Department of Veterans Affairs
Office of Inspector General

ADMINISTRATIVE SUMMARY
Review of Post-Traumatic Stress Disorder Consult Management
Battle Creek VA Medical Center
Battle Creek, Michigan
September 29, 2017

1. Why the inspection was initiated:

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess the merit of allegations made regarding the management of outpatient post-traumatic stress disorder (PTSD) consults by the PTSD Clinical Team (PCT) at the Battle Creek VA Medical Center (facility), Battle Creek, MI.

Specifically the complainant alleged the following:

- Between May and July of 2016, consults were being improperly designated as complete although a PCT provider had not evaluated the patients. The complainant identified five patients whose care was allegedly compromised because of this practice.
- A mental health provider used computer-based and written psychological testing as a substitution for an evaluation.
- Staff psychologists were unproductive.

2. How the inspection was conducted:

- **On-site visit:** October 3-6, 2016.
- **Interviews conducted:** We interviewed the Facility Director, Acting Chief of Staff, Chief of Psychiatry, Chief of Psychology, PTSD Program Manager, three PCT psychologists, referring Patient Aligned Care Team (PACT) Staff Physician, two PCT social workers, PCT Staff Psychiatrist, Quality Management staff, Group Practice Manager, and clinical and administrative staff.

- **Records/documents reviewed:**

  - Facility policies related to: clinic cancellations, rescheduling, consultations, and referrals; patient no shows to appointments; clinical responsibilities of team members in planning and providing treatment; the authority of a psychologist to write orders and consultation requests; electronic health record (EHR) documentation of care provided to patients; and patient rights and staff responsibilities in the care of patients.

  - EHRs of the five patients identified by the complainant and all other patients who had consults for PCT service from January 1, 2016 through March 31, 2016, and May 1, 2016 through July 30, 2016, to identify the occurrence of PTSD treatment delays and potential for adverse clinical impact.[1]

  - Veterans Health Administration (VHA) Support Service Center (VSSC) data for provider workload and patient utilization data.

  - Facility Mental Health Care Committee minutes.

  - Veterans Integrated Service Network (VISN) 11 Consult Management Handbook, revised June 13, 2013. (Recertification due June 2016.).

  - VHA policies and procedures including:

    - VHA Directive 2010.027, *VHA Outpatient Scheduling Processes and Procedures,* June 9, 2010; rescinded and replaced by VHA Directive 1230, *Outpatient Scheduling Processes and Procedures*, July 15, 2016.

    - VHA Directive 2008.056, *VHA Consult Policy*, September 16, 2008; rescinded and replaced by VHA Directive 1232 VHA Directive 1232, *Consult Processes and Procedures*, August 24, 2016.

    - VHA Handbook 2006.041, *Veterans Health Care Service Standards*, June 27, 2006. (Expired June 30, 2011.)

    - VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics,* September 11, 2008 and amended November 16, 2015. (Recertification due last working date of September 2013.)

    - VHA Handbook 1160.03, *Programs for Veterans With Post-Traumatic Stress Disorder (PTSD),* March 12, 2010, and revised

[1] The facility implemented a new process in April 2016. For comparison purposes, we reviewed EHRs 3 months prior to the new process and 3 months after the new process.

December 8, 2015. (Recertification due last working day of March 2015.)

- VHA Handbook 1160.05, *Local Implementation of Evidence-Based Psychotherapies for Mental and Behavioral Health Conditions,* October 5, 2012, revised December 8, 2015.

See Appendix A for other relevant OIG reports published in the past 3 years.

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

3. Summary of our findings:

Allegation 1 Improper Consult Closure

We substantiated that some consults to the PCT were improperly identified as completed between May 1, 2016 and July 30, 2016 although the patients had not been evaluated by a PCT provider either electronically or face-to-face. As outlined in the VISN Handbook[2] current during this timeframe and VHA's current consult policy,[3] a consult is considered completed when appropriate documentation is available within the EHR and electronically "linked" to the consult request.

According to staff interviews, beginning in April 2016, facility managers implemented a new assessment process for PCT consults to determine if a patient's mental health needs could be best met in PTSD clinic, which focused on combat related post-traumatic stress, or another clinical treatment program. The new assessment process involved an intense pre-treatment testing that clinical staff thought would help to evaluate a patient's motivation level to engage in a prolonged treatment program.

As part of the new assessment process, the patient received a demographic and medical history questionnaire to be completed prior to the initial assessment appointment. The initial assessment appointment involved a one-on-one intake with a PCT clinician as well as in depth computer-based and written psychological testing. Based on the results of the testing and a clinical assessment interview, the patient and provider would discuss further management options. Staff allotted

[2] VISN 11 Consult Management Handbook, revised June 13, 2013.
[3] VHA Directive 2008.056, *VHA Consult Policy,* September 16, 2008; rescinded and replaced by VHA Directive 1232; VHA Directive 1232, *Consult Processes and Procedures,* August 24, 2016.

2 to 3-hour appointments for the testing and interview. According to staff, there was a high no-show rate for these lengthy appointments, which led to an inefficient use of staff time.

Shortly after the new assessment process began, the initial appointment was divided into two phases involving two separate appointments. The Phase I session could be on a walk-in basis, and involved an orientation to the PTSD Clinic and other facility Mental Health programs. Patients completed the computer-based and written psychological tests during the Phase 1 session. A Phase II session would be scheduled with a psychologist who would review the testing results with the patient, conduct a clinical assessment, and make some management decisions.

According to a staff interview, immediate confusion relating to when the consult was considered complete occurred with introduction of the 2 Phases. Some PCT consults were being designated as complete after staff made only an initial phone call inviting the patient to Phase I. In other instances, staff designated the consult complete after the patient attended only Phase I. PCT members expressed concern that prematurely completed consult designations could lead to patients being lost to follow-up. In addition, team members felt that the two-phased process could discourage patients from completing Phase II, which could mean that patients would not receive a complete evaluation of their symptoms. According to interviews, in August 2016, PCT leadership decided to return the PCT consult process to its previous operation.

We substantiated that four of the five patients identified by the complainant had PCT consults that were inappropriately designated as complete during the new 2-phase scheduling process, roughly between May 1, 2016 and July 30, 2016. However, we did not find that any of the patients suffered adverse clinical impact.[4] Documentation within the EHRs of the five patients at issue suggested that PCT follow-up care was either provided to the patients, declined by the patients, or determined to be inappropriate for the patients based on the psychological testing results and patient interviews.

Since there was potential for other patients who were referred to PCT during the new scheduling process period to be lost to follow-up due to premature consult closure, we also reviewed the EHRs of the 111 patients who received PCT consults between January 1, 2016 and March 31, 2016, before the change in process, and patients between May 1, 2016 and July 30, 2016, after the change in process. We found that staff designated 37 of 111 consults (33 percent) as completed prior to Phase I or Phase II visits with a PCT provider. However, we found that none of the 37 patients suffered adverse clinical impact related to the inappropriately completed consults.

[4] For this report, the team considered adverse clinical impacts to include hospitalizations, suicide, suicide attempt, and documentation of other clinical encounters of untreated PTSD symptoms.

Allegation 2 Inappropriate Use of Computerized and Written Psychological Testing

We did not substantiate that a mental health provider used computer-based and written psychological testing as a substitution for an evaluation. With the new 2-phased scheduling process, patients initially had computer-based and written psychological testing. However, each patient then received an individual appointment with a psychologist, who reviewed the results of the testing with the patient, conducted a more in-depth assessment interview, and then determined an appropriate management plan.

Allegation 3 Productivity and Management of Staff Psychologists

We did not substantiate that during the timeframe the new scheduling process was in place, several staff psychologists were unproductive. We reviewed the productivity data of PCT psychologists utilizing the VSSC Provider Productivity Data Cube for the months of May, June, and July 2016, and compared that data with productivity data for January, February, and March 2016. We found that productivity was within the appropriate ranges identified by VHA for psychologists at a facility with this complexity level.

4. Conclusions:

We substantiated that some consults to the PCT were improperly identified as completed between May 1, 2016 and July 30, 2016. We substantiated that four of the five patients identified by the complainant had PCT consults that were inappropriately designated as complete during the new scheduling process, roughly between May 1, 2016 and July 30, 2016. However, we did not find that any of the patients suffered adverse clinical impact. We also reviewed the care of all patients who received a consult to PCT between January 1, 2016 and March 31, 2016 before the process change, and patients between May 1, 2016 and July 30, 2016, after the process change. We found that 37 of the 111 (33 percent) consults were designated as completed prior to actual completion of the full assessment process with a PCT provider. However, we did not find that any of the patients suffered adverse clinical impact. We confirmed that PCT managers decided to return the PCT consult process to its previous operation prior to our site visit in August 2016. In that the consult scheduling process was corrected and we found no adverse impact to patients, we made no recommendation.

We did not substantiate that a mental health provider used computer-based and written psychological testing as a substitution for an evaluation.

We did not substantiate nonproductive work hours for psychologists while the new scheduling process was in place.

We made no recommendations.

The Veterans Integrated Service Network and Facility Directors concurred with the report. (See Appendixes B and C, pages 10–11 for the Directors' comments.) No further action is required.

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

Prior OIG Reports

Facility Reports

Healthcare Inspection – Alleged Unsafe Blood Transfusion Practices, Battle Creek VA Medical Center, Battle Creek, Michigan
5/25/2017 | 15-01043-247

Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Battle Creek VA Medical Center, Battle Creek, Michigan
10/22/2015 | 15-00155-16

Combined Assessment Program Review of the Battle Creek VA Medical Center, Battle Creek, Michigan
8/31/2015 | 15-00606-495

Combined Assessment Program Review of the Battle Creek VA Medical Center, Battle Creek, Michigan
3/21/2013 | 12-04188-140

Reports on Consult Management

Healthcare Inspection – Consult Delays and Management Concerns, VA Montana Healthcare System, Fort Harrison, Montana
3/10/2017 | 16-00621-175

Review of Alleged Consult Mismanagement at the Phoenix VA Health Care System, Phoenix, Arizona
10/4/2016 | 15-04672-342

Combined Assessment Program Summary Report – Evaluation of Coordination of Inpatient Consults in Veterans Health Administration Facilities
5/23/2016 | 16-01489-311

Alleged Improper Management of Dermatology Requests, Fayetteville VAMC, Fayetteville, North Carolina
5/3/2016 | 14-02890-286

Healthcare Inspection – Quality of Mental Health Care Concerns, VA Long Beach Healthcare System, Long Beach, California
3/30/2016 | 14-04897-221

Healthcare Inspection – Pulmonary Medicine Clinic Appointment Cancellations, William Jennings Bryan Dorn VA Medical Center, Columbia, SC
1/6/2016 | 15-00992-71

Healthcare Inspection – Mismanagement of Mental Health Consults and Other Access to Care Concerns, VA Maine Healthcare System, Augusta, ME
6/17/2015 | 14-05158-377

Staffing Review of the Implementation of the Veterans Choice Program
1/30/2017 | 15-04673-333

Healthcare Inspection – Eye Care Concerns, Eastern Kansas Health Care System, Topeka and Leavenworth, Kansas
12/22/2015 | 15-00268-66

Healthcare Inspection – Poor Access to Care Allegedly Resulting in a Patient Death at the Oxnard Community Based Outpatient Clinic, VA Greater Los Angeles Healthcare System, Los Angeles, California
10/28/2015 | 14-02890-497

Healthcare Inspection – Access to Urology Service, Phoenix VA Health Care System, Phoenix, AZ
10/15/2015 | 14-00875-03

Healthcare Inspection – Quality of Care Concerns in a Diagnostic Evaluation, Jesse Brown VA Medical Center, Chicago, Illinois
9/29/2015 | 14-02952-498

Review of VHA's Alleged Mishandling of Ophthalmology Consults at the Oklahoma City VAMC
8/31/2015 | 15-02397-494

Healthcare Inspection - Deficient Consult Management, Contractor, and Administrative Practices, Central Alabama VA Health Care System, Montgomery, Alabama
7/29/2015 | 14-04530-452

Review of Alleged Delays in Care Caused by Patient-Centered Community Care (PC3) Issues
7/1/2015 | 14-04116-408

Healthcare Inspection – Alleged Consult Processing Delay Resulting in Patient Death, VA Eastern Colorado Health Care System, Denver, Colorado
7/7/2015 | 14-04049-379

Healthcare Inspection – Quality of Care and Access to Care Concerns, Jack C. Montgomery VA Medical Center, Muskogee, OK
6/16/2015 | 14-04573-378

Healthcare Inspection – Lapses in Access and Quality of Care, VA Maryland Health Care System, Baltimore, Maryland
4/14/2015 | 14-03824-155

Healthcare Inspection — Alleged Mismanagement of Gastroenterology Services and Quality of Care Deficiencies, Captain James A. Lovell Federal Health Care Center, North Chicago, Illinois
3/3/2015 | 14-04473-132

Alleged Consult Management Issues and Improper Conduct, W.G. (Bill) Hefner VA Medical Center, Salisbury, North Carolina
2/18/2015 | 14-04194-118

Interim Report - Review of Phoenix VA Health Care System's Urology Department, Phoenix, AZ
1/28/2015 | 14-00875-112

Healthcare Inspection – Alleged Delay in Gastroenterology Care, Durham VA Medical Center, Durham, NC
11/6/2014 | 14-03298-20

Healthcare Inspection - Improper Closure of Non-VA Care Consults, Carl Vinson VA Medical Center, Dublin, GA
8/12/2014 | 14-03010-251

Healthcare Inspection – Podiatry Clinic Staffing Issues and Delays in Care, Central Alabama Veterans Health Care System, Montgomery, Alabama
5/19/2014 | 13-04474-157

Review of Alleged Improper Non-VA Community Care Consult Practices at Ralph H. Johnson VA Medical Center, Charleston, South Carolina
12/20/2016 | 14-02890-352

Healthcare Inspection – Summarization of Select Aspects of the VA Pacific Islands Health Care System, Honolulu, Hawaii
9/22/2016 | 15-04655-347
Review of VA's Award of the PC3 Contracts
9/22/2016 | 15-01396-525

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VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: September 13, 2017

From: VISN 10 Network Director, Cincinnati, OH (10N10)

Subj: Administrative Summary: Review of Post-Traumatic Stress Disorder Consult Management, Battle Creek VA Medical Center, Battle Creek, Michigan

To: Director, Dallas Office of Healthcare Inspections (54DA)
Director, Management Review Service (VHA 10E1D MRS Action)

1. I have reviewed the Office of Inspector General (OIG) Administrative Summary of the Post-Traumatic Stress Disorder Consult Management Healthcare Inspection regarding the Battle Creek VA Medical Center, Battle Creek, Michigan and concur with the report and findings.

2. Thank you for your support as we continue to improve the services and processes at the Battle Creek VA Medical Center for the best outcomes for our Veterans. If there are any questions, please contact William Bloem, Ph.D., Associate Chief of Staff for Mental Health, at (269) 966-5600, extension 31151.

for ROBERT P. MCDIVITT, FACHE

Appendix C

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: September 13, 2017

From: Medical Center Director, VAMC Battle Creek, MI (515/116)

Subj: Administrative Summary: Review of Post-Traumatic Stress Disorder Consult Management, Battle Creek VA Medical Center, Battle Creek, Michigan

To: VISN 10 Network Director, Cincinnati OH (10N10)

1. I have reviewed the Office of Inspector General (OIG) Administrative Summary of the Post-Traumatic Stress Disorder Consult Management Healthcare Inspection regarding the Battle Creek VA Medical Center, Battle Creek, Michigan and concur with the report and findings.

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Mary Beth Skupien

MARY BETH SKUPIEN, Ph.D.

Appendix D

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 E

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