule out dysthymic disorder. The patient requested help for panic attacks and relationships. The patient's case was discussed with the treating psychiatrist who agreed the patient would "…receive appropriate treatment…" in the MHC. The supervising psychologist submitted consults for medication management and anxiety management group approximately 3 weeks following the evaluation. Almost 3 months later, the APRN evaluated the patient and diagnosed depression, NOS; anxiety, NOS; and PTSD, non-combat. The APRN documented that the patient had a community-based therapist and would only be receiving medication management at the MHC. That same day, a MHC psychologist completed an outpatient treatment plan with the patient and indicated that the patient would attend both a mood disorders and anxiety management group.

No action was taken on the original anxiety management group except for a nurse writing, "Will forward to the clinician who runs group for completion."

Given that the patient was diagnosed with non-combat related PTSD and the PCT 2 Clinic is a combat-related treatment program, staff's referral of this patient to the MHC was appropriate. Neither the psychology intern nor the psychiatrist documented discussion with the patient about the treatment plan which included a transfer to the MHC. However, the patient followed up with the MHC APRN as scheduled and received treatment accordingly.

Patient 23

We substantiated Complainant 3's allegation that this patient "attends groups, but no treatment from clinic." However, we found this treatment plan to be consistent with the patient's needs and did not pose any clinical danger.

This patient was service-connected for PTSD upon discharge from the military. In 2005, the treating psychiatrist submitted a consult requesting the patient attend a specific PTSD group. The PTSD psychiatrist assessed the patient and agreed to the patient's placement in the group. The PTSD nurse documented that the patient would continue "…to be followed…" in the MH clinic. In 2008, the patient was assigned a prescriber in the MHC, and a psychologist noted that the patient was satisfied with the treatment arrangement and wished to continue.

We substantiated that the patient attended a group in the PCT 1 Clinic and received medication management in the MHC. It appears that the arrangement of the patient's treatment across two clinics was established 10 years ago and has been successful in satisfying this PTSD service-connected patient's care needs. More currently, a patient's treatment in two different clinics may be less likely to occur as a result of clinics' established treatment criteria and multidisciplinary team based approaches. Given that the current prescribing provider's treatment plan included that the patient is to continue in PTSD groups, this arrangement seems consistent with current needs.

Appendix E

Transgender Patient Evaluation – Patient 24

We did not substantiate the complainant's allegation that a veteran in a minority group was denied care "based on a very poor psychological evaluation."

The American Psychological Association defines transgender "as an umbrella term for persons whose gender identity, gender expression or behavior does not conform to the sex to which they were assigned at birth."[111] Transgender individuals may seek medical care to support the transition to the physical characteristics consistent with the patient's gender identity. Medical interventions for transitional care include feminization or masculinization of the body through hormone therapy and/or sex reassignment surgery.[112] Beginning in June 2011, VHA provides and funds hormone therapy.[113] It is standard practice for a medical provider to require a MH evaluation to determine if the patient would benefit from a gender transition.[114]

VHA does not provide clinical guidelines for the assessment and treatment of transgendered individuals nor does VHA endorse any standards of care. However, VHA suggests the Standards of Care (SOC) developed by the World Professional Association for Transgender Health as a useful resource for clinicians.[115] The 2009 Endocrine Society Clinical Practice Guidelines recommends that a MH professional diagnose gender identity disorder (GID). GID is the psychiatric disorder diagnosis assigned prior to the establishment of Gender Dysphoria[116] introduced in the May 2013 American Psychiatric Association's DSM – Fifth Edition.[117] A diagnosis of GID requires evidence of two criteria. Criterion A is a strong and persistent cross-gender identification that is not merely be a desire for any perceived cultural advantages of being the other sex. Criterion B is persistent discomfort about one's assigned sex or a sense of inappropriateness in the gender role of that sex. The SOC emphasize that a MH professional who refers for feminizing/masculinizing hormone therapy shares the ethical and legal responsibility for the decision with the physician who provides the hormone therapy. The SOC recommend that the MH clinician documentation includes

[111] American Psychological Association, http://www.apa.org/topics/lgbt/transgender.aspx. Accessed January 18, 2015.
[112] *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, Version 7*, International Journal of Transgenderism, 13:165–232, 2011.
[113] VHA Directive 2011-024, *Providing Health Care for Transgender and Intersex Veterans*, June 9, 2011. This Directive was rescinded and replaced by VHA Directive 2013-003, *Providing Health Care for Transgender and Intersex Veterans*, February 8, 2013.
[114] Glicksman, Eve, *Transgender Today*, Monitor on Psychology, April 2013, Vol 44, No. 4, American Psychological Association.
[115] *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, Version 7*, International Journal of Transgenderism, 13:165–232, 2011.
[116] Gender Dysphoria is a condition in which there is a conflict between a person's physical gender and the gender with which he or she identifies. http://www.nlm.nih.gov/medlineplus/ency/article/001527.htm. Accessed April 13, 2015.
[117] *Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline*, Journal of Clinical Endocrinology Metabolism, September 2009, 94(9): 3132–3154.

results of psychosocial assessment including any diagnoses; an explanation that the criteria for hormone therapy have been met and a brief description of the clinical rationale for supporting the client's request for hormone therapy. Specifically, the SOC recommends:

> *…assessment includes gender dysphoria in the context of an evaluation of their psychosocial adjustment and includes, at a minimum, assessment of gender identity and gender dysphoria, history and development of gender dysphoric feelings, the impact of stigma attached to gender nonconformity on mental health, and the availability of support from family, friends, and peers (for example, in-person or online contact with other transsexual, transgender, or gender-nonconforming individuals or groups). The evaluation may result in no diagnosis, in a formal diagnosis related to gender dysphoria, and/or in other diagnoses that describe aspects of the client's health and psychosocial adjustment. The role of mental health professionals includes making reasonably sure that the gender dysphoria is not secondary to, or better accounted for, by other diagnoses.*[118]

The SOC also specifically states that criteria for hormone therapy include persistent, well-documented gender dysphoria, and if significant MH concerns are present, they must be effectively managed.

In 2013, a system endocrinologist referred the patient for a MH evaluation; the assigned psychologist noted that the referral was for a "clinical interview as is necessary to assist in determining veteran's appropriateness for hormone replacement therapy following the veteran' [sic] request for hormonal transition to the female gender." Using information from the EHR review and clinical interview, the psychologist documented elements consistent with the SOC. The psychologist reported that the patient exhibited a "pattern of vacillating….between these [feminine and masculine] personas, and reporting confusion over sexual orientation…", citing that there was no evidence that the patient had presented as female or requested to have a female name used in the "extensive" EHR. The psychologist assessed the patient's psychosocial context of gender dysphoria and documented that the patient's immediate family was supportive although they were not present to verify the information. The psychologist concluded that the patient did not meet the two criteria of GID. The psychologist suggested that the patient's identity issues were symptoms of personality disorder and recommended ongoing psychotherapy. Additionally, the psychologist wrote that "medical interventions that have permanent physical consequences may further exacerbate the veteran's identity disturbance."

Based on the EHR review, observations, and interview data, the psychologist documented reservations about a GID diagnosis, a potential alternative MH diagnosis

[118] *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, Version 7*, International Journal of Transgenderism, 13: p. 180, 2011.

that might account for the patient's gender dysphoria symptoms, and concern about initiating hormone therapy at that time. Although the psychological evaluation lacked organization and had several weaknesses, including an insufficiently developed diagnostic formulation and some speculative conclusions, we did not substantiate that it was "grossly inadequate" or "extremely poor" by comparison with reasonable standards of practice and SOC guidelines.

The endocrinologist provided the patient with the psychologist's report, and subsequently, the patient complained about the evaluation experience and requested a second opinion from outside VHA, which the endocrinologist requested and the then Chief of Psychology later approved. A community psychologist evaluated the patient (approximately 3 months after the referral for a MH assessment) and diagnosed the patient with GID and supported hormone therapy. In our EHR review, we found the community psychologist's handwritten notes and template general assessment but not a formal psychological evaluation report. It is noted that the community psychologist documented that the patient reportedly informed his wife of his wishes to be female, but we found no evidence of further contact or verification with the family. Two months later, hormone therapy was initiated through non-VA care referral.

Appendix F

Inpatient Suicide Attempt – Patient 25

In 2013, a male patient in his early sixties with a long history of MH care at the system presented at the ED with depressed mood and suicidal ideation and was admitted to the inpatient MH unit that same day. Daily nursing notes reflect constant observation for suicide prevention. On Day 5, a nurse documented that the patient disclosed an interpersonal issue that contributed to his depression. Mr. A. also expressed feeling safe in the hospital but could not guarantee his safety from hanging himself if he were discharged home that day. On Day 6, the psychiatrist and a nurse documented improvement in Mr. A.'s mood. On Day 7, Mr. A. complained of a migraine headache to a nurse in the dayroom. The nurse documented consulting with a staff psychiatrist and when the nurse returned to the dayroom to speak with Mr. A "…He had left the dayroom and when I walked to his room I found him trying to peel the screen off the ceiling in an attempt to find a way to hang himself. Immediately got him off the bed and talking to me." The discharge summary notes, "During the course of his hospital stay, he was found tampering with a vent in what was thought to be an act of self-harm. After the event, Mr. A. denied thoughts of harm."

Based on the definitions and EHR review, we concluded that the incident in question does not qualify as a suicide attempt. The behavior was not self-directed or potentially injurious, as would be required to meet the CDC definition.[119] Further, this act did not involve more than mere preparation, as would be required by the definition.

From the perspective of the CDC definition, Mr. A.'s behavior was directed toward the environment rather than himself, and he was not likely to be injured as a result of his behaviors. His behavior could be viewed as analogous to that of a person searching through a medicine cabinet for a means to overdose. While such behavior is surely worrisome from a clinical standpoint, it does not rise to the level of an actual attempt at self-injury.

In applying the legal definition, the patient's behavior might be seen as exploring the environment for potential means for suicide that is, making preparations for suicide rather than attempting suicide. We found no evidence that the patient actually had or could have obtained all of the means necessary to make a suicide attempt, which bears on the logic of reporting the incident.

[119] The Center for Disease Control and Prevention (CDC) defines a suicide attempt as non-fatal self-directed potentially injurious behavior with any intent to die as a result of the behavior.[119] A suicide attempt may or may not result in injury. http://www.cdc.gov/violenceprevention/suicide/definitions.html. Accessed January 6, 2015.

Appendix G

Follow-Up Investigations of Patient Deaths Patients 26–28

Patient 26

The complainant alleged an insufficient follow-up investigation was conducted when a patient died in a motor vehicle accident 3 days after discharge from a 1-day inpatient MH hospitalization for suicidal ideation with intent and a plan. He also complained that his request for an RCA was denied.

A patient in his mid-twenties died in a motor vehicle accident 3 days after discharge from a 1-day inpatient MH hospitalization for suicidal ideation with intent and a plan. His death was ruled accidental; the patient's blood alcohol level was 0.212 percent (intoxicated). It is not possible to rule out suicide given his risk status, but neither is there conclusive evidence to support suicide. Either way, his behavior appears to have contributed to his death, and this behavior in turn was likely influenced by the effect of his psychiatric illness on his judgment, impulse control, and other brain executive functions.

The system conducted a peer review, which is required under certain circumstances including when a death in the community setting is brought to the attention of the facility.[120] [Redacted pursuant to 38 U.S.C. § 5705].

Three months following the death, the chairperson of the peer review committee communicated the findings of the peer review via memo to the attending psychiatrist, social worker, and the Chiefs of MH and Social Work. [Redacted pursuant to 38 U.S.C. § 5705].

We found no evidence of further administrative action related to this patient death. In June 2013, the complainant requested an RCA; the system Risk Manager (since retired) informed him that another VA was conducting an RCA. The patient's EHR does not indicate that he was receiving care at another VA.

We did not substantiate insufficient investigation of the death. As required, a peer review was conducted [Redacted pursuant to 38 U.S.C. § 5705].

The complainant had requested an RCA be conducted. While an RCA was not required in this case, an RCA would have provided an action plan and follow-up for potential system issues. While the complainant emphasized insufficient investigation, what seems more clearly lacking is appropriate administrative follow-up [Redacted pursuant to 38 U.S.C. § 5705]. We have no evidence of any administrative follow-up [Redacted pursuant to 38 U.S.C. § 5705], other than the findings notification memo sent to the

[120] VHA Directive 2010-025, *Peer Review for Quality Management,* June 3, 2010. This Directive expired June 30, 2015, and has not yet been updated.

attending psychiatrist, one social worker, and their respective service chiefs. However, it appears that the other two subjects of the peer review, [Redacted pursuant to 38 U.S.C. § 5705] were informed of the findings. [Redacted pursuant to 38 U.S.C. § 5705].

Although the allegation of insufficient investigation of a patient death is not substantiated, our review found that the [Redacted pursuant to 38 U.S.C. § 5705] were not addressed fully by facility leadership. The complainant's requested RCA would have been an appropriate means to potentially accomplish this, although other methods could alternatively have been utilized by facility managers.

Patient 27

The complainant alleged that his request for an RCA was denied regarding a patient who "…died the night he was admitted" to the inpatient MH unit and that his tracheitis was not adequately addressed in the ED.

In 2013, this 87-year-old patient was hospitalized for 9 days for dementia-related symptoms.[121] The facility subsequently discharged him to live with a family member with a plan for follow-up by outpatient behavioral health geriatrics and PC. Three days following discharge, he presented to the ED with a chief complaint of yellow discharge and chronic pain from his tracheostomy site, and the patient denied any other significant symptoms. A diagnosis of tracheitis was made, and the patient was transferred to JB inpatient MH unit since his family was unwilling to take him home due to combativeness. Vital signs in the ED were unremarkable except a briefly decreased O2 saturation in the 80's that responded to suction; labs were generally within normal range. The ED physician concluded the patient was stable and noted he was admitted to JB.

At JB, the medical staff did not complete a comprehensive admission History and Physical evaluation. During the patient's brief admission including approximately an hour before his death, nurses documented that the patient's breathing was unlabored, pulse oximetry normal, blood pressure intermittently mildly increased, and he was afebrile. He was noted to be taking fluids well. A little more than 24 hours after his ED discharge, he was found cyanotic and unresponsive and subsequently noted to have pulseless electrical activity and later asystole. An autopsy was not performed.

The complainant alleged that the patient died the night he was admitted; however, the death occurred a little more than 24 hours after the patient left the ED. Based on the patient's stable vital signs, unremarkable laboratory studies and imaging, and the nursing documentation of a stable clinical status, we do not find that the patient was acutely medically unstable at the time of his admission to the psychiatric unit. Specifically, the patient did not appear to present with an acute medical condition, such as tracheitis. In fact, the ED physician documented that the patient would have been

[121] Dementia is not a specific disease. It's an overall term that describes a wide range of symptoms associated with a decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities. http://www.alz.org/what-is-dementia.asp, Accessed November 16, 2015.

discharged home if the family had not refused. In an OHI interview, the ED physician acknowledged that the diagnosis of tracheitis was an "overcall" and that the patient was admitted for placement. Although an autopsy was not conducted to provide a definitive conclusion, the patient's death appeared related to an acute event, such as a cardiac event or respiratory mucus plug. Therefore, we found no evidence to support the allegation that the ED staff did not adequately treat the patient's tracheitis.

In June 2013, the complainant sent an e-mail to the system Risk Manager requesting an RCA be completed addressing the circumstances surrounding this patient's death; he was informed that an RCA was not indicated. The day after the death, the system Quality Management staff completed an occurrence screen[122] and then conducted required code and peer reviews. The occurrence screen did not trigger the need for a systems issues review; therefore, an RCA was not pursued.

Patient 28

We substantiated that the follow-up investigation of care management of a MH Intensive Case Management (MHICM) patient's suicide was inadequate. Specifically, we found that peer reviews were not completed timely and not conducted for all health care professionals. Further, follow-up actions were delayed.

The 69-year-old patient was diagnosed with [Redacted pursuant to 38 U.S.C. § 7332] and schizophrenia and had a history of suicidal ideation and at least one suicide attempt. The patient's medical history was remarkable for prostate cancer for which he was service-connected. During the years of 2011–2014, the patient's physical condition gradually deteriorated, and the patient canceled or failed to present for scheduled diagnostic evaluations. The patient engaged in MH treatment at the system beginning in 1995 and had 15 psychiatric admissions with the last one in 2004. The patient was enrolled in the MHICM program (since 2004) and in psychiatric treatment with a Senior Veteran Clinic psychiatrist.

The patient was being visited approximately once a week by a MHICM nurse. In 2014, a Senior Veteran Clinic nurse documented that the patient presented with command auditory hallucinations telling him to shoot himself and requested a suicide prevention hotline card after noticing them in the nurse's desk drawer. The psychiatrist saw the patient the same day and encouraged compliance with medications and prescribed an additional medication for his "persistent dysphoric mood." The patient canceled the follow-up appointment (3 weeks later) due to weather.

Approximately two months later, the PC provider was unable to reach the patient by phone to discuss his test results, so the facility mailed the patient a test result general letter to let him know that his kidney function "is getting worse," he was "slightly

[122] The occurrence screen is a Veterans Health Information Systems and Technology Architecture Software package to increase efficiency in the documenting of occurrences, permit better trend analysis, and provide a consistent format for stored data to be used for QM review at the regional and national levels. The occurrence screen triggers the type of review required. http://architecture.osehra.org/index.htm?goto=4:30:1870. Accessed April 6, 2015.

anemic," and his prostate-specific antigen[123] results were "abnormal." The patient died from a self-inflicted gunshot wound approximately 2 weeks after receiving the letter.

The MHICM nurse informed leadership the day he learned of the patient's death, entered an EHR note 5 days later, and signed the note 2 days after starting the note. The nurse included the Suicide Prevention Coordinator as an additional signer on the note; however, the Suicide Prevention Coordinator did not sign the note until the OIG site visit, 4 months later.

Within a week following the discovery of the patient's death, a leadership team member (LTM) requested an internal management review[124] of other patients managed by the treating psychiatrist and the MHICM nurse. The LTM said that he asked for the management review because he did not want to wait for the peer review since it was a "pretty serious miss." The LTM told us that two psychiatrists completed the management review of the subject psychiatrist's care of other patients and verbally informed the LTM that they did not identify concerns. The LTM acknowledged to us that not asking for written feedback from the psychiatrist reviewers was "an oversight." The written nursing review identified no concerns about standard of nursing care and suggested future consideration of a meeting to include the patient and both MH and PC teams "when a serious health issue" is discussed. Quality Management did not request a formal peer review of the psychiatrist or nurse until the OIG requested the information while on site visit, 112 days after discovery of the event.[125] The delinquent initial review was completed 113 days following discovery of the event although the final review was completed within the 120 calendar days required.

Although the LTM requested corrective action in response to the serious lapse in professional performance, the corrective action requested by the LTM was not completed until approximately 4 months after the completion of the peer review and 8 months after the patient's death. We also found no evidence of consideration of a peer review of the treating PC provider although the patient had clinical encounters with the provider within 30 days of the suicide.[126]

[123] Prostate-specific antigen test measures the blood level of protein-specific antigen, a protein that is produced by the prostate gland. The higher a man's PSA level, the more likely it is that he has prostate cancer.
[124] VHA Directive 2010-025, *Peer Review for Quality Management,* June 3, 2010 defines a management review as any review that is conducted for purposes other than confidential quality improvement related to decisions affecting individual providers. This Directive expired June 30, 2015, and has not yet been updated.
[125] VHA Directive 2010-025, *Peer Review for Quality Management,* June 3, 2010. A peer review is required if a suicide occurs within 30 days of a clinical encounter with a VA health care professional.
[126] VHA Directive 2010-025, *Peer Review for Quality Management,* June 3, 2010. Suicide attempts within 30 days of any clinical encounter do not require a mandatory peer review; however, they must be assessed to determine if a peer review needs to be initiated.

Appendix H

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: January 13, 2016

From: Director, VA Heartland Network (10N15)

Subj: Healthcare Inspection—Review of Complaints Regarding Mental Health Services Clinical and Administrative Processes, VA St. Louis Health Care System, St. Louis, Missouri

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

1. I have reviewed the report of Healthcare Inspection – Review of Complaints Regarding Mental Health Services Clinical and Administrative Processes, VA St. Louis Health Care System, St. Louis, Missouri. I concur with the facility's responses and action plans developed by the facility.

2. If you have any questions or require additional information, please contact Mary O'Shea, VISN 15 Quality Management Officer

William P. Patterson, MD, MSS
Network Director
VA Heartland Network (VISN 15)

Appendix I

Interim System Director Comments

Department of Veterans Affairs

Memorandum

Date: January 12, 2016

From: Interim Director, VA St. Louis Health Care System (657/00)

Subj: Healthcare Inspection—Review of Complaints Regarding Mental Health Services Clinical and Administrative Processes, VA St. Louis Health Care System, St. Louis, Missouri

To: Director, VA Heartland Network (10N15)

1. Thank you for the opportunity to review and discuss the report Healthcare Inspection—Review of Complaints Regarding Mental Health Services Clinical and Administrative Processes, VA St. Louis Health Care System, St. Louis, Missouri.

2. We appreciate the opportunity to work with the Office of Inspector General as we continually strive to improve the quality and service to our Veterans. The professionalism, collaboration, and cooperation that occurred between the Inspection Team and our facility staff was greatly welcomed and valued.

3. An action plan has been developed and implemented for each of the recommendations made and am confident that findings that were identified have been addressed.

Keith Repko
Interim Medical Center Director

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that the Acting VA St. Louis Health Care System Director ensure that Mental Health Service reviews daily psychiatric patient care activity and determine if productivity is consistent with work relative value unit-based productivity and also meets reasonable expectations for number of patients treated.

Concur

Target date for completion: December 31, 2015 (Closed per 2016 Update)

Facility response: In March 2015 the Associate Chief of Staff for Mental Health Service established the Mental Health Productivity Work Group. This group meets monthly to review VASTLHCS performance with national benchmarks and examine individual provider who have work RVU of 90% or lower than performance targets, work RVU per encounter outlier either higher than or lower than national targets, and tacking of results and actions to automated auditing report. The group provides feedback to individual providers and program managers when variation is identified and recommends changes to address the identified issue. The Associate Chief of Staff for Mental Health is responsible for ensuring that individual providers and program managers complete the process.

OIG Update: Based on information provided to us in November 2016, we determined the planned actions have been completed for Recommendation 1 and we consider the recommendation closed.

Recommendation 2. We recommended that the Acting VA St. Louis Health Care System Director ensure that staff psychiatrists' scheduling grids are consistent with expected patient care activity.

Concur

Target date for completion: December 31, 2015 (Closed per 2016 Update)

Facility response: The ACOS Mental Health and Mental Health Outpatient Program Manager have established standard scheduling criteria for psychiatrist. An example is for full time psychiatrist it is expected that a full clinic day would be 6 ½ hours of 30 minute appointments with one 30 minute overbook appointment for 14 appointment per day in direct patient care activities. These activities include various types of appointments such as face to face appointment, telephone appointments, intake and telehealth appointments. Additionally, criteria for administrative duties such as APRN collaboration reviews and the manner in which scheduling grids are blocked for these duties were established. A review of psychiatrist scheduling grids was completed by the

Mental Health Administrative Officer and Associate Chief of Staff Mental Health Services and found that 100% complied with the established criteria and expected patient care activity.

OIG Update: Based on information provided to us in November 2016, we determined the planned actions have been completed for Recommendations 2 and we consider the recommendation closed.

Recommendation 3. We recommended that the Acting VA St. Louis Health Care System Director strengthen processes to review and rectify psychiatry staff's Current Procedural Terminology coding errors.

Concur

Target date for completion: September 30, 2017

Facility response: VA St Louis Health Care System Health Information Management Coding specialist has provided education sessions to psychiatry staff on April 7, 2015 and September 1, 2015. A follow up education session is planned for January 5, 2016. The Mental Health Productive Work Group identified common coding error through their review process. Using this information the Mental Health Data Analysist has developed an automated audit report that identifies some of the common coding errors. An example is use of psychotherapy code or medication management code with intake code. This audit is completed monthly and used as an ongoing monitor. This is information if provided to the psychiatry staff to act upon to correct the error and remedial education is provided as identified. The VASTLHCS HIM staff will conduct coding audit by May 2016 of a sample of each psychiatrist encounters as a follow up monitor to the previously performed coding audits.

Recommendation 4. We recommended that the Acting VA St. Louis Health Care System Director strengthen processes for timely response to mental health clinic group treatment patient referrals.

Concur

Target date for completion: September 30, 2017

Facility response: The Associate Chief of Staff directed the Mental Health Director of Operation to strengthen the process for timely response to mental health clinic group referrals. The Mental Health Director of Operations identified that gaps that occurred was in the management of the mental health clinic group consults. To address this issue all Mental Health staff responsible for managing or completing mental health group consults completed TMS training "What Every Clinician should know about Consults." This training was completed by August 1, 2015. Additional training has been provided on a one on one basis for induvial who continued to have difficulties with managing or completing the consult appropriately. These individuals are identified through the consult quality audit conducted by Program Managers. Monitoring of this process will continue through 2nd quarter fiscal year 2016.

Recommendation 5. We recommended that the Acting VA St. Louis Health Care System Director ensure that mental health staff adequately assess and document treatment needs and follow-up arrangements for unscheduled (walk-in) patients.

Concur

Target date for completion: September 30, 2017

Facility response: The Associate Chief of Staff for Mental Health Services chartered an inter-disciplinary work group to develop a standard procedure for unscheduled (walk-in) patients to ensure that the appropriate assessment, treatment and follow up is established and documented. Mental Health Service Standard Operating Procedure 116-29 "Same Day and Direct Access to Mental Health Services" was developed, approved and published on February 12, 2015. All applicable staff received communication and information on this standard procedure.

Recommendation 6. We recommended that the Acting VA St. Louis Health Care System Director ensure that facsimile machine numbers provided to referral sources are functional and appropriately located for timely response.

Concur

Target date for completion: December 29, 2015 (Closed per 2016 Update)

Facility response: Mental Health Program Managers completed a review of all material provided to referral sources to check the accuracy of facsimile numbers. The facsimile machine in all locations were found to be functional and located in areas with staff to ensure that a timely response.

OIG Update: Based on information provided to us in November 2016, we determined the planned actions have been completed for Recommendation 6 and we consider the recommendation closed.

Recommendation 7. We recommended that the Acting VA St. Louis Health Care System Director strengthen the Compensation and Pension evaluation documentation processes to enhance accuracy of information.

Concur

Target date for completion: January 31, 2016 (Closed per 2016 Update)

Facility response: A retrospective chart review will be conducted on a random sample of 70 records Compensation and Pension Evaluations completed between October 1, 2014 to September 30, 2015 using a standardize audit tool to review the compliance with documentation standard and accuracy in documentation. If results of this audit are less than 95% then action plans will be developed to address the identified area of noncompliance and monitoring will continue until 95% is reached. If 95% compliance is achieved then no further auditing will be conducted.

OIG Update: Based on information provided to us in November 2016, we determined the planned actions have been completed for Recommendations 7 and we consider the recommendation closed.

Recommendation 8. We recommended that the Acting VA St. Louis Health Care System Director strengthen processes to include patients in treatment planning when there is a transfer to another clinic.

Concur

Target date for completion: September 30, 2017

Facility response: The Associate Chief of Staff for Mental Health directed the Mental Health Outpatient Manager to establish a standard process for transferring a Veteran to another clinic to ensure that the Veteran is involved in the discussion and decision making for the change in treatment plan. This information will be documented as an update to Veteran's treatment plan. Upon implementation, the Mental Health Outpatient Program Manager will monitor to 100% of clinic transfer for two months to ensure compliance with this process change.

Recommendation 9. We recommended that the Acting VA St. Louis Health Care System Director ensure that management and peer reviews are inclusive of all relevant clinicians and timely and that managers take appropriate follow-up actions, if indicated.

Concur

Target date for completion: September 30, 2017

Facility response: The VASTLHCS Risk Manager completed a retrospective review of peer reviews completed in 2nd quarter of Fiscal Year 2015 showed that 74 peer review were completed that resulted in 115 providers requiring notification. 115 providers received communication on the results of peer review and follow up actions if required were completed for a 100% compliance rate (115/115). 2nd quarter Fiscal Year 2015 peer review timeliness report showed that all peer review timeliness requirements were met.

Appendix J

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
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Appendix K

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