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Office of Healthcare Inspections

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Healthcare Inspection

Mental Health Care Concerns, Atlantic County Community Based Outpatient Clinic Northfield, New Jersey

November 15, 2017

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General conducted a healthcare inspection at the request of Senator Cory Booker, Senator Robert Menendez, and Congressman Frank LoBiondo, to assess concerns that a patient's insufficient access to timely mental health (MH) care may have contributed to the patient's suicide, and that general access to MH care was limited at the Atlantic County Community Based Outpatient Clinic (CBOC), Northfield, NJ. Prior to our review of these concerns, Senators Booker and Menendez, and Congressman LoBiondo communicated other issues surrounding the CBOC to the Deputy Under Secretary for Health for Operations and Management, which led to Veterans Integrated Service Network 4 assuming supervision of the CBOC in May 2016.

The patient at the center of this review received routine MH care for Obsessive Compulsive Disorder (OCD) at the CBOC for several years, up until 2014. In the last 2 years of his life, clinicians added a diagnosis of a particular neurodevelopmental disorder (NDD) and he was awaiting therapy for it in the community.

In late 2015, the patient walked into the CBOC MH clinic seeking an appointment with his psychologist. The psychologist assessed the patient in the waiting room, determined he appeared to be in no distress, and sent him to the front desk with instructions for the scheduler to make an appointment and to overbook if needed. The scheduler told us that he did not remember this patient or these instructions. The scheduler set the appointment for a date over 3 months later, and recorded the appointment as the patient's desired/preferred date. The Veterans Health Administration (VHA) requires appointments to be scheduled based on providers' clinically indicated dates and if no such dates are specified, then appointments should be scheduled based on patients' desired/preferred dates. We could not determine if the patient told the scheduler about the instructions to overbook and we could not determine the patient's actual preferred date to understand why the appointment was scheduled for a date over 3 months after the request to see the psychologist.

In early 2016, shortly before his scheduled appointment, the patient completed suicide. The people we interviewed told us that between late 2015 and the scheduled appointment in early 2016, the patient was in distress as he was facing serious life stressors including a divorce and the loss of his job. CBOC clinicians had not seen him during this time frame nor did we find evidence that he attempted to contact CBOC staff for an earlier appointment. We also did not find records of him contacting the Veterans Crisis Line to report suicidal thoughts. We could not determine if an earlier appointment with MH would have made a difference in the outcome.

Family members reported they had no warning signs that the patient might try to take his own life and no suicide note was found. Family members also told us he was upset with VA and the CBOC because he believed some staff members were rude, staff did not return his telephone calls, and he had problems scheduling appointments. We were unable to substantiate these concerns.

At the time of his death, it had been about a year since his last therapy session and over a year since he had seen the psychiatrist who prescribed his medications for OCD. He had been waiting for an appointment for therapy in the community to address his particular NDD for over a year. Clinicians in primary care, orthopedics, and gastroenterology saw him prior to his death, but none of them documented any indications of MH issues or the life stressors mentioned above.

From 2011 to 2014, the patient met with a CBOC licensed clinical social worker for therapy centered on his diagnosis of OCD, missing only 2 of the 29 regularly scheduled appointments. During his subsequent therapy (2014—2015) with a psychologist, he maintained an irregular schedule for appointments with occasional cancellations and no-shows. During these visits, it was noted he denied suicidal thoughts or ideas.

We found several of the patient's clinic appointments were scheduled beyond 30 days from the clinically indicated date. We reviewed 23 MH appointments from 2014 through 2016. For 11 of the 23 appointments, providers had specified a clinically indicated date, and for 6 of these, (54 percent), the wait time exceeded the 30 days allowed by VHA policy. We noted that the patient's desired/preferred dates for these appointments were recorded as within 30 days of the actual appointments.

We found that in addition to the lack of timely appointments, staff failed to follow up on no-shows, clinic cancellations, termination of services, and Non-VA Care Coordination (NVCC) consults as required. This led to a lack of ordered MH therapy and necessary medications for the patient's OCD, and may have contributed to his distress.

In addition, MH providers failed to address the patient's lack of participation in active care appointments for over a year. Facility policy on patient termination requires MH providers to contact patients in an attempt to re-engage them after 12 months without active treatment. We found no attempts to follow this process.

CBOC schedulers canceled an appointment scheduled for the fall of 2015 because the provider was not available. We did not find documentation that CBOC schedulers attempted to contact the patient to reschedule the appointment or to renew medications, if needed, as required by VHA.

In early 2015, a psychologist requested the patient's referral to a community provider for treatment of his particular NDD. NVCC staff approved the request for several therapy sessions. We found no evidence that NVCC staff contacted the patient or made appointments for this therapy. The non-VA provider, who had been contacted by the psychologist, told us she did not see the patient and was unable to make contact with the patient or NVCC staff, despite making several attempts. This failure of the NVCC staff led to non-delivery of ordered care that might have benefited this patient.

We found an overall lack of communication between psychiatry and psychology services led to unclear treatment goals for this patient, including his diagnoses, prognosis, and treatment. We were told of a disagreement between MH providers regarding the diagnosis of the NDD that created a lack of clarity in the care and services needed.

Regarding general MH access, we found the CBOC had several positive processes in place, including appropriate automated phone greetings, extended operating hours, sufficient MH staffing (with plans to increase staffing), and appropriate use of telehealth. We noted that CBOC patients reported overall higher satisfaction scores for access than VHA patients nationally.

CBOC staff generally scheduled MH appointments within 30 calendar days of patients' documented desired/preferred dates. However, the CBOC's wait times for new and established patients were higher than national averages by 7 days for new patients and 1.5 days for established patients.

We found a lack of scheduling practices oversight by CBOC managers and/or the Acting Chief of Health Administration Service. This led to noncompliance in patient follow-up care and clinic management. Specifically, processes for management of walk-in patients, no-shows, clinic cancellations, termination of services, and NVCC did not comply with VHA and facility policies. The facility did not complete audits of CBOC scheduling practices and provided no onsite management oversight of appointment schedulers.

We made six recommendations. We recommended that the Veterans Integrated Service Network Director ensure:

- Atlantic County CBOC schedulers determine and document appointment dates using clinically indicated and preferred dates and facility managers monitor compliance.
- Atlantic County CBOC managers implement a process for management of established MH patients seeking an unscheduled appointment that includes communication between patients and clinical and administrative staff.
- Atlantic County CBOC managers implement a process including a definition of supervisor responsibilities for oversight and auditing of no-shows and CBOC scheduling practices, and facility managers monitor compliance.
- Atlantic County CBOC managers implement a process to manage patients who still need care when CBOC staff have cancelled appointments, and facility managers monitor compliance.
- Atlantic County CBOC managers implement the CBOC MH services termination process as outlined in local policy and monitor for compliance.
- The Facility Director implements oversight processes that ensure NVCC staff follow up on all consults in a timely manner and facility managers monitor compliance.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with our recommendations and provided an acceptable action plan. (See Appendixes A and B, pages 16–22 for the Directors' comments.) We will follow up on the planned actions until they are completed.

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Purpose

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the request of Senator Cory Booker, Senator Robert Menendez, and Congressman Frank LoBiondo, to assess concerns that a patient's insufficient access to timely mental health (MH) care may have contributed to the patient's suicide, and that general access to MH care was limited at the Atlantic County Community Based Outpatient Clinic (CBOC), Northfield, NJ.

Background

The Wilmington VA Medical Center (facility) is the designated parent facility for the CBOC and is a teaching facility that provides primary, acute, and long-term care. It serves Delaware and southern New Jersey. Other CBOCs under the facility's auspices are located in Cumberland and Cape May Counties in New Jersey, as well as Kent and Sussex Counties in Delaware. The facility is part of Veterans Integrated Service Network (VISN) 4.

The CBOC is an urban, mid-sized clinic, which in fiscal year (FY) 2016, operated from Monday through Friday, 8:00 a.m. through 4:30 p.m., and served approximately 2,900 unique patients.

In May 2016, prior to our review, VISN 4 leaders began supervising the CBOC due to concerns raised about facility leaders' management of the CBOC. As a result, VISN leaders began direct oversight of the CBOC and performed an assessment to address concerns expressed by congressional representatives, including staffing, coordination of care, MH clinic hours, telehealth (TH), non-VA care, and oversight.

Wait Times for Mental Health Programs

Over the last several years, VA implemented several programs to purchase private medical care, including the Veterans Choice Program (Choice), which under the Veterans Access, Choice, and Accountability Act of 2014 (Act), allows eligible veterans to receive care from providers in their communities.[1] The Act defined Veterans Health Administration (VHA) wait time goals as "…not more than 30 days from the date on which a veteran requests an appointment for hospital care or medical services from the Department."[2] However, the Act permitted VA to establish an alternate wait time standard by submitting a report to Congress, which was accomplished on October 3, 2014.[3] Pursuant to this authority VA re-defined wait time goals for the Choice program as "…not more than 30 days from either the date that an appointment is deemed clinically appropriate by a VA health care provider, or if no such clinical determination

[1] Under the Choice program, VA contracts with third-party administrators to purchase care from community providers. Veterans are eligible to receive care through Choice if; for example, they live more than 40 miles from a VA facility or would wait greater than 30 days to receive services through VA.
[2] Veterans Access, Choice and Accountability Act of 2014, (Pub.L.113-146), Section 101(s) (1).
[3] Ibid.

has been made, the date a Veteran prefers to be seen for hospital care or medical services."

VHA facilities must provide access to general and specialty MH services when clinically appropriate.[4] These services are provided by a variety of staff and in different clinical settings.[5] Clinic-based TH[6] services are designed to achieve increased capacity, improve access to primary and specialty care, reduce wait times, and decrease non-VA care costs.

A clinical consult is a specific document, most often electronic, which facilitates and communicates consultative and non-consultative service requests and subsequent activities. A clinical consultation is a response to a request seeking opinion, advice, or expertise regarding evaluation or management of a specific problem sent by the consulting healthcare provider to the provider initiating the consult.[7] When indicated, the service receiving the consult arranges an appointment with the patient.

At the time of the events discussed in this report, VHA required that the scheduling of outpatient appointments meet the patient's needs, with appointments on or as close to the patient's desired/preferred date as possible. The desired/preferred date was defined by the patient and could not be changed to a date the patient accepted when desired appointments were not available.[8] In addition, VHA required providers to specify a return date indicating when they wanted to see the patient again. This requirement expired during the period of this review and was replaced by a new directive that no longer uses the term "desired date." The new directive defines preferred date as the date the patient wants to be seen, and the return date as the clinically indicated date.[9] For purposes of recommendations in this report, we will use clinically indicated and desired/preferred dates. Facility directors are required to ensure standardized systems are in place and that clinics follow VHA business rules for outpatient scheduling.

VHA requires staff to make three attempts by telephone to contact patients who miss scheduled MH appointments and to document these calls in the electronic health record

[4] VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics, September 11, 2008. This VHA Handbook was scheduled for recertification on September 30, 2013 but has not been recertified. It was amended November 16, 2015, but the date of recertification was not altered after the November amendment. The handbook, without the amendment, was in effect at the time of our review.
[5] Ibid.
[6] TH is the use of video technologies to provide clinical care in circumstances where distance separates those receiving services and those providing services.
[7] VHA Directive 1232(1), *Consult Processes and Procedures,* August 24, 2016, Page 1. This Directive defines consults in VHA.
[8] VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures*, June 9, 2010, page 8. This directive was in effect at the time of the events discussed in this report; it was rescinded and replaced by VHA Directive 1230, *Outpatient Scheduling Process and Procedures*, July 15, 2016, which states, "schedule all patient appointments with patient's input." The 2010 Directive defined "desired date" as "the date on which the patient or provider wants the patient to be seen." while 2016 Directive defines a clinically indicated date as the date the provider wants the patient to return and preferred date as the date the patient wants to be seen.

(EHR).[10] In addition, all VHA facilities are required to have local policies addressing the management of patient no-shows that include procedures for compliance audits.[11] Sometimes the patient is not compliant with the treatment plan and misses appointments. Local standard operating procedures describe the process to manage a MH patient who is not active in treatment for a period of 12 months. This process requires the provider to reach out to attempt to re-engage the patient in care. If the patient does not wish to continue in therapy, the services are to be terminated.

Suicide

Suicide, the act of taking one's own life, is a serious public health concern. As a medical, psychiatric, and social issue, it is of special concern in the veteran population. In July 2016, VHA released the results of a review of 55 million veteran suicides covering the period from 1979–2014, wherein VA estimated that the number of veteran deaths by suicide averaged 22 per day.[12] The rate of 22 veteran suicides per day exceeds the national average. For example, in 2014, the annual rate of suicide among U.S. civilian adults was 15.2 per 100,000, while the rate of suicide among veterans was 35.3 per 100,000.[13] Suicide was the tenth leading cause of death in the United States in 2013, and fifth among 45 to 54 year olds.[14] Research studies have shown that over 90 percent of suicide victims have a diagnosable MH and/or substance use disorder. The American Foundation for Suicide Prevention[15] notes that suicide has no single cause, but "most often occurs when stressors exceed the current coping abilities of an individual suffering from a MH condition."[16] Various treatments exist for many of the underlying MH conditions that increase the risk of suicide. However, many in emotional distress cannot, will not, or do not have the ability to contact a MH provider or other caregiver directly.

Request for Review

On May 18, 2016, the OIG received a request from Senator Cory Booker, Senator Robert Menendez, and Congressman Frank LoBiondo, to assess issues regarding MH services at the CBOC, specifically:

[10] DUSHOM Memo. *Failure to Attend Appointments*, June 25, 2013. This Memo provides requirements to contact patients who do not show up for a MH appointment and for facility staff to create local policy defining the process.
[11] Ibid.
[12] VA Office of Public and Intergovernmental Affairs, "VA Conducts Nation's Largest Analysis of Veteran Suicide," July 7, 2016, 09:56:00 AM, http://www.va.gov/opa/pressrel/pressrelease.cfm?id=2801. Accessed December 12, 2016.
[13] Facts about Veteran Suicide, July 2016, VA Suicide Prevention Program, http://www.va.gov/opa/publications/factsheets/Suicide_Prevention_FactSheet_New_VA_Stats_070616_1400.pdf. Accessed December 5, 2016.
[14] Suicide: Facts at a Glance, Centers for Disease Control, Website. https://www.cdc.gov/violenceprevention/pdf/suicide-datasheet-a.pdf. Accessed September 19, 2016.
[15] Established in 1987, the American Foundation for Suicide Prevention is a voluntary health organization that gives those affected by suicide access to a nationwide community empowered by research, education and advocacy.
[16] American Foundation for Suicide Prevention, 120 Wall Street, 29th Floor, New York, NY 10005. https://afsp.org/about-suicide/Accessed December 4, 2016.

1) To assess issues regarding a patient's insufficient access to MH care that may have contributed to the patient's suicide.

2) To assess the extent to which general access to MH care at the Atlantic County CBOC may be limited.

Scope and Methodology

We initiated our review on May 31, 2016. We made a site visit July 11–14, 2016, and conducted additional interviews in August and September 2016. We interviewed CBOC providers and managers, the suicide prevention coordinator, the TH coordinator, the patient advocate, and appointment schedulers. We interviewed facility staff who managed NVCC and MH, a non-VA care provider, a Veterans Service Officer, a surviving family member of the patient and senior managers from the VISN and the facility, including involved service chiefs. We reviewed the patient's EHR, including clinical and administrative records for approximately a 9-year period (1997 – 2016).[17] We physically inspected the CBOC, including the site of the suicide.

To evaluate general access to MH, we reviewed facility policies and procedures, meeting minutes, quality review documents, patient satisfaction data, and appointment data. We tested the telephone system at the facility and CBOC for mandated after-hours voice messaging in MH. We reviewed historical OIG reports, and other applicable documents. We reviewed provider "Individual Appointment Listings" reports[18] and schedules as well as VHA national wait times data and reports.[19] We reviewed relevant VHA and facility policies related to outpatient scheduling processes and procedures and system-wide patient complaints data.

VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015, cited in this report expired September 2013. We considered this policy to be in effect, as it 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),[20] 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."[21] The USH also tasked the Principal Deputy Under 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." In the absence of current VA/VHA policy,

[17] Clinical and administrative records include individual patient records showing appointments and clinical notes of services provided.
[18] Individual Appointment Listing reports denote available appointment slots, overbooks, or appointments that fall outside of a clinic's regular hours.
[19] VHA Support Service Center (VSSC) provides data to internal VA and Program offices for the purposes of healthcare delivery analysis and evaluation.
[20] VHA Directive 6330(1), *Controlled National Policy/Directives Management System*, June 24, 2016, amended January 11, 2017.
[21] VA Under Secretary for Health Memorandum. *Validity of VHA Policy Document*, June 29, 2016.

we considered previous guidance to be in effect until superseded by an updated or re-certified Directive, Handbook, or other policy document on the same or similar issues(s).[22]

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.

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

Case Summary

The patient was in his fifties when he completed suicide in 2016. He had been receiving VHA care for a variety of medical conditions, including obsessive-compulsive disorder (OCD)[23] and a particular neurodevelopmental disorder (NDD).[24] The patient received medical care intermittently at several VA hospitals since 1997. In 1997, the patient indicated he had been treated for depression in the past. His first VHA MH treatment began with management of OCD in 2000. At that time, the patient reported to the psychiatrist that he had been treated for the past 2 years by a non-VA therapist and a non-VA psychiatrist and had been taking fluvoxamine (Luvox®).[25]

The patient continued on Luvox® and remained in psychiatric treatment. In 2005, he indicated that he was doing well and performing better at work with reduced compulsiveness. He attributed this improvement to the medication Luvox®. During the visit in 2005, the psychiatrist continued treatment for OCD with Luvox®. At his next psychiatry visit in February 2008, he indicated he had run out of his medication and was experiencing increased OCD symptoms that were contributing to problems at work. For the remainder of 2008, the patient reported adherence in taking his medication and fewer symptoms.

In mid-2011, after a period of stressful life events, he had a MH Initial Assessment Consult with the Licensed Clinical Social Worker (LCSW) and began psychotherapy. During the initial session, the patient denied active thoughts of suicidal ideation. However, he stated that he had experienced suicidal ideation in the past with no history of a suicide attempt. He continued with ongoing individual therapy sessions until early 2013.

In 2012, according to the LCSW's clinical notes, the patient exhibited negative thought patterns that he attributed to his OCD. This created difficulty for him in maintaining personal relationships and employment. The LCSW also noted "Pt's mood and affect remains dysphoric [a mood of unhappiness]. He denies SI/HI [suicidal ideations/homicidal ideations], however, he admits to feeling hopeless at times. Thoughts were tangential but he responded to redirection, which was reinforced. Insight and judgement is limited." The patient attended several individual

[23] OCD is a disorder used to describe an individual that is having unreasonable thoughts and fears that lead to repetitive actions. People with OCD experience obsessions, compulsions, or both. Obsessions are repetitive and persistent thoughts (such as contamination), images (such as violent or horrific scenes), or urges (such as to stab someone). Compulsions (or rituals) are repetitive behaviors (such as washing) or mental acts (such as counting or repeating words silently) that the individual feels driven to perform in response to an obsession (such as washing rituals in response to obsessive fears of contamination) or according to rules that must be applied rigidly (such as to get it "just right").

[24] The neurodevelopmental disorders are a group of conditions with onset early in life, typically before grade school, and are characterized by impairments of personal, social, academic, or occupational functioning. The range of developmental deficits varies from very specific limitations of learning, reasoning, problem solving, and planning to wide reaching impairments of social skills or intelligence

[25] Fluvoxamine (Luvox®) is an antidepressant approved for the treatment of OCD.

psychotherapy visits with the LCSW in 2012, then a final visit with the LCSW in early 2013.

A psychiatrist's note shows he started the patient on sertraline (Zoloft®)[26] in early 2013, at which time his compliance with Luvox® was in question. In late 2013, the patient reported he was seeking care from a non-VA "therapist, and she is helping with ocd [*sic*]." He did not provide records for these visits. He noted that he wanted to keep his medications the same as his obsessive symptoms were reduced; he was sleeping better, and was calmer. He reported he felt his OCD was worse after stopping his medication and that he felt better after restarting it. In mid-2014, the patient provided a written outline of work history (dates, employers, and reasons for being terminated) to his psychiatrist. According to the psychiatrist, this large number of different types of jobs demonstrated "…a long extensive pattern of severe work impairment that is caused directly by his obsessive compulsive disorder [OCD] despite being [on] multiple medications and [seeing a] therapist… referring to a new therapist."

One month later, a VA psychologist assessed the patient for psychotherapy. She noted "DIAGNOSIS: OCD, will add new diagnosis of [neurodevelopmental disorder (NDD)] …Diagnosis of NDD due to patient's report of difficulties in social situations and rigid thinking patterns."

Two months later, the psychologist requested individual psychological testing to clarify the patient's diagnoses "between OCD and [NDD] or both. As well as treatment recommendations." While the psychology providers agreed his diagnosis was [a particular NDD], the psychiatrist disagreed and noted, "…this is classic ocd [*sic*]" and "… consistent with a diagnosis of obsessive-compulsive disorder [OCD], in my opinion."

In early 2015, the psychologist saw the patient three times. During each of these 50-minute individual therapy visits for both of his diagnoses of a particular NDD and OCD, the patient denied suicidal and homicidal thoughts, plans, or ideation. He reported stress and frustration about financial and employment issues. According to the psychologist in early 2015, the patient's "thought process was goal oriented with no evidence of thought disorder noted." He denied auditory or visual hallucinations, unusual experiences, special powers, etc. No contrary evidence was elicited during this interview." Orientation and memory "appeared intact for both long term and short term memory recall. He demonstrated fair insight and judgement." His prognoses during two of these three visits were documented as fair; his prognosis the following month was documented as guarded.

A specialist in the particular NDD was not available at the facility. In early 2015, the psychologist requested and received authorization for the patient to have several outpatient non-VA visits for his NDD. The non-VA provider, who had been contacted by the psychologist, told us the patient had not been seen despite the non-VA provider's

[26] Sertaline is a type of drug (selective serotonin reuptake inhibitor) used to treat several disorders such as depression, OCD, panic disorder, social anxiety disorder, and post-traumatic stress disorder.

attempts to schedule an appointment with the patient and telephone calls to the facility on more than one occasion.

Also in early 2015, at the request of the treating psychologist, the patient and his wife attended a 50-minute marital therapy appointment at the MH clinic with a marriage and family therapist. No other MH visits occurred in 2015 or 2016. However, the patient did seek medical and surgical care unrelated to his MH issues from other VA outpatient clinics during 2015 and early 2016. In late 2015, the patient walked in to the MH clinic to request an appointment with his therapist and, after speaking with the therapist briefly, was directed to a scheduling clerk who scheduled an appointment for 3 months later. The patient completed suicide before this scheduled appointment in 2016.[27]

Inspection Results

Issue 1: The Patient's Insufficient Access to Timely Mental Health Care.

We found that several failed CBOC processes reduced the patient's timely access to MH care. In late 2015, the patient walked in to the MH clinic to request an appointment with his therapist and was given an appointment for 3 months later. We were unable to determine the exact sequence of events, including the communication between the provider, patient and scheduler. The scheduler said he did not remember this patient. The EHR shows the scheduled appointment was the patient's desired date. The patient completed suicide before the scheduled appointment in 2016.

We found that a series of CBOC staff failures prevented the patient from receiving requested MH care during the 11 months prior to his death, including deficiencies in the CBOC's management of walk-in patients, no-shows, clinic cancellations, termination of services, and NVCC. These failures led to a lack of follow-up and therapy for this patient who denied suicidal ideation yet, according to a family member, was in distress. Prior to his suicide, the patient had lost his job and was on the verge of a divorce. We could not determine if an earlier appointment would have made a difference in the outcome.

A family member provided us with some additional information that reflected the patient's state of mind. She had not known he was suicidal and was surprised about the suicide. The family member could not comment, with certainty, about the patient's medication adherence. The patient was concerned about his employment. When the family recommended seeking other jobs, he would say, "I can't do that, I am not smart enough." The patient lost his job in the month before his suicide, and was unemployed at the time of his death.

We also learned that the patient was very upset with VA and the CBOC because he believed staff did not return calls and were rude, and he experienced problems

[27] We found no evidence that he attempted to contact the CBOC staff for an earlier appointment or the veterans' crisis line to report suicidal thoughts.

scheduling appointments. We found no evidence of any such complaints filed with the facility.

Wait Times for VA MH Appointments

We found several of the patient's clinic appointments were not scheduled within 30 days of the clinically indicated date. We reviewed 23 MH appointments from 2014 through 2016. For 11 of the 23 appointments, providers had specified a clinically indicated date, and for 6 of these, (54 percent), the wait time exceeded the 30-days allowed by VHA policy. We noted that the patient's desired/preferred dates for these appointments were recorded as within 30 days of the actual appointments.

For return appointments, VHA requires that the provider communicate the intended return timeframe (such as "return to clinic in 6 weeks") to the scheduler, who then establishes the patient's desired/preferred date by telling the patient when the provider wants to see him/her again, and then asking when the patient would like to be seen. The scheduler is to make the appointment on, or as close to, the patient's desired/preferred date as possible. If a discrepancy exists between the date the patient chooses and when the provider wants to see the patient, the scheduler is to contact the provider for the return appointment decision.[28]

Communication Between Clinical and Scheduling Staff

We found differing accounts of the communication process between the patient, schedulers, and the providers, regarding the relative urgency of scheduling an appointment. The psychologist told us when the patient walked into the MH clinic in late 2015, he was not in any distress. She sent him to the front desk for an appointment, asking him to tell the scheduler to overbook if needed. The psychologist told us the instructions to overbook meant to add an additional appointment slot in an upcoming day, beyond the normal workload or hours. We were told the scheduler would sometimes ignore the instructions to overbook appointments, because he was trying to protect the providers' personal time. In contrast, the scheduler said he did not remember being told to overbook if needed nor did he remember this patient. The scheduler made the appointment for 3 months later and indicated that the patient's desired/preferred date was 2–3 weeks earlier than the date scheduled. We were unable to determine what was communicated and if the appointment was within 30 days of the patient's actual desired/preferred date or just an available time offered by the scheduler.

VHA requires staff to manage patients who walk in to any clinic seeking care without having a scheduled appointment by having a defined plan to meet the needs for walk-in

[28]H.R. 3230 Veterans Access, Choice and Accountability Act 2014 Sec 101-(s) Wait times goal. https://www.govtrack.us/congress/bills/113/hr3230/text/enr (Accessed February 1, 2017). The definition of *wait-time goals of the VHA* means not more than 30 days from the date on which a veteran requests an appointment for hospital care or medical services from VHA.

patients.[29] Although the facility had a policy that addressed the management of new patients who walk in without appointments, the policy did not address established patients who walk in without appointments.

Lack of Follow-Up: No Shows, Clinic Cancellations, and Termination of Services

We found no evidence that CBOC staff contacted the patient to reschedule appointments after the patient failed to show or when staff cancelled his appointments. From 2014 to 2016, the patient cancelled three MH appointments, the CBOC cancelled three MH appointments, and the patient failed to show for one MH appointment.

We were unable to determine if CBOC staff evaluated the patient's records for care needs or attempted to contact the patient as required. VHA requires facility staff to make three attempts to contact a patient who fails to show up for MH appointments, and document this in the EHR. VHA also requires staff to make provisions for necessary medication renewals and patients' needs for rescheduling as soon as possible when the clinic cancels an appointment.[30]

The patient saw his psychiatrist in the fall of 2014, with a return appointment scheduled for 3 months later, as clinically indicated by the provider. The patient cancelled this appointment and did not reschedule. He was being treated for OCD with sertraline and had a 3-month supply with one refill that was not requested by the patient. Despite his previous history of worsening symptoms of OCD when not compliant with his medication regimen, he had no further follow-up with the VA psychiatrist and we found no documentation in his EHR of OCD medications being provided to the patient during the final year of his life.

The psychiatrist explained to us in an interview that the patient would come to appointments for "a while" and then "not come for a while." The psychiatrist attributed this to a lack of engagement in the treatment relationship. Regarding follow-up for missed appointments, the psychiatrist told us that if patients "no-show," "we give a couple of calls." The psychiatrist clarified that if a patient cancels an appointment on the day of the appointment there is a list of canceled appointments available for review, but if the patient cancels prior to the day of the appointment, it would not appear on the list. The psychiatrist expressed that he was comfortable with the situation that "if a person doesn't show for a couple of appointments, I am not going to say he's terminated." He expressed the opinion that the patient knew he could call and would be seen.

Contributing to the problems with care coordination and follow-up, an overall lack of communication between the psychiatry and psychology services led to unclear NDD treatment plans and goals for this patient and a lack of consensus about his diagnosis, prognosis, and treatment.

[29] Acting Deputy Under Secretary for Health for Operations and Management (10N) Memorandum, *PACT Clinical Process for Unscheduled Patient "Walk-ins"*, September 28, 2015, states each clinic needs to have a plan to manage walk in patients with clearly defined staff roles. Accessed September 1, 2016.
[30] Deputy Under Secretary for Health for Operations and Management Memo, June 25, 2013, Guidance for Patients Failure to Attend Appointments (No Shows), requires staff to contact patients who miss MH appointments.

In addition, we found the patient did not receive MH services from the CBOC for an extended period and therefore met criteria to be administratively terminated from this care. The psychiatrist had the obligation to formally terminate the patient's care because he was not active in treatment for over 12 months. Had the local policy for termination been followed, it would have required the staff to make at least three attempts to contact the patient to re-engage him in treatment with the psychiatrist and formal monitoring of his medications and treatment plans. These actions could have been useful in promoting engagement and treatment coordination and planning. Instead, the patient's clinical situation was excluded from attention as a result of his clinical caretakers tolerating his lack of engagement.

During the three individual therapy visits with the psychologist in 2015, the patient denied suicidal and homicidal thoughts or plans. At the final 2015 therapy session, the psychologist documented in the EHR that the patient was to return in one month. The patient was a no-show for that return appointment.[31] After the no-show, an appointment was scheduled for 3 months later, but was subsequently cancelled by CBOC staff because the provider was not available. The appointment was not rescheduled, and thus, the patient's last therapy session was approximately one year prior to his suicide. We could not determine if an earlier appointment would have made a difference in the outcome.

NVCC management

We found NVCC staff failed to follow-up with the patient regarding his consult for non-VA care. Because a therapist specializing in the particular NDD was not available at the facility in 2015, the psychologist requested, and facility managers approved and authorized several outpatient non-VA appointments. We found no evidence that NVCC staff contacted the patient or that any appointments were made for this therapy. The psychologist researched community resources and spoke to a therapist who was able to provide the needed services. This non-VA provider told us she had been contacted by the psychologist about the possible referral, but she was unable to make contact with the patient or the facility despite making several attempts. The NVCC staff's failure to schedule this care led to non-delivery of care that may have benefited this patient.

VHA requires NVCC staff to enter an authorization, schedule an appointment for the patient with the non-VA provider, and enter a progress note in the EHR.[32] We interviewed the NVCC employee who was listed on the authorization and were told the ordering provider was responsible for making the appointment and notifying the patient. In this case, it appears the misunderstanding of VHA policy by NVCC staff and the lack of follow through communication by the provider to resolve it, led to the patient not receiving ordered care.

[31] Deputy Under Secretary for Health for Operations and Management Memo, *Guidance for Patients Failure to Attend Appointments (No Shows)*, June 25, 2013.
[32] VHA Chief Business Office Non-VA Care Coordination Process Guide, July 2012, section 4.0.

Issue 2: General Mental Health Access

We found that CBOC managers had several positive processes in place to meet access needs in MH, including appropriate automated phone greetings, extended operating hours, sufficient MH staffing (with plans to increase staffing), and appropriate use of TH. We noted that CBOC patients reported overall higher satisfaction scores for access than patients nationally. However, we identified the following areas of concern.

CBOC MH Appointment Wait Times

We analyzed FY16 MH appointment wait-time data for the CBOC as seen in the table below. Although within the 30-day timeframe, we found wait times at the CBOC were longer than the national averages for both new and established patients. The table below compares the national average wait times for MH appointments across VHA with wait times at the CBOC.

Table. VHA and CBOC MH Appointment Wait Times From October 2015 Through September 2016

Month/Year	CBOC New Patient Wait time Average Days	National New Patient Wait time Average Days	CBOC Established Patient Wait time Average Days	National Established Patient Wait time Average Days
October 2015	10.5	5.1	3.7	2.7
November 2015	4.8	4.9	4.2	2.6
December 2015	15.0	5.1	3.8	2.6
January 2016	3.0	5.1	4.3	2.9
February 2016	9.2	4.9	2.7	2.7
March 2016	11.2	4.5	3.5	2.3
April 2016	4.3	3.6	3.3	2.1
May 2016	6.2	4.5	2.9	2.1
June 2016	9.3	4.9	3.2	2.4
July 2016	0.0	4.5	4.2	2.4
August 2016	5.6	4.5	5.7	2.4
September 2016[33]	27.3	4.0	7.0	2.3

Source: OIG Analysis of VSSC data

Scheduling Practices and Oversight of Those Practices at the CBOC

We found inconsistent understanding of scheduling requirements. Clinical leaders acknowledged the practice of scheduling multiple appointments into the future, a lack of

[33] During the month of September, the CBOC psychologist was on extended leave.

clinical need for frequency of appointments and the potential impact of these practices on access for patients who need more frequent appointments.

The psychologist told us her practice was to schedule patients on a regular basis, every month for therapy. This provider reported being told by facility leaders not to book appointments more than 30 days out or to book more than one appointment at a time. In May 2016, staff/leaders/managers completed a review and reported that 95 percent of patients were scheduled within 30 days of their desired/preferred dates, but were scheduled for more than three sessions at a time. The facility review outlined concerns that the practice of scheduling multiple successive monthly visits at the same time was inconsistent with VHA's recovery approach to MH care, which promotes psychosocial rehabilitation and recovery, full community integration, and improved quality of life.[34] With the recovery approach model of care, patients need fewer regular appointments as they are in charge of their recovery and aware of steps to take to maintain functioning. This is compared to previous models where the patient was dependent on facility providers to manage their care through frequent visits. We validated these concerns in various interviews with VISN 4 and facility leaders.

Facility staff/leaders/managers also reported in their review that EHRs did not support the clinical need for the frequent rate of sessions scheduled. In August 2016, after our visit, the facility provided MH staff with guidance for required scheduling practices. This guidance addressed clinic cancellations, communication with other MH providers to coordinate services, and considering attendance contracts for those patients who keep scheduled appointments.

Management and Oversight

We found that facility managers did not complete audits of scheduling processes or provide onsite management/oversight of schedulers. VHA requires facility directors to ensure a standardized yearly audit of the timeliness and appropriateness of scheduling actions and the accuracy of desired/preferred dates.[35] VA requires facilities to have a local policy for the management of patient no-shows that includes a process for audits. Without this oversight, errors in scheduling processes may go undetected. The facility acknowledged the lack of standardized supervisory oversight of follow-up to no-shows and clinic appointment cancellations.

In May 2016, opportunities were identified to improve MH services, which led to the following actions:

- MH Service leaders notified staff by email dated August 4, 2016, that appointments are not to be scheduled out greater than 90 days and that providers should schedule only one appointment at a time, unless otherwise indicated based on practice or high risk.

[34] In 2007, VHA embraced the recovery model and moved from an illness-oriented model that places the doctor in charge, to a recovery-oriented model of care where the patient is the team leader and is in a partnership with clinical staff.
[35] VHA Directive, 2019-027, *Outpatient Scheduling Processes and Procedures,* June 9, 2010, pg. 9.

- MH Services leaders developed a more robust employee orientation that is consistently utilized throughout all disciplines of psychiatry, psychology, social work, and nursing.
- Facility leaders developed an action plan that standardized supervisory oversight review of follow-up after no-shows and clinic cancelations.
- Facility leaders hired an additional psychiatrist.
- Facility leaders developed and implemented a plan to hire additional CBOC staff, including administrative and MH clinical staff.
- Facility leaders added MH TH services to provide additional capacity for urgent psychiatry and psychology services for New Jersey CBOCs 5 days per week, and added a TH agreement with the Pittsburgh VA TH hub to provide additional capacity.
- Facility leaders completed a patient survey regarding extended clinic hours. Based on the results, they started CBOC extended hours one day per week.

Conclusions

In late 2015, the patient walked into the CBOC MH clinic seeking an appointment with his psychologist. The psychologist assessed the patient in the waiting room, determined he appeared to be in no distress, and sent him to the front desk with instructions for the scheduler to make an appointment and to overbook if needed. The scheduler told us that he did not remember this patient or these instructions. Staff gave the patient an appointment for 3 months later.

We could not determine if the patient told the scheduler about the instructions to overbook and we could not determine the patient's actual preferred date to understand why the appointment was scheduled for a date over 3 months after the request to see the psychologist. People we interviewed told us that during the three-month period the patient was in distress and facing serious life stressors, including a divorce and loss of employment. The patient completed suicide shortly before his scheduled MH appointment.

We found the patient had not been seen by a MH provider for almost a year prior to his death, and was without his previously beneficial MH medications for over a year. Family members reported they had no warning signs that the patient might try to take his own life and no suicide note was found. Family members also told us he was upset with the VA and the CBOC because he believed some staff members were rude, staff did not return his telephone calls, and he had problems scheduling appointments. We were unable to substantiate these concerns.

We found several of the patient's clinic appointments were scheduled beyond 30 days from the clinically indicated date. We reviewed 23 MH appointments from 2014 through 2016. For 11 of the 23 appointments, providers had specified a clinically indicated date,

and for 6 of these, (54 percent), the wait time exceeded the 30 days allowed by VHA policy. We noted that the patient's desired/preferred dates for these appointments were recorded as within 30 days of the actual appointments.

We found that staff failed to follow up on clinic cancellations, patient no-shows, and appointments for approved care in the community, leaving the patient without follow up appointments and refills for prescribed medications.

We found that clinical staff failed to acknowledge and document the lack of appointments for this patient and failed to reach out to the patient to re-engage him in therapy as required in the local patient termination policy. In addition, NVCC staff failed to make appointments for his NDD care in the community as authorized.

The facility did not have appropriate supervision and oversight of clinic processes for management of walk in patients, patient no shows, clinic cancellations, NVVC consults, and patient termination; as such, these failures were not addressed with staff.

We were unable to determine whether addressing these issues during the course of treatment would have resulted in a different outcome for the patient. However, addressing these issues now will help facilitate a more patient-centered environment, especially for veterans with complex, MH, and psychosocial issues such as the patient discussed in this report

Recommendations

1. We recommended that the Veterans Integrated Service Network Director ensure that Atlantic County Community Based Outpatient Clinic schedulers determine and document appointment dates using clinically indicated and desired/preferred dates and facility managers monitor compliance.

2. We recommended that the Veterans Integrated Service Network Director ensure Atlantic County Community Based Outpatient Clinic managers implement a process for management of established mental health patients seeking an unscheduled appointment that includes communication between patients and clinical and administrative staff.

3. We recommended that the Veterans Integrated Service Network Director ensure Atlantic County Community Based Outpatient Clinic managers implement a process including a definition of supervisor responsibilities for oversight and auditing of scheduling and no-shows, and facility managers monitor compliance.

4. We recommended that the Veterans Integrated Service Network Director ensure Atlantic County Community Based Outpatient Clinic managers implement a process to manage patients who still need care when Community Based Outpatient Clinic staff have cancelled appointments, and facility managers monitor compliance.

5. We recommended that the Veterans Integrated Service Network Director ensure Atlantic County Community Based Outpatient Clinic managers implement the

Community Based Outpatient Clinic Mental Health services termination process as outlined in local policy.

6. We recommended that the Veterans Integrated Service Network Director ensure the Facility Director implements oversight processes that ensure non-VA care coordination staff follow-up on all consults in a timely manner and facility managers monitor compliance.

Appendix A

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: September 19, 2017

From: Network Director, VA Healthcare VISN 4 (10N4)

Subj: Draft Report: Healthcare Inspection—Mental Health Care Concerns, Atlantic County Community Based Outpatient Clinic, Northfield, New Jersey

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

1. I have reviewed the responses provided by the Wilmington VA Medical Center, Wilmington, Delaware, and I am submitting to your office as requested. I concur with their responses.

MICHAEL D. ADELMAN, M.D.

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

OIG Recommendations

Recommendation 1. We recommended that the Veterans Integrated Service Network Director ensure that Atlantic County Community Based Outpatient Clinic schedulers determine and document appointment dates using clinically indicated and desired/preferred dates and facility managers monitor compliance.

Concur

Target date for completion: July 1, 2018

Facility response: Community Based Outpatient Clinic (CBOC) schedulers completed the National face-to-face scheduling training in March 2017. The training focuses on the correct usage of the clinically indicated dates (CID) and the preferred patient dates. Providers have been instructed by the Primary Care and Behavioral Health Leadership to only use Return to Clinic (RTC) orders when requesting a patient to return to the clinic (November 2016). In this order, the CID is clearly defined to ensure that the scheduler is scheduling the appointment well within the providers clinically indicated timeframe. Appointments are audited once a month by the CBOC MSA Supervisor. Random samples of appointments are pulled per scheduler using the Business Intelligence Service Line (BISL) to ensure they are scheduling within VHA Scheduling Directive 1230 (20 audits/Medical Support Assistant/month). Scheduling audits will be reviewed for 90% scheduling accuracy until goal is met and sustained for 3 consecutive months or until further notification from VHA Central Business Office. Results are reported monthly to the Executive Leadership Board through the Facility Compliance Committee.

Recommendation 2. We recommended that the Veterans Integrated Service Network Director ensure Atlantic County Community Based Outpatient Clinic managers implement a process for management of established mental health patients seeking an unscheduled appointment that includes communication between patient and clinical and administrative staff.

Concur

Target date for completion: April 30, 2018

Facility response: A new CBOC organizational structure has been implemented. This new structure includes the hiring of a Medical Director and manager for all CBOCS, as well a Nurse Manager for Atlantic County CBOC. This new leadership team is collectively responsible for the day-to-day oversight and management of the clinic. The newly appointed New Jersey Behavioral Health Program Director oversees the technical aspects of behavioral health care.

New providers for behavioral health service added to Atlantic County CBOC included a fulltime psychiatrist and part-time LCSW.

Staff shared by Atlantic County CBOC with other southern New Jersey clinics, include suicide prevention coordinator, substance abuse social worker, social worker case manager, and Primary Care Mental Health Integration (PCMHI) psychiatrist.

Utilization of psychiatry and psychology telehealth/ virtual care services and a fee basis psychiatrist have been added to increase access and capacity at the Atlantic County CBOC.

New scheduling staff at the Atlantic County CBOC includes one MSA supervisor and one MSA.

The Atlantic County CBOC has adopted and implemented same day services for primary care and behavioral health. MSA contacts Nurse Manager and Nurse Manager will triage the patient. Upon triage, if the nurse manager determines same day access is needed, the Nurse Manager facilitates a warm handoff of the patient to the first available BHS provider. Providers will reciprocate warm hand off process to MSA or Nurse Manager if provider encounters patient. We are in the process of restructuring clinic grids to incorporate open access among all BHS providers. There will be two hours of open access scheduled for each day. This will be staggered among different clinicians. Training will be provided to all staff and documented in departmental service line meeting minutes. All new staff will receive same training upon new orientation.

Recommendation 3. We recommended that the Veterans Integrated Service Network Director ensure Atlantic County Community Based Outpatient Clinic managers implement a process including a definition of supervisor responsibilities for oversight and auditing of scheduling and no-shows and facility managers monitor compliance.

Concur

Target date for completion: February 1, 2018

Facility response: The Wilmington VA Medical Center Director will ensure that the Atlantic County Community Based Outpatient Clinic staff implement and utilize a standard operating procedure to address a Veteran’s failure to present for a scheduled appointment that expressly includes a definition of supervisory responsibilities related to oversight and auditing.

A scheduling supervisor position was posted and selected. The supervisor will be on site and will coordinate the day-to-day operations for the MSAs (schedulers). The supervisor addresses all questions and concerns regarding scheduling, ensures that the staff are functioning within the purview of their functional statements, as well as following the VHA Scheduling Directive guidelines.

The supervisor reports to the CBOC manager for day-to-day operational issues and to the Chief, Health Administrative Services for technical issues, training and compliance with all National Directives.

Current policy titled "Veterans Who Fail to Attend a Scheduled Behavioral Health or Substance Abuse Appointment (No Show)", BHS SOP 0008 dated July 10, 2015, will be updated to include an express definition of a BHS supervisor's responsibilities related to oversight and auditing.

The provider with whom the Veteran was scheduled is responsible for the initial contact when the patient no-shows. The supervisor receives/reviews the weekly no show report and conducts a chart audit to ensure provider compliance with the no show policy. Based on the supervisor's findings, progressive supervisory intervention is implemented.

The new definition of supervisory duties shall include monitoring of no-shows, no less than weekly. MSAs will provide all the no-show information to the Program Director for follow-up audits that will focus on the quality of documentation, evidence of follow-up and employee performance. The data shall be aggregated and reported during the weekly BHS leadership meeting as well as the monthly business meeting with Chief of Staff until 90 percent compliance is met and sustained for 3 consecutive months.

Recommendation 4. We recommended that the Veterans Integrated Service Network Director ensure Atlantic County Community Based Outpatient Clinic managers implement a process to manage patients who still need care when Community Based Outpatient Clinic staff have cancelled appointments and facility managers monitor compliance.

Concur

Target date for completion: February 1, 2018

Facility response: A new CBOC organizational structure has been implemented. This new structure includes the hiring of a Medical Director and manager for all CBOCS, as well a Nurse Manager for Atlantic County CBOC, who are collectively responsible for the day-to-day oversight and management of the clinic. A New Jersey Behavioral Health Program Director was also hired to oversee the technical aspects for behavioral health services, as well as provide direct patient care.

Within the new structure that includes additional administrative and clinical resources the expectation is when a patient appointment is cancelled or the clinic is cancelled, the MSAs shall notify the leadership within 30 minutes.

The BHS Program Director for NJ CBOC (or designee) will provide follow up calls to the Veterans upon an unexpected clinic cancellation. The Program Director (or designee) will then complete a clinical review for each Veteran to establish a need for a same day appointment. If the need is for a same day appointment, Program Director (or designee) will facilitate a face-to-face or telehealth appointment. If the need is not for a

same day appointment, the appointment is scheduled based on the Veteran's desired date.

The cancelled appointment data will be reported monthly to the Chief of Staff through Behavioral Health leadership meetings and monthly CBOC performance reviews.

Recommendation 5. We recommended that the Veterans Integrated Service Network Director ensure the Facility Director implements the Community Based Outpatient Clinic Mental Health services termination process as outlined in local policy.

Concur

Target date for completion: February 1, 2018

Facility response: BHS Program Managers will provide "Termination of/Discharge from Behavioral Health Service", per BHS SOP 0002, dated June 2, 2014, through email and review at all service-line staff meetings.

Daily provider huddles and weekly treatment team meetings currently in existence shall provide designated time for this process and will ensure fully engaged Veterans are benefitting from their treatment.

In addition, the treatment planning process, which requires periodic review and updating at designated intervals, but none greater than 6 months, will guide providers in the determination of service efficacy for each patient.

The Behavioral Health Program Director will be responsible to monitor data, report trends, and will make every effort to ensure that Veterans are fully engaged at the appropriate level of care and that no Veteran is lost from care. Results of supervisory reviews (treatment termination process followed/total number of treatment termination decisions) follow up will be presented monthly to CBOC leadership and Medical Executive Board through BH council until 90% compliance is sustained for 3 consecutive months.

Recommendation 6. We recommended that the Veterans Integrated Service Network Director ensure the Facility Director implements oversight processes that ensure non-VA care coordination staff follow up on all consults in a timely manner and facility managers monitor compliance.

Concur

Target date for completion: March 1, 2018

Facility response: The Veteran Integrated Service Network Director has been collaborating with the Wilmington Facility Director to ensure non-VA care consults are followed up in a timely, coordinated manner and that the facility has a process in place to monitor compliance. Wilmington is in the process of implementing a new model and supervisory structure for the Non-VA Care Coordination (NVCC). The new structure

promotes personalized care, standardizes care coordination, promotes seamless transmission of information, enhances collaboration with community partners, ensures high quality and timely care closer to where the Veteran lives, and provides structure with defined roles and responsibilities for staff participating in non-VA care. The transition to the new model and reporting structure has already been initiated and the target date for this model to be fully implemented in every CBOC is December 1, 2017. The goal is to have the non-VA care process based out of the PACT teams that deliver the care in the CBOCs. PACT staff will be enhanced to ensure they are responsible for their specific Veterans to ensure care is delivered in a timely, more accessible and coordinated manner. The PACT staff will also be able to monitor the non-VA care process and ensuring a seamless experience for Veterans by coordinating health information and care across the VAMC and community partners. Leadership for the non-VA care will also perform on-going monitoring of the program, resolve Veteran concerns and track and improve performance.

As we transition to the new model, the VISN and medical center are monitoring the non-VA care process on a weekly basis to ensure that care is delivered timely and that pertinent information related to non-VA care is documented in the veteran's medical record to ensure more collaborative and coordinated care. Currently the Chief of Staff and a physician provider are available to review non-VA consults and to assist with ensuring veterans are getting timely access to services. Non-VA Care consult reviews will be conducted weekly by the non-VA care coordinator until 90% compliance is met for 3 consecutive months. Facility leadership will receive a weekly report to communicate the timeliness of Non-VA care consult timeliness.

Appendix B

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: September 19, 2017

From: Director, Wilmington VA Medical Center, Delaware (460/00)

Subj: Healthcare Inspection— Mental Health Care Concerns, Atlantic County Community Based Outpatient Clinic, Northfield, New Jersey

To: Director, VA Healthcare- VISN 4 (10N4)

1. I have reviewed and concur with 6 of 6 recommendations made during the Office of Inspector General's (OIG) Mental Health Care Review of the Atlantic County's CBOC that occurred in July 2016 and have provided responses to all recommendations.

Electronic Signature on file

Robert M. Boucher, MD

ACTING DIRECTOR

For VINCENT KANE

Appendix C

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 D

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