**Department of Veterans Affairs**
**Office of Inspector General**

**Office of Healthcare Inspections**

**Report No. 15-01653-226**

# Healthcare Inspection

# Alleged Program Mismanagement and Other Concerns at the VA Southern Oregon Rehabilitation Center and Clinics White City, Oregon

**May 17, 2017**

**Washington, DC 20420**

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# Executive Summary

The VA Office of Inspector General conducted a healthcare inspection in response to allegations received from a complainant regarding program mismanagement and other concerns at the VA Southern Oregon Rehabilitation Center and Clinics (SORCC), White City, OR. Specifically, the complainant alleged that:

- Home Based Primary Care (HBPC), the Transitional Care Unit (TCU), the Non-Institutional Purchased Care program (specifically, the Homemaker and/or Home Health Aide services (H/HHA)), and the Housing and Urban Development Veterans Affairs Supported Housing (HUD-VASH) program were mismanaged and lacked appropriate oversight.
- Services, such as occupational therapy, physical therapy, case management, discharge planning, and mental health, were unavailable.
- Services were denied to patients as a result of other patients receiving services inappropriately.
- TCU patients' lengths of stay (LOS) were based on need for reimbursement rather than clinical criteria.
- H/HHA service hours were inflated.
- Patients were harmed at the SORCC.
- Training and educational resources were unavailable for staff.

We did not substantiate that:

- The HBPC program and the TCU were mismanaged or lacked oversight. We found that the HBPC program and the TCU complied with selected Veterans Health Administration requirements; oversight committees were in place; members attended meetings; and action items were identified, addressed, and resolved.
- H/HHA and HUD-VASH programs were mismanaged. We initially substantiated that these programs lacked appropriate oversight as the Community Care Oversight Committee (H/HHA oversight) and the HUD-VASH program committee did not have required attendance or documentation of relevant program issues as described in VHA and local policy. However, based on updated information we received in 2016, we noted new committee leadership, required attendance, and discussion of relevant program issues.
- Services, such as occupational therapy, physical therapy, case management, discharge planning, and mental health care were unavailable. The complainant did not specify which programs or patients had services unavailable to them. Therefore, we determined what programs to review through our interviews with multiple staff and review of required services identified in each program directive or handbook.

HBPC and Mental Health (MH) have difficulty recruiting rehabilitation therapists, psychologists, and psychiatrists for the SORCC rural area; however, the patients we reviewed received required services. Case Management provided support to all patients assigned to the TCU during our onsite visit in February 2015. Discharge Planning was provided to an identified HUD-VASH patient and to all of the TCU patients present during our site visit in February 2015.

- Services were denied to patients because of other patients receiving services inappropriately. One patient was denied admission to the Mental Health Residential Rehabilitation Program (MH RRTP) due to the patient's history of disruptive behavior. The patient was provided the rationale for non-acceptance into the MH RRTP and assisted to explore alternative sources of care. We were not provided, and our inspection did not reveal, names of other patients who were denied services.
- TCU patients' LOS were based on need for reimbursement rather than clinical criteria. During our February 2015 site visit, we identified 11 patients with LOS over 90 days. The facility addressed MH and clinical care needs for these patients. By using the SORCC TCU Provision of Care document as our reference, we determined the increased LOS were appropriate based on the inability of the patients to be fully successful in the traditional SORCC setting or in the community.
- H/HHA inflated service hours. We found the H/HHA Coordinator expressed concerns regarding inflation of care needs without clinical justification; however, the H/HHA coordinator was the individual responsible for approving the required hours. The billing office paid the hours that were clinically justified; however, they did question the spike in billable hours. The business office requested communication regarding increases in clinical needs, which would impact the resources required for the veteran. There was miscommunication between the billing office and the H/HHA coordinator.
- Patients suffered harm. The complainant did not provide names of specific patients who may have suffered harm. A staff member provided us the name of a patient who, while on an authorized absence, was allegedly assaulted and stranded in another town and "kicked out" of the MH RRTP without appropriate housing or follow-up care. We found that SORCC staff made travel arrangements for the patient to return to the SORCC campus and determined that the patient had been appropriately discharged from the MH RRTP according to SORCC criteria, was placed in community housing, and provided follow-up care.
- Training and educational resources were unavailable to staff. We found that various educational resources were available to staff and that management supported necessary clinical training.

We made no recommendations.

## Comments

The Veterans Integrated Service Network and SORCC Directors reviewed the report and concurred with the conclusions. (See Appendixes A and B, pages 14–15 for the Directors' comments.) No further action is required.

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

# Purpose

The VA Office of Inspector General (OIG) conducted a healthcare inspection in response to allegations received from a complainant concerning program mismanagement and other concerns at the VA Southern Oregon Rehabilitation Center and Clinics (SORCC), White City, OR. The purpose of the inspection was to determine if the allegations had merit.

# Background

VA SORCC provides residential rehabilitative care and outpatient primary and mental health care to veterans. Rehabilitation and therapeutic services are provided through the following programs: Substance Abuse Treatment, Psychosocial Rehabilitation and Recovery, Home Based Primary Care (HBPC), Vocational Rehabilitation, Housing and Urban Development-Veterans Affairs Supported Housing (HUD-VASH), and Non-Institutional Purchased Care. In addition, programs are offered for Operation Enduring Freedom, Operation Iraqi Freedom, and Native American Veterans. The SORCC currently operates 525 residential rehabilitation beds, including 64 transitional care unit (TCU) beds.[1]

### Allegations

On November 26, 2014, we received a complaint with multiple allegations concerning program mismanagement and other concerns at the SORCC. Specifically, it was alleged that:

- HBPC, the TCU, the Non-Institutional Purchased Care Program (specifically, the Homemaker and/or Home Health Aide services (H/HHA)) and the HUD-VASH program were mismanaged and lacked appropriate oversight.
- Services were unavailable for occupational therapy (OT), physical therapy (PT), case management, discharge planning, and mental health (MH).
- Services were denied to patients due to others receiving services inappropriately.
- TCU lengths of stay (LOS) were determined on need for reimbursement rather than clinical or program criteria.
- H/HHA service hours were inflated.
- Patients were harmed at the SORCC.
- Training and educational resources were unavailable for staff.

[1] About the Southern Oregon Rehabilitation Center and Clinics. http://www.southernoregon.va.gov/about/index.asp. Accessed December 30, 2015.

# Scope and Methodology

We conducted our review from January 1, 2014 through March 20, 2016 with an update in February 2017. We made a site visit February 3–5, 2015. We interviewed the complainant, SORCC Director, Associate Director of Patient Care Services/Nurse Executive, Acting Chief of Staff, Associate Chief of Staff for MH, Quality Management Director, the Compliance/Equal Employment Opportunity Officer, Patient Safety Manager, Human Resources Officer, a former SORCC Business Office Analyst, Veterans Integrated Service Network (VISN) 20 Business Office Director, VISN 20 Quality Manager, and SORCC program managers and staff.

We reviewed Veterans Health Administration (VHA) and SORCC policies and procedures, SORCC staffing data, position descriptions, committee meeting minutes and reports, external accreditation reviews, electronic health records (EHR), and other relevant documents.

Six policies cited in this report were beyond their recertification due dates:

1. VHA Handbook 1141.01, *Home-Based Primary Care Program*, January 31, 2007, (recertification due date February 28, 2012)

2. VHA Handbook 1162.02, *Mental Health Rehabilitation Treatment Program* December 22, 2010 (recertification due date December 31, 2015)

3. VHA Handbook 1160.01, *Uniform Mental Health Services In VA Medical Centers and Clinics*, September 11, 2008 (recertification due date September 20, 2013)

4. VHA Handbook 1140.6, *Purchased Home Health Care Services,* July 21, 2006, (recertification due date July 31, 2011)

5. VHA Handbook 1162.05, *Housing and Urban Development (HUD)-Department of Veterans Affairs Supported Housing (VASH) Program,* September 14, 2011 (recertification due date September 30, 2016)

6. VHA Handbook 1170.01, *Accreditation of Veterans Health Administration Rehabilitation Program.* September 5, 2008 (recertification due date September 30, 2013)

We considered these policies to be in effect, as they had not been superseded by more recent policy or guidance. In a June 29, 2016 memorandum to supplement policy provided by VHA Directive 6330(1),[2] the VA Under Secretary for Health (USH) mandated the "…continued use of and adherence to VHA policy documents beyond their recertification date until the policy is rescinded, recertified, or superseded by a more recent policy or guidance."[3] The USH also tasked the Principal Deputy Under

[2] VHA Directive 6330(1), *Controlled National Policy/Directives Management System,* June 24, 2016, amended January 11, 2017.
[3] VA Under Secretary for Health Memorandum. *Validity of VHA Policy Document,* June 29, 2016.

Secretary for Health and Deputy Under Secretaries for Health with ensuring "…the timely rescission or recertification of policy documents over which their program offices have primary responsibility."[4]

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.

[4] VA Under Secretary for Health Memorandum. *Validity of VHA Policy Document,* June 29, 2016.

# Inspection Results

## Issue 1: Program Mismanagement and Oversight

We reviewed the management and oversight of the following programs: HBPC, TCU, H/HHA, and HUD/VASH. We did not substantiate the allegation that the HBPC or TCU programs were mismanaged or lacked appropriate oversight. We did not substantiate the allegation that the H/HHA and HUD-VASH programs were mismanaged, but we substantiated that these programs lacked appropriate oversight. For purposes of this report, management is defined as the day-to-day operations of a program, and oversight is the governance that ensures structures, functions, and processes comply with VHA policies and procedures.

<u>HBPC Program</u>

The HBPC program provides health care services to veterans in their homes VHA requires HBPC programs to establish interdisciplinary teams; have weekly meetings to discuss patients and formulate care plans; and maintain local policy and procedures that address safety, environmental safety, and medication management and integration with non-VA Home Care Services.[5] Our evaluation of HBPC program management found that the program has a multi-disciplinary care team that provides services including primary care visits and care management through a physician, nurse practitioner, or physician's assistant; coordination of care through a social worker; rehabilitation services; MH services; nutrition counseling; and medication management. HBPC Committee weekly meeting minutes included discussion of interdisciplinary Team Treatment Plans for enrolled patients, necessary referrals, admission and discharge information, discussion of quality and safety, and provider updates. HBPC Standard Operating Procedures for fiscal year (FY) 2014 were current. We found staff used the Zarit Caregiver Burden tool to assist in assessing the veteran and caregivers' need for additional resources.[6]

Oversight of the HBPC program included systematic measurement and assessment of patient care outcomes and systems and processes affecting patient care as required by VHA.[7] We found SORCC staff conducted quarterly HBPC EHR oversight reviews, and action plans were developed for FY 2014 and the first quarter of FY 2015 to improve unsatisfactory performance measures for HBPC.[8] SORCC staff also conducted a risk assessment (Healthcare Failure Mode and Effect Analysis) to evaluate home based oxygen therapy processes. In addition, they identified a need for HBPC expansion into

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[5] VHA Handbook 1141.01, *Home-Based Primary Care Program*, January 31, 2007. This VHA Handbook was scheduled for re-certification on or before the last working day of February 2012 but has not yet been re-certified.

[6] The Zarit Burden Interview is a tool used to assess the burden among caregivers of cognitively impaired adults. http://gerontologist.oxfordjournals.org/citmgr?gca=geront%3B41%2F5%2F652 Accessed January 4, 2016.

[7] VHA Handbook 1141.01, *Home-Based Primary Care Program*, January 31, 2007.

[8] Per updated information received in December 2016, we determined that the facility continued to conduct systematic measurement and assessment of HBPC program patient care outcomes throughout FYs 2015 and 2016.

a third site and identified available and required full-time equivalent employees (FTE) for safe and adequate staffing.

TCU

The SORCC TCU staff care for veterans with significant psychosocial/medical conditions including substance use disorders, severe and persistent mental illness, homelessness, traumatic brain injury (non-acute), and neurocognitive disorder. Veterans may also have medical conditions including limited mobility, increased fall risk, oxygen dependency, incontinence, stroke or cardiac history, and poor self-care resulting in declining physical function.[9]

The SORCC opened the TCU in June 2014 after managers analyzed data from non-institutional purchased care and a survey assessing the needs of veterans. They found service gaps for veterans who were unable to meet the requirements of the standard mental health residential rehabilitation treatment program (MH RRTP) and instances in which hospitalization or nursing home level of care was not medically necessary.

We evaluated the management of the TCU program. The facility provided us with a summary of requirements for admission to the TCU. We reviewed 36 EHRs of patients who were in the TCU the week of February 5, 2015 and found the patients had significant psychosocial/medical needs that met admission requirements. The TCU has adopted and incorporated the standards of practice from VHA Handbook 1162.02, *Mental Health Rehabilitation Treatment Program* (December 22, 2010), and VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics* (September 11, 2008), as required by accrediting bodies.[10] The VHA Handbooks and the local provision of care include requirements for interdisciplinary assessments, reassessments, treatment, and discharge planning. The 36 EHRs reviewed included documentation of multidisciplinary assessments, reassessments, treatment plans, and discharge planning. We found interdisciplinary services included licensed practical nurses, registered nurses, certified nursing assistants, dietician, social workers, a psychologist, and a recreation therapist. In February 2015, a consult was submitted if rehabilitation therapy was required. Projections for future staffing included an occupational therapist, a physical therapy assistant, and a gero-psychiatrist.

We found the Rehabilitation Executive Committee provided oversight as the TCU increased its census gradually from 7 to 36 patients in February 2015. We reviewed FY 2014 meeting minutes from the TCU, Rehabilitation Executive Council, and Health Information Management Committee, which reflected oversight of patient safety,

[9] Transitional Care Unit Brochure, Department of Veterans Affairs Southern Oregon Rehabilitation Center and Clinics. http://www.southernoregon.va.gov/TCUPub1.pdf. Accessed February 6, 2015.

[10] VHA Handbook 1162.02 was scheduled for recertification on or before the last working day of December 2015 and has not yet been recertified. VHA Handbook 1160.01was scheduled for recertification on or before the last working date of September 2013; it was amended November 16, 2015, but the recertification date was not affected by the November amendment.

development of standard operating procedures, and identification of quality measures for access, effectiveness, efficiency, and satisfaction.

H/HHA Program

The H/HHA program contracts with non-VA health care services for a home health aide to provide assistance to veterans with activities of daily living and/or other care needs.[11] We reviewed the management of the H/HHA program and found services were provided under registered nurse supervision, as required by VHA, though the registered nurses were provided from the contracted home health care agencies. The SORCC provided an H/HHA Coordinator who is a social worker and additional support from a social worker intern.

The SORCC Business Office provided us a list of patients who received H/HHA services from July 1, 2014, through February 4, 2015. We reviewed all 86 EHRs of unique patients who received services for greater than 6 months and were not respite-only patients. We found that, as required by VHA, the H/HHA Coordinator completed all initial evaluations and assessed the need for additional hours or services after visiting with patients and/or designated family members. The H/HHA Coordinator, with agency registered nurse input, completed assessments at least every 6 months, which included verification of service hours provided.[12,13]

We found that, as required by VHA, the H/HHA Coordinator placed patients on an electronic wait list (EWL) if budget or agency resources were not sufficient to meet all identified home health care needs. Priority was given to veterans who were in receipt of, or were in need of nursing home care primarily for the treatment of a service-connected disability, or who had a service-connected disability rated at 50 percent or more.[14]

We reviewed an audit submitted by SORCC to VHA Office of Geriatrics and Extended Care and found that the facility's H/HHA agencies remained in good standing with state licensing and certifying agencies. Medicare certified home health care agencies under VA contract performed better than the state average on at least 50 percent of the Centers for Medicare and Medicaid Services quality measures and complied with Centers for Medicare and Medicaid Services requirements.[15] This met criteria for agencies under VHA contract.[16]

In a local policy memorandum, the Rehabilitation Executive Committee defines the charge of the Community Care Oversight Committee (CCOC) to provide multidisciplinary support, guidance, quality oversight, and a venue for problem solving

[11] VHA Handbook 1140.6, *Purchased Home Health Care Services,* July 21, 2006. This VHA Handbook was scheduled for re-certification on or before the last working day of July 2011 but has not yet been re-certified.
[12] Ibid.
[13] Medical Center Memorandum 00-102, *Medical Executive Committee, Attach K*, July 7, 2012.
[14] VHA Handbook 1140.6.
[15] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics.*
[16] VHA Handbook 1140.6.

concerns. The memorandum further describes the requirements of quarterly meetings, core membership, and relevant issues to be discussed at committee.[17]

We assessed H/HHA oversight by reviewing the meeting minutes of the SORCC's CCOC from FY 2014 and quarter 1 of FY 2015. Though required in the local memorandum, we found no evidence in the minutes of required attendance and no documented discussions of relevant program issues as described in local policy.[18] We also requested 6 months of CCOC minutes for quarters 2 and 3 of FY 2016, which showed that the Committee Chair has changed, attendance had improved, and an updated local policy was in place. These 2016 minutes included evidence of required attendance and documented discussions of relevant program issues.

HUD-VASH

HUD-VASH is a partnership between HUD and VA in which HUD provides rental assistance vouchers to homeless veterans and VA provides case management staff and other clinical services as needed.[19] We reviewed the management of the HUD-VASH program to determine if case managers were providing outreach services, screening and assessing patients to determine appropriate placements, conducting psychosocial evaluations to determine case management needs and recovery goals, and providing access to appropriate treatment, supportive case management, and referrals as required by VHA.[20]

The SORCC conducted quarterly HUD-VASH chart audits for quarters 1 through 4, FY 2014 and quarter 1 FY 2015. These audits reviewed performance measures in the areas of emotional/behavioral assessments, social history, care, treatment, and services planned. We reviewed these audits and found an occasional quarter where a performance measure dropped below 90 percent compliance but subsequently was improved and maintained. In addition, 90 percent of the time or greater, an emotional and behavioral assessment and a psychosocial assessment or social history of each veteran was completed and entered in the EHR. Care, treatment, and services planned were compliant 90 percent of the time or greater.

Oversight required by VHA includes ensuring that HUD-VASH meets all accreditation requirements and that staff meetings discuss treatment plans, compliance issues, progress, and discharge from the program. In addition, program planning, administration, and quality and performance initiatives or activities should be addressed.[21] We found that the facility attained accreditation from the Commission on

[17] Medical Center Memorandum 00-102, Attachment K.
[18] Ibid.
[19] VHA Handbook 1162.05, *Housing and Urban Development (HUD)-Department of Veterans Affairs Supported Housing (VASH) Program,* September 14, 2011. This VHA Handbook was scheduled for re-certification on or before the last working day of September 2016 and has not yet been recertified.
[20] Ibid.
[21] Ibid.

Accreditation of Rehabilitation Facilities in 2013.[22] However, in our review of HUD-VASH committee meeting minutes for quarters 1 through 4 of FY 2014 and quarter 1 of FY 2015, we found no evidence of required attendance and no documented discussion of relevant program issues as required by VHA policy.[23] We also requested 6 months of HUD/VASH minutes for quarters 2 and 3 of FY 2016, which showed that the Committee Chair had changed and included evidence of required attendance and documented discussions of relevant program issues.

### Issue 2: Availability of Services

We did not substantiate the allegation that services, such as rehabilitation services (OT and PT), case management, discharge planning, and MH, were unavailable. The complainant did not specify which programs or patients had services unavailable to them. Therefore, we determined what programs to review through our interviews with multiple staff and review of required services identified in each program directive or handbook.

HBPC Rehabilitation Services (OT, PT)

The complainant and other staff we interviewed did not provide names of specific patients or instances in which OT or PT services were denied or unavailable. According to VHA, HBPC teams must include staff from rehabilitation services (OT or PT) to perform an initial and ongoing assessment of the veteran's functional needs, home evaluation for safety and accessibility, need and education for home medical equipment, equipment troubleshooting, and education to caregivers to minimize risk.[24] We did not identify additional programs that required rehabilitation services except for TCU, and we were not told of any concerns in TCU.

The HBPC program was allocated three rehabilitation therapist positions. However, in February 2015, only one rehabilitation therapist position was filled to cover White City, Klamath Falls, and the recently expanded Grant Pass HBPC teams. The HBPC Manager indicated that program leaders had been actively recruiting for the two other positions. The HBPC Manager informed us that it has been difficult to recruit a therapist for these rural areas. As of May 2016, each of the three facilities had a full-time Physical Therapist on staff.

We reviewed the EHRs of 22 HBPC patients who, according to the SORCC, received rehabilitation therapy consults during the period January 2013 through February 2015. We found that rehabilitation therapists conducted in-home environmental safety risk assessments within 30 days, developed environmental/safety risk care plans, and documented interventions, even though two of the three rehabilitation positions were not filled during this period.

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[22] VHA Handbook 1170.01, *Accreditation of Veterans Health Administration Rehabilitation Program.* September 5, 2008. This VHA Handbook was scheduled for re-certification on or before the last working day of September 2013 but has not yet been recertified.

[24] VHA Handbook 1141.01, *Home-Based Primary Care Program*, January 31, 2007.

Case Management

The complainant and other interviewees did not provide specific names or incidences of patients who should have but did not receive case management. VHA requires case management services be provided to individuals who require higher levels of care.[25] These individuals may "require intensive support and monitoring due to complex medical, mental health, or psychosocial factors beyond the services offered by the care management team."[26]

We reviewed all 36 EHRs of patients in the TCU at the time of our February 2015 onsite visit, as these patients met the criteria of individuals who required intensive support. We found that each patient had a case manager and that documentation in the EHR met VHA[27] and local[28] policy requirements. We reviewed the SORCC's 2013 Commission on Accreditation of Rehabilitation Facilities Survey and did not find case management recommendations.

Discharge Planning

An interviewee identified a HUD-VASH patient who allegedly did not receive discharge planning. We reviewed the EHR of the identified patient and found documentation of interdisciplinary team discharge planning and an anticipated discharge date as per local policy.[29] Additionally, as discussed previously, we reviewed the EHRs of 36 TCU patients and found documentation of interdisciplinary team discharge planning in all 36 EHRs.

MH Services

The complainant and other interviewees did not provide patient names or specific cases related to unavailability of MH services. VHA Handbook 1160.01 describes the structure and governance of MH services as programs that must not function as isolated entities. Core MH professions include psychiatry, psychology, social work, and nursing.[30]

We reviewed meeting minutes for HBPC, HUD-VASH, TCU, Rehabilitation Executive Council, and the CCOC. We found active participation from all the core MH professions.

We interviewed the Associate Chief of Staff for Mental Health. He described the active process that has been progressing to identify current and projected staffing needs for MH at the SORCC. An MH GAP Analysis in January 2015 identified that MH RRTP

[25] VHA Handbook 1110.04, *Case Management Standards of Practice*, May 20, 2013.
[26] Ibid.
[27] Ibid.
[28] Medical Center Memorandum 11-014, *Treatment Management,* February 6, 2014.
[29] Ibid.
[30] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics,* September 11, 2008.

staff provided almost all outpatient services, and outpatient MH staffing did not adequately increase to meet the demand. However, MH staff increased from 140 to 220 FTE positions between May 2013 and February 2015. In January 2015, the MH Gap Analysis revealed that 139 patients were on the EWL and the wait time for new MH patients (outpatient and residential) was approximately 3 months. We requested and reviewed updated information in February 2017, and noted no MH patients were on the EWL.

MH staffing management indicated that throughout the SORCC, they have had issues with hiring and retaining psychiatrists and psychologists; however, they are actively working to fill positions by advertising for additional staff, hiring locum tenens, and contracting with a recruiting agency. In addition to onsite Mental Health Providers, a VISN 20 Telehealth Psychiatry Hub in Boise, ID, is providing MH Telehealth services. While we identified delays in the provision of MH care, the Associate Chief of Staff for Mental Health and other staff we interviewed were unable to identify patients who did not receive MH services as needed.

### Issue 3: Denial of Services

We did not substantiate the allegation that services were denied to patients as a result of other patients receiving services inappropriately. The complainant did not specify which services were denied.

A staff member provided the name of a specific patient who was offered a less restrictive treatment alternative in an outpatient program after having been denied admission to the MH RRTP for his history of disruptive behavior. Staff provided information to the patient regarding rationale for non-acceptance into the program and assisted the patient to explore alternative sources of care.[31] The patient completed the outpatient treatment within 6 months, and the Disruptive Behavior Committee evaluated and subsequently admitted the patient to the MH RRTP. We were not provided, and our inspection did not reveal, names of other patients who were denied services.

### Issue 4: Compliance

TCU LOS

We did not substantiate the allegation that the LOS of TCU patients was based on need for reimbursement rather than clinical criteria. TCU admission criteria requires that patients admitted to the TCU have significant psychosocial[32] and/or medical[33] needs and the ability to attain independent daily functioning within 100 days of intensive psychosocial and physical rehabilitation services.

[31] Medical Center Memorandum 11-013, *Admission Screening Guidelines.* January 29, 2014.
[32] Typical psychosocial conditions include substance use disorders, severe and persistent mental illness, homelessness, traumatic brain injury (non-acute), and neurocognitive disorder.
[33] Typical medical conditions include limited mobility, increased fall risk, oxygen dependency, incontinence, stroke or cardiac history, and declining physical function owing to poor self-care.

We reviewed the EHRs of the 36 TCU patients in residence at the time of our February 2015 onsite visit and found documentation of clinical admissions criteria. Of the 36 patients reviewed, we found 11 patients with an LOS over 90 days. The facility addressed MH and clinical care needs for these patients. By using the SORCC TCU Provision of Care document as our reference, we determined the increased LOS was appropriate based on the patients' inability as of February 4, 2015, to be fully successful in the traditional SORCC setting or in the community.

H/HHA Inflated Service Hours

We did not substantiate the allegation that H/HHA services had inflated service hours without clinical justification.

We found the H/HHA Coordinator expressed concerns regarding inflation of care needs without clinical justification; however, the H/HHA coordinator was the individual responsible for approving the required hours. The billing office paid the hours that were clinically justified; however, they did question a spike in billable hours. The business office requested communication regarding increases in clinical needs, which would impact the resources required for the veteran. There was miscommunication between the billing office and the H/HHA coordinator.

From the list of H/HHA patients provided to us by the business office,[34] we reviewed the EHRs of the 86 unique patients and found that the hours paid matched the approved hours from the H/HHA coordinator.

### Issue 5: Patient Safety

We did not substantiate the allegation that patients were harmed. The complainant did not provide names of specific patients who may have suffered harm.

We asked staff members onsite about possible harm to patients. We were provided the name of a patient who, while on an authorized absence, was allegedly assaulted and stranded in another town and "kicked out" of the MH RRTP without appropriate housing or follow-up care.

We reviewed the patient's EHR and found documentation of a visit to a non-VA emergency department where he/she was evaluated and referred to a shelter. We found that SORCC staff made travel arrangements for the patient to return to the SORCC campus and determined that the patient had been appropriately discharged from the MH RRTP according to SORCC criteria,[35] was placed in community housing, and provided follow-up care.

[34] The SORCC Business Office provided us a list of patients who received H/HHA services from July 1, 2014, through February 4, 2015 (see p. 6).
[35] Resident Handbook SORCC, May 30, 2012.

### Issue 6: Training and Educational Resources

We did not substantiate the allegation that training and educational resources were unavailable to staff. VHA requires that all employees receive the appropriate training for the development and maintenance of a competent workforce. Staff informed us that they had many opportunities for training to include training through the online VA Learning University Talent Management System, offsite VA training, SORCC in-services, community classes, and/or non-VA conferences and seminars.[36]

## Conclusions

We did not substantiate the allegation that the HBPC program and the TCU were mismanaged or lacked oversight. We found that HBPC program and the TCU complied with VHA requirements and that committee members attended meetings and action items were identified, addressed, and resolved.

We did not substantiate the allegation that the H/HHA and HUD-VASH programs were mismanaged. We initially substantiated that these programs lacked appropriate oversight. We found that the CCOC (H/HHA oversight) and the HUD-VASH program committee did not have required attendance, and no documentation of relevant program issues as described in VHA and local policy. However, as of 2016, we noted new committee leadership, required attendance, and discussion of relevant program issues.

We did not substantiate the allegation that services, such as OT, PT, case management, discharge planning, and MH care, were unavailable. The complainant did not specify which programs or patients had services unavailable to them. Therefore, we determined what programs to review through our interviews with multiple staff and review of required services identified in each program directive or handbook. HBPC and MH have difficulty recruiting rehabilitation therapists, psychologists, and psychiatrists for the SORCC rural area; however, the patients we reviewed received required services. Case management staff provided support to all patients assigned to the TCU during our onsite visit in February 2015. Discharge planning was provided to an identified HUD-VASH patient and to all of the TCU patients present during our site visit.

We did not substantiate the allegation that services were being denied to patients because of other patients receiving services inappropriately. One patient was denied admission to the MH RRTP due to the patient's history of disruptive behavior. The patient was provided the rationale for non-acceptance into the MH RRTP and assisted to explore alternative sources of care. We were not provided, and our inspection did not reveal, names of other patients who were denied services.

We did not substantiate the allegation that TCU patients' LOS were based on need for reimbursement rather than clinical criteria. We found 11 patients with LOS over

90 days. The facility addressed MH and clinical care needs for these patients. By using the SORCC TCU Provision of Care document as our reference, we determined the increased LOS was appropriate based on the patients' inability as of February 4, 2016, to be fully successful in the traditional SORCC setting or in the community.

We did not substantiate the allegation of H/HHA inflated service hours. We found the H/HHA Coordinator expressed concerns regarding inflation of care needs without clinical justification; however, the H/HHA coordinator was the individual responsible for approving the required hours. The billing office paid the hours that were clinically justified; however, they did question the spike in billable hours. The business office requested communication regarding increases in clinical needs, which would impact the resources required for the veteran. There was miscommunication between the billing office and the H/HHA coordinator.

We did not substantiate the allegation of possible harm to patients. The complainant did not provide names of specific patients who may have suffered harm. We were provided the name of a patient who, while on an authorized absence, was allegedly assaulted and stranded in another town and "kicked out" of the MH RRTP without appropriate housing or follow-up care. We found that SORCC staff made travel arrangements for the patient to return to the SORCC campus and determined that the patient had been appropriately discharged from the MH RRTP according to SORCC criteria,[37] was placed in community housing, and provided follow-up care.

We did not substantiate the allegation that training and educational resources were unavailable. We found educational resources were available and that management supported necessary clinical training.

We made no recommendations.

**Appendix A**

# VISN Director Comments

**Department of Veterans Affairs** **Memorandum**

**Date:** Date: March 16, 2017

**From:** Director, Northwest Network (10N20)

**Subj:** Healthcare Inspection— Alleged Program Mismanagement and Other Concerns at the VA South Oregon Rehabilitation Center and Clinics, White City, Oregon

**To:** Regional Director, Denver Office of Healthcare Inspections (54DV)
Director, Management Review Service (VHA 10E1D MRS Action)

1. I have reviewed and concur with the findings and with the conclusions of no recommendations regarding the Office of Inspector General Healthcare Inspection report.

(*original signed by:)*

Michael J. Murphy

Appendix B

# SORCC Director Comments

## Department of Veterans Affairs

## Memorandum

Date: Date: March 15, 2017

From: Director, VA Southern Oregon Rehabilitation Center and Clinics (692/00)

Subj: Healthcare Inspection— Alleged Program Mismanagement and Other Concerns at the VA South Oregon Rehabilitation Center and Clinic, White City, Oregon

To: Director, Northwest Network (10N20)

1. I have reviewed and concur with the findings and with the conclusions of no recommendations regarding the Office of Inspector General Healthcare Inspection Report.

Phillip G. Dionne
Director

**Appendix C**

# OIG Contact and Staff Acknowledgments


| | |
|---|---|
| **Contact** | For more information about this report, please contact the OIG at (202) 461-4720. |
| **Contributors** | Laura Dulcie, BSEE, Co-Team Leader<br>Ann Ver Linden, RN, MBA, Co-Team Leader<br>Jennifer Kubiak, RN, MPH<br>Clarissa Reynolds, CNHA, MBA<br>Glen Trupp, RN, MSHM<br>Amy Zheng, MD |

**Appendix D**

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