



DEPARTMENT OF VETERANS AFFAIRS  
**OFFICE OF INSPECTOR GENERAL**

*Office of Healthcare Inspections*

VETERANS HEALTH ADMINISTRATION

Concerns with Access and  
Delays in Outpatient Mental  
Health Care at the New  
Mexico VA Health Care  
System

Albuquerque, New Mexico



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## Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to address concerns with access and delays in outpatient mental health care at the New Mexico VA Health Care System, Albuquerque, New Mexico (facility).

This inspection originated from a March 22, 2017, anonymous complaint that the OIG referred to the facility for evaluation and response. The facility acknowledged the allegations cited in the complaint and responded with an action plan that addressed continuing recruitment, changing medical support assistants' (MSAs) supervision from the outpatient mental health department to health administrative services, training MSAs, updating and standardizing scheduling processes, and in areas where clinics had lost providers or assistance from other VA clinics, offering the telemental health program and non-VA care options to patients.<sup>1</sup>

However, facility leaders' responses did not demonstrate progression toward a positive outcome for patients' access to mental health care. In addition, the responses indicated the number of patients waiting for mental health appointments had increased. Based on this information, the OIG opened a healthcare inspection on March 8, 2018, that focused on the following four concerns:<sup>2</sup>

1. Patients' limited access to outpatient mental health care
2. Delays in outpatient mental health care with a focus on clinical consults and ongoing patient care including telemental health<sup>3</sup>
3. Contributing factors, such as staffing and training, that affected outpatient mental health care access and delays
4. An incomplete Administrative Investigation Board review and action plan

### Access to Outpatient Mental Health Care

The OIG reviewed the facility's use of the electronic wait list (EWL) and indicators of access to outpatient mental health care. The scheduling staff was not using the EWL, because a previous supervisor instructed them not to use it, and consults were open beyond 90 days. In addition, the

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<sup>1</sup> Telemental health is the delivery of mental health services using electronic communication and information technology when distance separates the provider or service and the patient.

<sup>2</sup> An Administrative Investigative Board is a committee or board appointed by a facility director. Board members investigate, determine facts, and document evidence about an issue that has occurred and examine why the issue occurred. In addition, the board members may identify system deficiencies and suggest corrective actions.

<sup>3</sup> VHA Directive 1232(1), *Consult Processes and Procedures*, August 24, 2016, amended September 23, 2016. A clinical consult is a request by a provider (called a sending provider) for an opinion, advice, or expertise regarding evaluation or management of a specific patient problem.

facility had high appointment cancellations rates, a lower percentage of appointments completed within Veterans Health Administration timeframe goals, and longer wait times for new patients.<sup>4</sup> Reasons given for these indicators that OIG found reflected limited access included not utilizing alternatives, such as the telemental health program and the Veterans Choice Program to provide patient care, staff confusion with changes with scheduling procedures, inaccurate and numerous provider schedules or grids, and staffing vacancies for providers and MSAs.<sup>5</sup>

## Delays in Outpatient Mental Health Care

A major concern in health care has not only been patients' access to care, but also the timely provision of services and delays in providing care. Therefore, OIG staff reviewed appointment timeframes associated with consults for new patients and returning patient services. Upon review of patient consults and return-to-clinic appointments from January 1 through March 31, 2018, the OIG determined that patients experienced delays in mental health care; however, the review did not identify any patients that had completed suicide.<sup>6</sup>

The Veterans Health Administration's timeframe appointment goal is for an outpatient mental health patient to be seen within 30 days of the patient indicated date (includes consults and return-to-clinic appointments).<sup>7</sup> Delays in care may occur when appointments are made 30 days beyond this date.

### Consult Delays

OIG staff reviewed 536 consults and 410 (76 percent) were delayed between one and 256 days beyond the patient indicated date (range was from 31 to 286 days). As of July 17, 2018, 172 of the 410 (42 percent) consults had no appointments scheduled.

### Return-to-Clinic Delays

The OIG also reviewed 1,377 providers' return-to-clinic orders and determined 176 (13 percent) appointments were not scheduled within 30 days from the patient indicated date (range was from 31 to 280 days).

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<sup>4</sup> The EWL must be used to track patients who are waiting over 90 days for an appointment. Facility scheduling staff reported they were told not to use the EWL, and data collected at the facility and reported to VHA in August 2018 reflected that 191 of 801 open consults had been open between 90 and 180 days.

<sup>5</sup> A grid, in the context of this report, is a clinic schedule, based upon possible provider appointments, that identifies appointment availability to schedule patients.

<sup>6</sup> Return-to-clinic orders are made by the provider to set up an appointment for the patient to return to the same service for further treatment. The ordered return-to-clinic date is used as the patient indicated date.

<sup>7</sup> The patient indicated date encompasses earlier VHA definitions of the clinically indicated date and preferred date. The patient indicated date is determined by the date the provider requests an appointment for a patient, by the date when the provider decides an appointment is clinically appropriate, or the date that is requested by a patient.

## **Telemental Health Delays**

Telemental health consult delays occurred with six consults and averaged 88 days beyond the patient indicated date. Twenty of 65 (31 percent) telemental health return-to-clinic appointments were beyond the patient indicated date (average delay was 59 days).

## **Factors that Affected Mental Health Care Access and Delays**

Several factors contributed to patients' mental health care access and delays. These factors included provider and scheduling staff shortages and hiring practice delays, underutilization of non-VA care and telemental health services, disproportionate provider productivity, scheduling staff training and supervision issues, and policy non-compliance for pending consults and follow up with no-show patients or patients who miss their mental health appointments.

## **Administrative Investigation Board Review**

An administrative investigation board was convened by the Facility Director in February 2018 in response to the Chief of Staff's request to review scheduling practice issues in the facility's outpatient mental health program. According to the Director's request to the board, the administrative investigation board members were to seek testimony and gather other evidence to conclude whether the issues identified in the request existed and make recommendations that address those issues.

However, the facility's February 2018 Administrative Investigation Board review's investigation and subsequent action plan did not completely address issues that affected outpatient mental health program scheduling practices. Issues not addressed included staffing hiring practices, the underutilization of non-VA services and telemental health services, an in-depth review and analysis of scheduling data (including timeliness) and patients' complaints, and the facility's policy compliance with Veterans Health Administration requirements. The administrative investigation board did address several issues with provider productivity, providers and scheduling staff shortages, staff training and supervisory audits, and full implementation of Behavioral Health Interdisciplinary Program teams.

## **Completion of Consults**

During the inspection, OIG staff reviewed consults that were marked complete, indicating that provider actions/requests were completed, and found that 137 of the 436 (31 percent) patients did not have appointments scheduled as requested on the consult. Although staff called these patients and documented instructions for the patients to use the Primary Care Mental Health Integration Team walk-in clinic, no mental health evaluations to determine the urgency and need for immediate care, such as suicide assessments, were documented. Of the 137 patients, 118 (86 percent) did not go to the walk-in clinic and did not have an appointment documented with mental health outpatient services (per OIG review of visits from January 1 through

September 10, 2018). Patients who were not seen at the walk-in clinic and who had consults marked complete may have been lost to the facility's consult tracking process and may not have received needed outpatient mental health care.

The OIG made 12 recommendations related to EWLs, outpatient mental health appointments, non-VA and telemental health care, delays in scheduling both patients' consults and return-to-clinic appointments, provider and scheduling staff shortages, hiring practices, consult and no-show policy compliance, Administrative Investigation Board review processes, and the process of marking a consult complete when no appointment was scheduled and staff did not document an evaluation identifying whether the patient's needs were urgent or needed immediate care.

## Comments

The Veterans Integrated Service Network and Facility Directors concurred with the recommendations and provided an acceptable action plan. (See appendixes A and B, pages 35–43 for the Directors' comments.) Based on information provided, the OIG considers recommendations 1 and 2 closed. For the remaining open recommendations, the OIG will follow up on the planned and recently implemented actions to ensure that they have been effective and sustained.



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## Abbreviations

AIB	Administrative Investigative Board
CHOICE	Veterans Choice Program
EHR	electronic health record
EWL	electronic waiting list
HCS	Health Care System
MSA	medical support assistant
OIG	Office of Inspector General
PID	patient indicated date
RTC	return-to-clinic
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network





## Introduction

### Purpose

The VA Office of Inspector General (OIG) conducted a healthcare inspection to address concerns about access and delays in outpatient mental health care at the New Mexico VA Health Care System, Albuquerque, New Mexico (facility).

### Background

The facility is part of Veterans Integrated Service Network (VISN) 22, which consists of a medical center and 13 community based outpatient clinics. The facility was previously aligned with VISN 18. After Veterans Health Administration (VHA) underwent reorganization, the facility was aligned with VISN 22 in October 2016. The facility is affiliated with the University of New Mexico School of Medicine.

Both inpatient and outpatient mental health services are provided at the facility. Outpatient mental health services include substance abuse and posttraumatic stress disorder treatment, individual counseling, and group therapy.

### Access to Health Care

Access to healthcare is defined as “the timely use of personal health services to achieve the best health outcomes.”<sup>8</sup> The process has three steps that patients must take: “(1) gaining entry into the health care organization, (2) accessing a location where needed health care services are provided, and (3) finding a health care provider whom the patient trusts and can communicate with.”<sup>9</sup>

One of the barriers to health care access is a shortage of available services (staff or coverage for a large geographic location) that can lead to unmet health needs as well as delays in receiving appropriate care.<sup>10</sup>

Three components affect a patient’s access to health care:

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<sup>8</sup> Office of Disease Prevention and Health Promotion: U.S. Department of Health and Human Services. <https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services>. (The website was accessed on June 28, 2018.); Institute of Medicine, Committee on Monitoring Access to Personal Health Care Services. Access to Health Care in America. Millman M, editor. Washington, DC: *National Academies Press*; 1993.”

<sup>9</sup> Office of Disease Prevention and Health Promotion: U.S. Department of Health and Human Services. <https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services>. (The website was accessed on June 28, 2018.)

<sup>10</sup> Office of Disease Prevention and Health Promotion: U.S. Department of Health and Human Services. <https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services>. (The website was accessed on June 28, 2018.)

- Financial coverage or eligibility to cover the costs of health care needs
- Services or providers who consistently deliver care, such as a provider who sees the patient on an ongoing basis and with whom the patient develops communication links and trust
- Timeliness or the ability to provide health care services within a reasonable timeframe after a need is identified including the availability of appointments<sup>11</sup>

The effects of limited access to services or delays in the timeliness of services may negatively impact patients' ability to obtain health care, including needed mental health care, and increase patients' risk for adverse clinical outcomes such as hospitalization and increased complications or outcomes that include completed suicide.<sup>12</sup>

## Access to VHA Health Care

VHA policy, in compliance with Public Law 104-262, the *Veterans Health Care Eligibility Act of 1996*, states that veterans are to be provided access to VA healthcare benefits, including medical (38 CFR § 17.38) and mental health (38 CFR § 17.109) care.<sup>13</sup> The veteran patient's access to VHA health care follows the same steps as other healthcare access as described above: (1) gaining entry to VHA health care through a determination of eligibility and enrollment, (2) finding an accessible facility, and (3) assignment to a primary care provider where a sustained and trusting relationship develops.<sup>14</sup>

After a patient is enrolled at a VHA facility and assigned to a primary care provider, the patient may need specialty services, such as mental health care. To access specialty care, VHA uses a process of referrals or consultations (consults) that are generally ordered by the patient's primary care provider.<sup>15</sup>

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<sup>11</sup> Office of Disease Prevention and Health Promotion: U.S. Department of Health and Human Services. <https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services>. (The website was accessed on June 28, 2018.)

<sup>12</sup> Office of Disease Prevention and Health Promotion: U.S. Department of Health and Human Services. <https://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services>. (The website was accessed on June 28, 2018.)

<sup>13</sup> 38 CFR § 17.38, VHA Medical benefits package, July 7, 2009; 38 CFR § 17.109, VHA Presumptive eligibility for psychosis and mental illness.

<sup>14</sup> VHA Directive 1601A.02, *Eligibility Determination*, June 7, 2017. Amended July 27, 2017; VHA Handbook 1101.10(1), *Patient Aligned Care Team Handbook*, February 5, 2014, amended May 26, 2017.

<sup>15</sup> VHA Handbook 1101.10(1).

To ensure continuity and access to ongoing comprehensive care, providers may use return-to-clinic (RTC) requests to inform schedulers of the clinically or patient indicated date (PID) for the patient's next appointment, given the patient's condition.<sup>16</sup>

VHA evaluates wait times for appointments, cancellation by clinic data, and clinic/provider utilization data to measure patient access to services.<sup>17</sup>

Staffing shortages, appointment availability, and geographic locations that necessitate long travel distances for health care are attributed as barriers for patients to access VHA health care.<sup>18</sup> When barriers exist, VHA facilities may use other means to access health such as home telehealth care, including telemedicine, and non-VA care, such as provided by the Veterans Choice Program (CHOICE), to ensure patients receive evaluation and treatment.<sup>19</sup>

### *Clinical Consults*

A clinical consult is a request by a provider (sending provider) for an opinion, advice, or expertise regarding evaluation or management of a specific patient problem.<sup>20</sup> The consult process allows a two-way communication between the sending provider and the provider receiving the consult (receiving provider), and the process includes an automatic notification or alert to the sending provider of actions or changes made to the consult by the receiving provider.<sup>21</sup>

VHA uses a specific step-by-step process known as consult statuses to schedule and manage consult appointments in a timely manner.<sup>22</sup>

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<sup>16</sup> VHA Memorandum, *Scheduling and Consult Policy Update* (VAIQ#7798804), June 5, 2017. VHA directive used two terms for this date; however, this memo directs the use of the patient indicated date rather than the clinically indicated date; VHA Directive 1230, *Outpatient Scheduling Processes and Procedures*, July 15, 2016.

<sup>17</sup> VHA Directive 1230.

<sup>18</sup> JAMA, Ensuring Timely Access to Quality Care for US Veterans. <https://jamanetwork.com/journals/jama/fullarticle/2670102>. (The website was accessed on June 28, 2018.)

<sup>19</sup> VA Telehealth Services, Home Telehealth. <https://www.telehealth.va.gov/ccht/index.asp>. (The website was accessed on July 16, 2018.); VHA Tele Mental Health Operations Manual Supplement, Clinical Specialist Supplement, Revised November 2012; VHA Directive 1230; *Veterans Choice Program*, October 25, 2016; VHA Veterans Choice Program. <https://www.va.gov/COMMUNITYCARE/programs/veterans/VCP/index.asp>. (The website was accessed on July 16, 2018.)

<sup>20</sup> VHA Directive 1232(1), *Consult Processes and Procedures*, August 24, 2016, amended September 23, 2016.

<sup>21</sup> VHA Directive 1232(1).

<sup>22</sup> VHA Directive 1232(1).

As it is processed, the receiving service updates the consult status:<sup>23</sup>

- Pending – the consult request has been ordered by a sending provider, but the receiving service has not acted on the request or updated the status. The status of the consult must be changed within 2 days of being placed in pending.<sup>24</sup>
- Active – the consult has been received and efforts are underway to fulfill the consult, but no appointment has been made.
- Scheduled – an appointment has been made with the receiving provider, but the patient has not seen the provider.
- Complete – the receiving provider has finished complying with the actions requested on the consult by the sending provider and the consult is closed.
- Discontinue – used by both the sending and receiving providers, this status designates that the consult is no longer wanted or needed. The request is not acted upon, and the consult no longer exists.
- Cancel – the receiving provider returns the consult request back to the sending provider because the sending provider did not ask an appropriate consult question or provide sufficient information for the receiving provider to act upon. The consult may be sent back to the receiving provider by the sending provider with new instructions or information.<sup>25</sup>

The VHA goal is to schedule the patient’s consult appointment within 30 days of the PID.<sup>26</sup> The PID is intended to ensure that the patient is scheduled according to the individualized plan of care and when a visit is clinically appropriate.<sup>27</sup>

### *Returning or RTC Patients*

Receiving providers may need to follow up with a patient’s care by continuing to see the patient. If the receiving provider, such as mental health, decides to continue to see the patient for

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<sup>23</sup> Consult status refers to changes in the consult as it progresses through the processes of scheduling and completing the consult or canceling/discontinuing the consult.

<sup>24</sup> VHA Directive 1232(1); VHA Memorandum, *Scheduling and Consult Policy Update* (VAIQ#7798804), June 5, 2017.

<sup>25</sup> VHA Directive 1232(1).

<sup>26</sup> The PID is determined by the date the provider requests an appointment for a patient, by the date when the provider decides an appointment is clinically appropriate, or the date that is requested by a patient. This may be a specific date or interval of times such as 2, 3, or 6 months. PID encompasses earlier VHA definitions of the clinically indicated date and preferred date; VHA Memorandum, *Scheduling and Consult Policy Update* (VAIQ#7798804) June 5, 2017; VHA Directive 1230 (Appendix C).

<sup>27</sup> VHA Directive 1230.

treatment, the provider writes an order for another appointment using an RTC order or request date.<sup>28</sup>

As with consult appointments, providers schedule RTC appointments within 30 days of the PID or RTC date.<sup>29</sup> However, as noted in the December 1, 2016, Assistant Deputy Under Secretary for Health for Access to Care memorandum, the patient may be scheduled with another provider in the same specialty or referred to non-VA care.<sup>30</sup>

## Access to Non-VA Care

Non-VA care refers to non-VA provider care purchased by VHA through either the Non-VA Care Coordination Program or CHOICE.<sup>31</sup>

Non-VA medical care is provided to eligible patients when VA facilities and services are not reasonably available.<sup>32</sup> Requesting providers submit consults that are reviewed by scheduling staff who determine administrative eligibility, authorization, and schedule a non-VA provider appointment.<sup>33</sup>

Once a patient completes the appointment, the non-VA provider sends the results of the consultation and further recommendations to the requesting facility, and the results are scanned into the patient's electronic health record (EHR). Requesting providers are alerted that the information is in the EHR and can determine the patient's needs for continued care and treatment.<sup>34</sup>

CHOICE is one of the non-VA programs through which a patient can receive care from a non-VA provider, paid for by VA. For instance, if the patient needs an appointment for a specific type of care, and VA cannot provide the care in a timely manner or the nearest VA medical facility is too far away or too difficult to get to, then the patient may be eligible for care through CHOICE.<sup>35</sup>

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<sup>28</sup> VHA Directive 1230.

<sup>29</sup> VHA Directive 1230.

<sup>30</sup> Assistant Deputy Under Secretary for Health for Access to Care Memorandum, *Implementation of Priority Appointments Identification*, December 1, 2016.

<sup>31</sup> VHA Directive 1601, *Non-VA Medical Care Program*, January 23, 2013; VHA Directive 1232(1).

<sup>32</sup> VHA Directive 1601.

<sup>33</sup> VHA Non-VA Medical Care Coordination Process Guide, *Community Care Consult/Referral Review*, June 30, 2017.

<sup>34</sup> VHA Directive 1232(1).

<sup>35</sup> VHA Directive 1700, *Veterans Choice Program*, October 25, 2016; VHA Veterans Choice Program. <https://www.va.gov/COMMUNITYCARE/programs/veterans/VCP/index.asp>. (The website was accessed on July 16, 2018.)

## Mental Health Services

### *Mental Health and Mental Illness*

Mental health is considered an essential part of a patients' overall health. However, mental health issues and mental illness are not the same; patients may have mental health issues but not have a diagnosed mental illness. "Mental illnesses are conditions that affect a person's thinking, feeling, mood or behavior such as depression.... Conditions may be occasional or long-lasting (chronic) and may affect how a person interacts socially and functions day-to-day."<sup>36</sup> Mental health issues include emotions and psychological well-being, and affect how individuals "think, feel and act" when handling stress and social situations.<sup>37</sup> Mental health issues may change over time and are caused by many factors including trauma, substance abuse, and biological factors such as genes or chemical imbalances in the brain.<sup>38</sup>

Treatment for mental health issues or illness varies depending on the severity of the symptoms and may include inpatient and outpatient treatment/counseling.<sup>39</sup>

According to a study published in 2013 (data collected during 2010), most primary care/mental health centers needed additional staff to provide on-site mental health treatment, and this need for additional services would continue to grow. Further, shortages of psychiatrists demonstrated the need for integrated services especially in rural and lower income areas.<sup>40</sup>

### *VHA Mental Health Care*

VHA offers mental health services along a continuum of care ranging from acute inpatient locked mental health units to less restrictive residential treatment programs, to aftercare and outpatient services.<sup>41</sup> VHA policy, outlined in the *Uniform Mental Health Services Handbook*, envisioned a broad, integrated network for mental health services within VA and that all veteran

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<sup>36</sup> Centers for Disease Control and Prevention (CDC), Learn About Mental Health. <https://www.cdc.gov/mentalhealth/learn/index.htm>. (The website was accessed on June 29, 2018.)

<sup>37</sup> Centers for Disease Control and Prevention (CDC), Learn About Mental Health. <https://www.cdc.gov/mentalhealth/learn/index.htm>. (The website was accessed on June 29, 2018.)

<sup>38</sup> Centers for Disease Control and Prevention (CDC), Learn About Mental Health. <https://www.cdc.gov/mentalhealth/learn/index.htm>. (The website was accessed on June 29, 2018.)

<sup>39</sup> National Institute of Mental Health, Mental Illness. <https://www.nimh.nih.gov/health/statistics/mental-illness.shtml>. (The website was accessed on June 29, 2018.)

<sup>40</sup> Burke, Bridget, Miller, Benjamin et al, US National Library of Medicine, National Institutes of Health, A Needs-Based Method for Estimating the Behavioral Health Staff Needs of Community Health Centers, July 2, 2013. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3750356/>. (The website was accessed on July 16, 2018.)

<sup>41</sup> VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010. This handbook was scheduled for recertification on or before the last working date of December 2015 and has not been recertified.

patients, would have access to mental health services, including telehealth.<sup>42</sup> The handbook addresses both general mental health services and more specialized programs focusing on issues such as substance use disorders, posttraumatic stress disorder, military sexual trauma, homelessness, and psychological rehabilitation.<sup>43</sup>

Although some mental health issues, such as anxiety, can be managed in a VHA primary care clinic and/or by the mental health providers integrated into the primary care system, mental health services provide care and consultation for serious mental illnesses or other mental health specialty services.<sup>44</sup> In addition, outpatient mental health clinics offer specialized treatment programs (individualized or group) and/or therapy.<sup>45</sup>

In August 2013, VHA “committed to developing an outpatient mental health staffing model,” the Behavioral Health Interdisciplinary Program “to ensure consistency in general outpatient mental health staffing.”<sup>46</sup> In addition to addressing staffing ratios per panel of patients, the model was developed to incorporate a team-based treatment approach. The model required that each Behavioral Health Interdisciplinary Program team has an appropriate number of mental health providers in relation to the number of patients assigned to each panel; thus, ensuring fewer access issues for patients related to staffing shortages. Each health care facility was to implement at least one these outpatient teams. Team staffing included nurse practitioners, psychiatrists, psychologists, pharmacists, nurses, social workers, program support such as medical support assistants (MSAs), and other administrative staff.<sup>47</sup>

### *VHA Telemental Health Care*

Telehealth is the delivery of medical services using electronic communication and information technology when distance separates the provider or service and the patient. Telemedicine is a type of telehealth that provides medical “care by a licensed independent health care provider [who] directs, diagnoses, or otherwise provides clinical treatment.”<sup>48</sup>

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<sup>42</sup> VHA Handbook 1160.01, *Uniformed Mental Health Services Handbook*, September 11, 2008, amended November 16, 2015.

<sup>43</sup> VHA Handbook 1160.01.

<sup>44</sup> The Primary Care Mental Health Integration team is a behavioral health consultative program embedded within the primary care clinic (not in behavioral health clinics), and whose providers work closely with patient primary care providers providing “curbside consultations,” targeted assessments, and pharmacological and behavioral interventions; VHA Handbook 1160.01; VHA Handbook 1101.10(1).

<sup>45</sup> VHA Handbook 1160.01.

<sup>46</sup> Deputy Under Secretary for Health for Operations and Management Memorandum, *General Mental Health Staffing Model Team Development: Behavioral Health Interdisciplinary Program (BHIP) Team-Based Care*, August 5, 2013.

<sup>47</sup> Deputy Under Secretary for Health for Operations and Management Memorandum, *General Mental Health Staffing Model Team Development: Behavioral Health Interdisciplinary Program (BHIP) Team-Based Care*, August 5, 2013.

<sup>48</sup> Facility Memorandum 115-13, *Telehealth Services*, December 27, 2017.

In 1997, VHA implemented the telemental health program, a mental health provider-based telemedicine program.<sup>49</sup> Currently, the program is set up to treat serious mental illness diagnosis using an evidence-based treatment modality. Telemental health care can take place at multiple sites of care including medical centers, community based outpatient clinics, or shelters and can be delivered by a variety of mental health providers such as psychiatrists, social workers, nurses, and psychologists.<sup>50</sup> Telemental health care has increased patients' access to mental health services where barriers such as distance, mobility, or transportation existed. According to VHA, the telemental health program "efforts will help close the gap in access to mental health care, particularly in those traditionally underserved communities."<sup>51</sup>

## Prior OIG Report

In June 2016, the OIG published the report, *Administrative Summary of Investigation by the VA Office of Inspector General in Response to Allegations Regarding Patient Wait Times, VA Medical Center in Albuquerque, New Mexico*.<sup>52</sup> The investigation substantiated manipulation of desired appointment dates and identified two officials who encouraged the activity. There was no evidence of adverse patient outcomes attributable to the delays in care. The OIG referred the matter to the VA's Office of Accountability Review.

## Concerns

On March 22, 2017, the OIG received an anonymous complaint with multiple allegations:

- The facility lost eight providers in the Mental Health and telemental health programs.
- A large number of patients waited to receive telemental health.
- Only one social worker provided therapy to all patients at the outpatient clinics.
- MSAs kept Excel spreadsheets [rather than using the electronic waiting list] to track clinic patients.
- Patients waited 6 to 18 months to receive mental health appointments or therapy.
- No follow up was provided to patients who were started on mental health medications.

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<sup>49</sup> VHA Clinic Based Telehealth Operations Manual, *Clinical Video Telehealth*, revised July 2014; VHA Telemental Health Operations Manual Supplement, *Clinical Specialist Supplement*, Revised November 2012.

<sup>50</sup> VHA Telemental Health Operations Manual Supplement.

<sup>51</sup> VA Office of Public and Intergovernmental Affairs, *VA Announces Telemental Health Clinical Resource Centers during Telemedicine Association Gathering*, May 16, 2016.

<sup>52</sup> VA Office of Inspector General, *Administrative Summary of Investigation by the VA Office of Inspector General in Response to Allegations Regarding Patient Wait Times, VA Medical Center in Albuquerque, New Mexico*, Report No. 14-02890-344, June 22, 2016.



On August 31, 2017, the OIG requested that facility managers review the anonymous allegations and submit a response to the OIG by October 31, 2017. On December 7, 2017, the OIG received the facility's responses and corrective action plans.

The facility managers substantiated the loss of providers, the large wait list for telemental health, and high staff turnover. A manager partially substantiated the allegations that patients waited 4 to 18 months to get appointments/therapy including telemental health patients, and no follow up was provided to patients started on medications.<sup>53</sup> The facility provided corrective action plans for these items. The facility did not substantiate that only one social worker was providing therapy and that MSAs kept Excel spreadsheets to track patients. The facility provided evidentiary support to the OIG for the unsubstantiated allegations.

The action plans addressed continuing recruitment, changing supervision of MSAs from the outpatient mental health department to health administrative services, training and updates to standardize scheduling processes, and, in areas where clinics had lost providers or assistance from other VA clinics, offering other telemental health services and CHOICE.

The OIG reviewed the facility's action plans on December 18, 2017, and requested an update on March 1, 2018. On March 6, 2018, the OIG received the facility's updated responses for substantiated and partially substantiated allegations referred to above:

- Staff turnover remained high with 36 outpatient staff vacancies that included 11 administrative, 23 clinical, and two nurses.
- A total of 347 patients were waiting to be scheduled in the telemental health program.
- As of February 28, 2018, new psychiatry appointments took six weeks to schedule, new psychotherapy appointments were three months, new telemental health psychiatry appointments were averaging four months, and new telemental health psychotherapy appointments were one month.

The OIG initiated a healthcare inspection on March 8, 2018, because the facility responses, its action plan, and Administrative Investigative Board (AIB) results did not demonstrate progression toward a positive outcome for patients' access to mental health care. Additionally, data provided by the facility indicated the number of patients waiting for appointments had increased. The OIG identified four ongoing concerns

- Limited access to outpatient mental health care,
- Delays in outpatient mental health care with a focus on consults and ongoing patient care including telemental health,

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<sup>53</sup> Although the allegation had a wait time of 6–18 months, the manager stated in an interview that the wait times were 4–18 months.

- Contributing factors, such as staffing and training, that affected outpatient mental health care access and delays, and
- An incomplete AIB review and action plan.

During the inspection, the OIG team identified an additional finding related to consults that were marked as complete without patients receiving scheduled appointments.

## Scope and Methodology

The OIG initiated the healthcare inspection on March 8, 2018, and conducted a site visit May 14–18, 2018.

The inspection included a review of outpatient mental health clinics on the first and second floor of the outpatient mental health department and did not include the substance abuse clinic, mental health urgent care program, integrated mental health providers in the primary care clinic or electronic consults (e-consults).<sup>54</sup> Patients who were seen through the facility's agreement with the VA Portland Health Care System Mental Health Program were excluded from this review.

OIG staff reviewed relevant VHA and facility policies and procedures concerning consults, RTC orders, staffing levels and productivity, and primary, urgent care, and mental health services. In addition, we reviewed MSA audit and training records. Other information reviewed included facility data regarding patients' wait times and access to mental health appointments, VHA patient data, and patients' EHRs.<sup>55</sup>

The initial documentation review was based upon

- Mental health consults and RTC orders from January 1 through March 31, 2018;
- Mental health consults marked as complete or scheduled status as of July 17, 2018;
- Mental health RTC appointments marked as complete or scheduled as of August 3, 2018; and
- PID for each mental health consult and RTC order.

The OIG medical consultant performed clinical EHR reviews for patients who had consults or RTC orders within the OIG initial review dates and who completed suicide.

In total, OIG staff reviewed 536 consults and 1,377 RTC orders for mental health patients (within patient EHRs) to ascertain delays in appointments and care, and, if delays occurred, whether any of these patients completed suicide. OIG staff found no patients that had died from suicide.

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<sup>54</sup> Urgent care centers provide acute medical or mental health care for patients without a scheduled appointment who urgently need care. The clinics do not operate 24 hours per day, seven days per week, and do not provide ongoing care.

<sup>55</sup> The VHA Support Service Center collects VHA healthcare and staffing data to provide reports to VHA staff including healthcare and business managers. Facility data used in this report refers to specific subject program data reports from the VHA Support Service Center; however, this data may not be accurate. The VHA Corporate Data Warehouse collects data from VHA sources, such as the patient EHR, creates data sets, and allows access/query of VHA historical data that is updated daily. Warehouse data contains demographic and clinical characteristics, as well as healthcare utilization data. OIG staff used independent sources to verify the accuracy of Warehouse data used in this report.

Data requests for the patient EHR reviews were made on May 2, 2018, and data was finalized and clarified for consult and RTC order review on June 29, 2018.

For purposes of this report, the OIG defined scheduling delays as consults and RTC orders without an appointment and beyond 30 days of the PID or with appointments scheduled beyond 30 days of the original consult PID.

The OIG considered the risk of an adverse clinical outcome associated with scheduling delays as a function of both the potential severity of the patient's mental illness and the magnitude of the delay. An inherent risk of increased symptoms occurs with a delay in mental health care; however, many factors, including those outside of mental health care treatment, may affect patients' risk.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

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

## Inspection Results

### Issue 1. Access to Outpatient Mental Health Care

Patients seeking outpatient mental health care at the facility experienced limited access to care. OIG staff evaluated access to the facility's outpatient mental health care by reviewing indicators of, and barriers to, access from facility data obtained on a specific date. The OIG concluded that limited access led to the inability of patients to obtain needed care and increased patients' risk of adverse outcomes.

#### Indicators of Access Issues

The OIG reviewed the following indicators of access issues based on facility data:

- Use of electronic wait list (EWL)
- Consults open over 90 days
- High appointment cancellation rates
- Lower number of appointments completed within VHA timeframe goals<sup>56</sup>

In addition, the facility's medical director of outpatient mental health stated that new patients have longer wait times.

Per VHA directive, facilities should use the EWL to track patients who have been waiting for more than 90 calendar days for an appointment.<sup>57</sup> VHA facilities also regularly collect, monitor, and analyze consults waiting for an appointment for more than 90 days that includes pending and completed appointments, patient appointments canceled by VHA clinics, and patients' wait times for services as indicators of access.<sup>58</sup>

#### *EWL*

The EWL consists of both new mental health patients (patients who were not seen within the past 24 months or were scheduled for a new clinical problem) and established patients who were returning for an ongoing problem.<sup>59</sup> Staff must not use any other wait list format including Excel

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<sup>56</sup> The completed appointment report includes telehealth and reflects appointments that are not no shows by patients and have an appointment date and have a checkout time.

<sup>57</sup> VHA Directive 1230.

<sup>58</sup> VHA Patient Access Data. <https://www.va.gov/health/access-audit.asp>. (The website was accessed on June 28, 2018.); VHA Directive 1230.

<sup>59</sup> Facility data refers to data obtained from the VHA Support Service Center, a national repository for data submitted by VHA facilities and programs.

documents, paper lists, calendars, or log books and must enter patients on the EWL if they cannot be seen within 90 days for an appointment.<sup>60</sup>

MSA staff stated that they were not using the EWL because a previous supervisor instructed them to not use it to track patients.<sup>61</sup> MSAs stated they never have a patient waiting 90 days for an appointment because they would offer the patient CHOICE. Should a patient opt out of CHOICE and elect to wait for an appointment with providers, the MSAs kept track of these patients on their own lists.

For this reason, EWL data for the outpatient mental health department could not be used by facility managers or OIG staff as an additional indicator of access to care issues or delays because MSAs were not following VHA requirements.

### *Open Consults*

The VHA open consult reports measures consult management and timeliness were based upon data that reflected whether the consults were in pending, active, or scheduled status and 90 days or more beyond the consult PID. Therefore, patients had not seen a provider although they may have been scheduled. VHA measures success using a specific day or point in time to produce reports.

Facility data on August 1, 2018, reflected there were 801 open mental health consults; 191 (24 percent) had been open between 90 and 180 days from the PID.

### *Appointment Cancellations by Clinic*

Appointment cancellations by clinic rates are facility data reports based upon the percentage of appointments that are canceled by the specific clinic where the patient has an appointment and the appointment is not canceled by the patient. If an appointment is canceled by the clinic for reasons such as the clinic is canceled due to weather issues or lack of clinic staffing, the appointment is not available.<sup>62</sup> Therefore, a high rate of appointments canceled by the clinic may impact patients' access to care.

VHA policy indicates that managers should have contingency plans to minimize clinic cancellations.<sup>63</sup> To measure this aspect of access, VHA monitors canceled by clinic appointment data.

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<sup>60</sup> VHA Directive 1230; VHA Memorandum, *Electronic Wait List Reminder for All Clinics*, October 20, 2017.

<sup>61</sup> The previous supervisor left approximately one month before the AIB was initiated.

<sup>62</sup> VHA Directive 1230.

<sup>63</sup> VHA Directive 1230.

Facility policy states that clinic cancellations will be kept to a minimum to assure continuity in the delivery of care to patients.<sup>64</sup>

In June 2018, the facility’s appointment cancellation by clinic was nine percent, which was higher than the national average of seven percent.<sup>65</sup> Appointment cancellations were between two to three percent higher than the national average throughout fiscal year 2018 third quarter (see Figure 1).

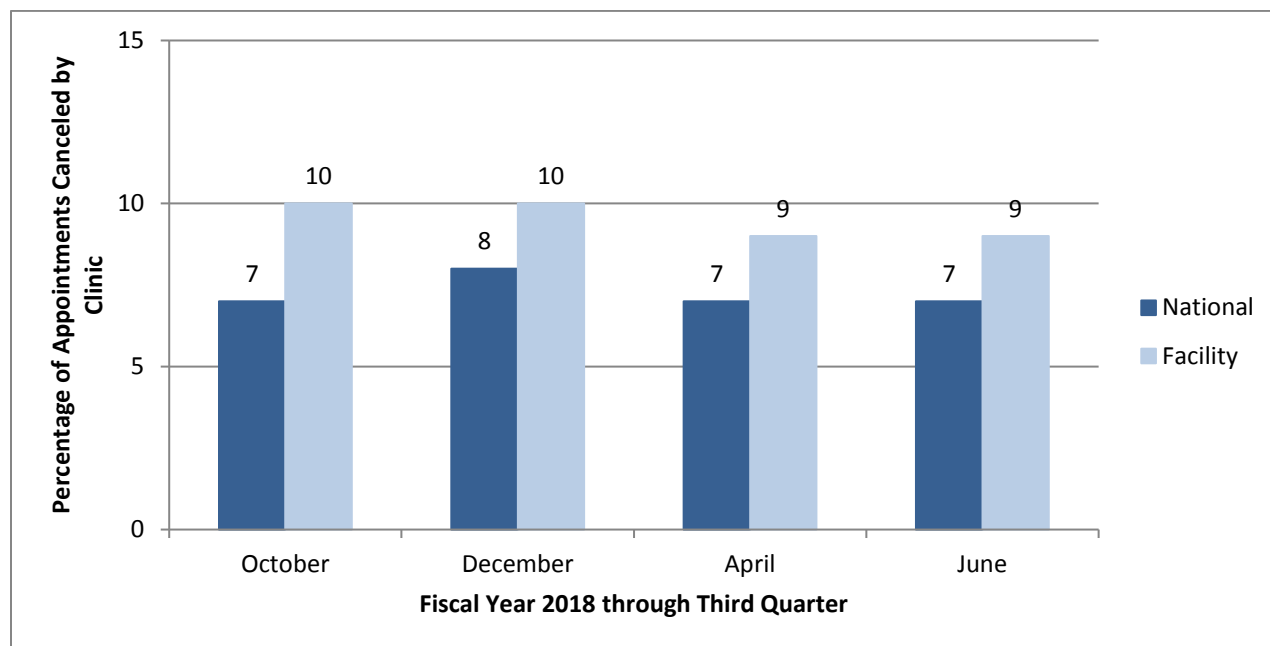


Figure 1. Comparison of VHA national and facility mental health appointment cancellations for fiscal year 2018 through June 30, 2018.

Source: VHA Support Service Center Cancellation Summary Report for June 30, 2018.

### Completed Appointments

VHA policy requires appointments, including consults, to be scheduled timely, accurately, and consistently using the goal of no more than 30 days from the PID.<sup>66</sup> Completed appointment data are measured by VHA facilities to evaluate the number of new and established patient appointments that did not meet that VHA timeframe.

Facility data for fiscal year 2018 through the first week of September indicated that 97 percent of established outpatient mental health appointments were completed in 30 days or less. The

<sup>64</sup> Facility Memorandum 11-41, *Outpatient Clinic Cancellations*, February 24, 2017.

<sup>65</sup> Facility data refers to data obtained from the VHA Support Service Center, a national repository for data submitted by VHA facilities and programs.

<sup>66</sup> VHA Directive 1230 (Appendix C); VHA Memorandum, *Scheduling and Consult Policy Update* (VAIQ#7798804) June 5, 2017.

percentage of appointments that were completed within 30 days or less for new (generally consults) outpatient mental health clinic patients was lower at 81 percent. The national average for established outpatient mental health patient appointments completion was 98 percent and for new patient appointments it was 95 percent.

The OIG was unable to specifically identify why the facility's percentage of completed new appointments was lower than the national average; however, this issue may be accounted for by the facility's staffing shortages and not utilizing alternatives, such as the telemental health program and CHOICE to provide patient care.

### *Wait Times for New Patients*

The facility's medical director of the outpatient mental health and telemental health program stated that the wait time for a new patient to receive an appointment was six weeks. However, OIG staff reviewed the February 2018 data provided by the director and noted that new patients had a four-month wait for new community based outpatient clinics' psychiatry and psychology mental health patients and psychiatry telemental health patients.

According to facility staff, reasons for the longer wait times and limited access to care included staff confusion with changes with scheduling procedures, inaccurate and numerous provider schedules or grids, and staffing vacancies for providers and MSAs.<sup>67</sup>

## **Issue 2. Delays in Outpatient Mental Health Care**

VHA specifies that the timeframe goal for appointments is within 30 days of the PID or RTC date designated in the order.<sup>68</sup> Therefore, patients not receiving an appointment within 30 days may experience a delay in their intended care.

### **Patient Consult Delays**

OIG staff determined that patients experienced delays in receiving consult appointments. Although patients may have been at a higher risk for a poor outcome because of delays, the OIG staff determined that of the 410 consult delays, no patients involved in those consults completed suicide as a result of delays in care.

After reviewing outpatient mental health data of consults ordered and not discontinued/canceled from January 1 through March 31, 2018, the OIG determined that, as of July 17, 2018, delays occurred for 410 of 536 (76 percent) outpatient mental health care consult appointments.<sup>69</sup> For 157 of 410 (38 percent) consults that were marked with a complete status, the average number of

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<sup>67</sup> A grid, in the context of this report, is a clinic schedule, based upon possible provider appointments, that identifies appointment availability to schedule patients.

<sup>68</sup> VHA Directive 1230.

<sup>69</sup> Delays ranged from 31 to 256 days beyond the PID.



days beyond the PID was 73 days. An additional 70 consults (17 percent) had appointments scheduled but not yet completed, on average, 142 days beyond the PID. Of the remaining consults beyond 30 days of the PID, 11 (3 percent) were CHOICE referrals, and 172 (42 percent) had no appointments scheduled. One hundred twenty-six consults were completed within 30 days.

Interviews with staff revealed that mental health provider shortages contributed to less available staff to treat and manage patients requiring mental health consults and evaluations.

## **RTC Delays**

The OIG determined that staff were not consistently scheduling RTC appointments within VHA timeliness goals, and therefore, appointment delays occurred.<sup>70</sup> Although the 176 patients identified with delays may have been at a higher risk for a poor outcome because of those delays, the OIG determined that no patients completed suicide.

OIG staff reviewed and analyzed RTC outpatient mental health data from January 1 through March 31, 2018, for the psychiatry, psychology, and clinical social work (mental health program services for ongoing treatment and care) to identify scheduling delays. The OIG identified that of 1,377 RTC orders reviewed, 176 (13 percent) were not scheduled within 30 days of the RTC date or PID requested by the provider.<sup>71</sup>

According to the Chief of Staff, delays in scheduling RTC appointments within the timeframe indicated by the provider were due to the large number of provider and MSA vacancies, productivity issues, and human resources hiring delays for new staff.

## **Telemental Health Delays**

Telemental health is provided at the facility clinics, community based outpatient clinics, and in home-based care. Appointments are scheduled by MSAs who are specifically trained to schedule this type of appointment.

Based on the OIG review mental health consult data from January 1 through March 31, 2018, 6 of 410 (2 percent) patients were referred to telemental health and 65 of 1,377 (5 percent) RTC orders were for telemental health. The six consults were beyond 30 days of the PID and patients experienced an average wait time of 88 days from the PID date. Delays beyond 30 days occurred for 20 of 65 (31 percent) RTC orders with an average number of 59 days beyond the PID.

With the small number of telemental health consults and RTC orders within the timeframe reviewed, the OIG could not discern if delays were common for the telemental health care program.

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<sup>70</sup> VHA Directive 1230.

<sup>71</sup> Delays ranged from 31 to 280 days beyond the RTC order or PID.

### **Issue 3. Barriers/Factors Affecting Outpatient Mental Health Care Access and Delays**

The OIG identified seven factors that affected patients' access to outpatient mental health care that may have resulted in mental health care access limitations and delays:

- Provider staffing shortages
- Underutilization of CHOICE and telemental health services
- Disproportionate provider productivity
- MSA shortages and hiring practice issues
- MSA training and supervision issues
- Pending consult timeframes
- No-show patient follow-up scheduling

#### **Provider Staffing Shortages**

The OIG reviewed the facility's outpatient mental health provider vacancies and allocated positions data as of August 30, 2018, and identified that 10 of the 108.3 (9 percent) full time employee equivalent allocated positions were vacant. The OIG also identified vacancies in 2 of 23.5 (9 percent) psychiatry, 2 of 38 (5 percent) psychology, 4 of 32.8 (12 percent) social worker, and 2 of 14 (14 percent) advanced practice nurse allocated positions.

In May 2018, facility leaders stated there were seven to eight vacant psychiatry positions. Facility leaders reported that delays in the human resources hiring and onboarding process made positions hard to fill and two or three providers were lost this year due to the delays. Vacant positions decrease availability for patient appointments and cause access issues. According to the Chief of Staff, provider hiring processes delayed bringing new staff on board.

To meet VHA requirements and assist with patient access and provider availability, the mental health outpatient clinics have been working on the development of several Behavioral Health Interdisciplinary Program teams. This approach encourages members of the team to support and assist providers with care; therefore, allowing providers to concentrate on the patient's mental health planning and treatment rather than scheduling and other support tasks.<sup>72</sup> Behavioral Health Interdisciplinary Program models were developed to ensure that the appropriate number of mental health providers were assigned to each panel of patients.<sup>73</sup>

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<sup>72</sup> VHA Memorandum, *General Mental Health Staffing Model Team Development: Behavioral health Interdisciplinary Program (BHIP) Team-Based Care*, August 5, 2013.

<sup>73</sup> VHA Memorandum, *General Mental Health Staffing Model Team Development: Behavioral health Interdisciplinary Program (BHIP) Team-Based Care*, August 5, 2013.

## Underutilization of CHOICE and Telemental Health Services

The OIG determined that CHOICE and the telemental health program were underutilized, given the staffing shortages and geographic location of the clinics and main hospital.

The facility is comprised of a large, mostly rural, area of 121,365 square miles in New Mexico.<sup>74</sup> According to the 2015 Veterans Profile and the U.S. Census, the facility serves from 152,055 to 157,413 veterans.<sup>75</sup>

### CHOICE

The OIG determined that staff were not routinely referring patients to the CHOICE program or documenting that the CHOICE program was offered to patients who may have been eligible for the program.

When a patient cannot be seen within 30 days of the PID, VHA requires that the scheduler ask the patient if they would prefer to make a non-VA care appointment or wait beyond 30 days for a VA appointment.<sup>76</sup> The offer of CHOICE and the patient's response, whether opting in or out, must be documented in the patient's EHR. OIG staff reviewed 410 consults from January 1 through March 31, 2018, that were beyond 30 days of the consult PID and determined that staff referred 11 of 410 (3 percent) mental health consults to the CHOICE program. Six additional consults contained documentation indicating that CHOICE was offered to the patient and the patient opted to wait for a VA provider.

An MSA said that when CHOICE is offered to a patient, the wait time for a CHOICE appointment may take as long as waiting for a facility provider. In addition, staff stated that it takes 4 to 12 weeks for the facility non-VA care department to upload patient referrals and requests for the CHOICE program. Another provider stated that shortages of non-VA providers in remote communities also affected the use of CHOICE for patients.

### Telemental Health Program

The OIG determined that the facility's telemental health program was not consistently receiving consults and RTC orders although staff were available to care for patients.

OIG staff reviewed consults and RTC appointments from January 1 through March 31, 2018, and identified 6 of 410 (2 percent) consults and 65 of 1,377 (5 percent) RTC orders were for telemental health.

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<sup>74</sup> New Mexico Department of Health, New Mexico State Health Assessment 2014–2016. <https://nmhealth.org/publication/view/report/407/>. (The website was accessed on August 27, 2018.)

<sup>75</sup> United States Census Bureau, Quick Facts New Mexico. <https://www.census.gov/quickfacts/nm>. (The website was accessed on August 27, 2018.); New Mexico Department of Health, New Mexico State Health Assessment 2014–2016. <https://nmhealth.org/publication/view/report/407/>. (The website was accessed on August 27, 2018.)

<sup>76</sup> VHA Directive 1230.

A telemental health provider described his schedule as not very full, and although the provider would get some new patients, the RTC patients were not scheduled. The provider reported this was due to shortages of trained MSAs to provide scheduling. A telemental health provider and nurse reported that telemental health providers had only one patient scheduled for an eight-hour day while the back log continued to increase.

MSAs and the MSA supervisor identified two possible reasons for limited telemental health referrals: the complicated appointment scheduling process and shortages of MSAs with appointment schedule training.<sup>77</sup> At the time of the OIG visit, the MSA supervisor stated that only 1 of 17 MSAs had received telemental health scheduling training. In addition, the Chief of Staff reported that the VA Portland Health Care System, which provided some telemental health to the facility's patients, reduced the number of patients seen by its providers.

### **Disproportionate Provider Productivity**

The OIG determined that mental health program providers productivity was disproportionate according to VHA guidance.

VHA developed productivity and staffing guidance for outpatient mental health staff to measure productivity and staffing needs for VHA facilities.<sup>78</sup> In June 2013, VHA released Directive 1161, *Productivity and Staffing in Outpatient Clinical Encounters for Mental Health Providers*. The policy provides guidelines for mental health outpatient provider productivity, staffing levels, and labor mapping for psychiatrists, psychologists, social workers, and mental health advance practice nurses.<sup>79</sup>

VHA policy uses a measure named a work relative value unit (unit) to assist with guidance in provider productivity. VHA policy stipulates a range of acceptable units for each type of mental health outpatient provider. (See Table 1.)<sup>80</sup> In addition to identifying the VHA unit goal, the facility data collected reflects facility unit information.

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<sup>77</sup> The scheduling process entailed collaboration between two sites, equipment in both sites, availability of that equipment (although purchased for mental health services, telemental health equipment was used by other services at the community based outpatient clinic sites) and scheduling two appointments within an electronic system that does not recognize or allow two appointments to be made at the same time. The patient appointment time and the provider appointment time were scheduled one minute apart in the electronic schedule to work around the restrictions of scheduling two appointments in one appointment slot.

<sup>78</sup> Productivity is the quality or state of producing or being effective in bring about results or benefits; VA Handbook 5011/27, *Hours of Duty and Leave*, October 21, 2014, "intermittent and fee basis employees are persons employed on an intermittent basis, per annum fee basis, or lump-sum fee basis, under [the] authority of 38 U.S.C. § 7405 who are paid for actual service rendered; their duty schedules are determined by procedural requirements issued by the Under Secretary for Health."

<sup>79</sup> VHA Directive 1161, *Productivity and Staffing in Outpatient Clinical Encounters for Mental Health Providers*. June 7, 2013.

<sup>80</sup> VHA Directive 1161.

**Table 1. Productivity for Outpatient Mental Health Providers**

Mental Health Provider Types	VHA Policy Productivity Work Relative Value Units – Goal/Guidance	Facility Productivity Work Relative Value Units
Psychiatrists	2317–2831	2837
Psychologists	1733–2119	1827
Social Workers	1075–1313	2536 (↑)
Advance Practice Nurses	1630–1992	777 (↓)

*Source: VHA Support Service Center Mental Health Workforce Report data accessed by OIG staff on August 22, 2018.*

According to VHA policy, the service chiefs should monitor productivity for their staff and adjust it accordingly when it does not meet the standard.<sup>81</sup>

The OIG established that the facility psychologists’ productivity level was within policy standard ranges. However, the social workers’ productivity level was nearly double the highest number of their policy standard range, and the advance practice nurses’ productivity level was less than half of their lowest policy standard range.

Productivity beyond the highest range levels can lead to staff turnover and burnout that may ultimately cause quality of care and access concerns. In turn, low productivity levels can also cause access issues and delays in care if staff are not meeting the desirable number of appointments. The OIG was unable to identify why the mental health staff patient assignments were disproportionate or why social workers had a high productivity level and advance practices nurses had a low productivity level.

### **MSA Shortages and Hiring Practice Issues**

The OIG identified a shortage of MSA staff who assist with scheduling patients in the outpatient mental health program and issues with human resources’ hiring practices that affected the number of MSAs working in the outpatient mental health program.

VHA requires that sufficient support staff, clinical and non-clinical, for specialty care clinics such as mental health, are assigned to ensure patients receive timely service, and that providers are not drawn away from their professional services to carry out duties that should be performed by support staff.<sup>82</sup>

<sup>81</sup> VHA Directive 1161.

<sup>82</sup> VHA Handbook 1065.01, *Productivity and Staffing Guidance for Specialty Provider Group Practice*, May 4, 2015; VHA Directive 1161.

MSAs are the support frontline employees who schedule appointments, answer calls, and respond to various needs of providers, patients, and patients' families. In 2016, VHA started the Hire Right Hire Fast initiative to hire MSAs and ensure "every VA facility had the right number of MSAs with the right skills."<sup>83</sup>

In May 2018, the facility human resources director provided MSA recruitment services for all facility departments. The health administration service department supervises MSAs in the outpatient mental health program, primary care clinics, and the benefits department. The human resources department reported that as of May 17, 2018, 29 MSA positions for health administration services were either being recruited, or a person had been selected and was going through the qualification process.

Using the VHA Hire Right Hire Fast Initiative, MSAs were hired as a pool using general qualifiers. Two of the 29 MSA open positions were advance level, requiring additional experience or education to qualify. One position was at the lowest level used to hire MSAs, and the remainder of the scheduling positions were at a higher level. MSA positions are filled on a first come first serve basis, meaning the department that submits a request to human resources first, receives the first qualifying MSA from the general pool.

According to the human resources and MSA supervisory staff, MSAs working at lower-level scheduling positions in clinics, may apply for the higher-level positions. If an MSA applies for the higher level, they may choose the department where they wish to work (if a position is open). Therefore, an MSA working in an outpatient mental health clinic, who applies and gets a higher-level position, may choose to leave outpatient mental health services and transfer to another department with an opening, such as primary care. If the MSA moves to another department, the MSA supervisor must submit a request for another MSA; however, this request is now at the bottom of the hire list. The MSA supervisor stated that it takes up to seven months to hire an MSA.

According to MSA supervisory staff, the mental health outpatient clinics needed 11 more MSAs to operate effectively (the total number of allocations was 26). A telemental health provider stated that, as soon as MSAs are promoted, they move to a different department.

## **MSA Training and Supervision**

### *Training*

The OIG established that outpatient mental health MSAs had not completed all required training for patient scheduling processes.

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<sup>83</sup> VHA Hire Right Hire Fast, VA Pulse. <https://www.vapulse.net/community/hire-right-hire-fast/blog/2016/08/26/hire-right-hire-fast>. (The website was accessed on May 18, 2018.)

VHA requires MSAs who schedule appointments to successfully finished required training, and that evidence of the completion is documented. The previously required MSA training courses included several patient scheduling modules.<sup>84</sup>

As of May 2018, the OIG reviewed the previously required MSA training courses for all current and new MSAs and determined that 8 of 17 (47 percent) MSAs had not finished training. When MSA staff do not complete the required training for their position, they may not be fully equipped to perform their functions successfully.

### *Supervision*

The OIG determined that supervisory audits of MSA scheduling practices did not meet VHA requirements.

VHA requires supervisory audits for scheduling MSAs every six months. The audits must include a review of at least 10 scheduled appointments per scheduler and must evaluate the timeliness and appropriateness of scheduling actions, and the accuracy of the PID.<sup>85</sup> On March 10, 2017, the Deputy Under Secretary for Health for Operations and Management issued a memorandum to VISN Directors mandating the scheduling audit outlined in VHA Directive 1230.<sup>86</sup>

In fiscal year 2017, health administration service MSAs scheduled 71,647 appointments. To meet the scheduling audit requirements, a minimum of 300 appointments should have been audited by MSA supervisors, consisting of 20 per MSA (15 outpatient mental health MSAs).<sup>87</sup> For fiscal year 2017, only 184 scheduling audits were performed. VHA also tasks the scheduling supervisors, based on identified deficiencies in competency or performance, to determine the number and scope of subsequent audits to improve scheduling proficiency when scheduling errors are found.<sup>88</sup> The MSA supervisory staff did not provide the minimum level of oversight and monitoring of outpatient mental health MSAs' scheduling practices. This oversight issue may have increased the non-compliance with VHA scheduling mandates and delayed the identification and correction of errors.

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<sup>84</sup> VHA Directive 1230.

<sup>85</sup> VHA Directive 1230.

<sup>86</sup> Deputy Under Secretary for Health for Operations and Management Memorandum, *Scheduling Audit*, March 10, 2017.

<sup>87</sup> Two of the 17 MSAs discussed in the preceding training review section had their supervisory appointments audit performed by a different service line. Only the 15 health administration services MSAs were reviewed in this section.

<sup>88</sup> VHA Directive 1230.

## Consult Policy

The OIG determined that facility policy and practices concerning consults' pending status timeframe did not comply with VHA requirements.

VHA policy specifies that facilities have two business days to change a consult status from pending to another status.<sup>89</sup> However, facility policy allows the pending consult status to change to another status, such as active or scheduled, within seven days of the consult request date. Facility policy requires an initial clinical review (triage) of all consults, including mental health consults.<sup>90</sup>

According to summary data gathered from January 1 through March 31, 2018, mental health consults were in pending status an average of 87.5 days.

## Staff Follow-Up to Schedule No-Show Patients

The OIG determined that the facility policy to follow up with no-show patients did not reflect VHA requirements, and staff did not consistently follow up with no-show patients.<sup>91</sup>

VHA requires that clinic staff reschedule a patient for another appointment when a patient does not present for a scheduled appointment. When a patient does not present (or no-shows) for a mental health appointment, clinic staff are required to make three phone call attempts to reach the patient. If these attempts are unsuccessful, a letter should be mailed. If no response from the patient is received after 14 calendar days, the provider decides if contact efforts should cease or if additional or different attempts should be made.<sup>92</sup>

Attempts to reach a patient must be documented in the patient's EHR. The June 25, 2013, Deputy Under Secretary for Health for Operations and Management memorandum required VHA facilities to have a qualified mental health provider follow up with high-risk no-show patients and contact local law enforcement if contact was unsuccessful. Additionally, VHA facilities were required to either develop or amend local policies to ensure consistency with the special follow-up requirements when mental health patients no-show and monitor compliance with the policy by performing EHR audits/reviews.<sup>93</sup>

Facility policy requires staff to enter a "Failure to Report Note" in the patient's EHR when a patient is a no-show or has not presented to staff by the end of a scheduled appointment. Staff

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<sup>89</sup> VHA Deputy Under Secretary for Health for Operations and Management Memorandum, *Scheduling and Consult Policy Update* (VAIQ#7798804), June 5, 2017.

<sup>90</sup> Facility Memorandum 11-29, *Consult Management*, February 24, 2017.

<sup>91</sup> A no-show occurs when a patient does not present for a scheduled appointment by the time the appointment was scheduled to start; VHA Directive 1230; Facility Behavioral Health Care Line Policy #1-5, *Failure to Report for Scheduled Clinic Appointments*, July 30, 2010.

<sup>92</sup> VHA Directive 1230 (Appendix I).

<sup>93</sup> DUSHM Memorandum, *Guidance on Patients Failure to Attend Appointments (no shows)*, June 25, 2013.



determine the follow-up urgency by assessing the patient using a classification process.<sup>94</sup> The provider reviews the patient's EHR and makes an assessment regarding the follow-up classification urgency.<sup>95</sup>

Unlike VHA policy, facility policy does not direct staff to contact local law enforcement in high-risk situations if the patient cannot be contacted but directs staff to submit information to the Mental Health Urgent Care Clinic. The policy also does not require the three telephone calls and letter requirements for mental health patients.<sup>96</sup> The policy places more of the focus to track and follow up with appointments on the mental health patient. This is not consistent with the requirements or intent of VHA policy.

### Example 1

*A consult was placed in early 2018 for a patient who had an anxiety disorder and wished to see a psychiatrist. The consult had directions added by the consult coordinator to discontinue the consult after two no-shows. The patient did not appear or present for the appointment. No attempts were documented to contact the patient to reschedule the appointment. A provider determined the patient was at low-risk, which should have required a call and/or a letter, but the consult was administratively discontinued. A new consult was placed by the patient's primary care provider approximately two months later, and an appointment was scheduled for six weeks later. The patient did not show up for the appointment. The consult was then discontinued, and no documented attempts were made to contact the patient. As of fall 2018, no attempts were documented to reschedule the appointment until three weeks later when staff sent the patient a letter asking him to call and reschedule.*

Upon review of EHRs for patients who no-showed from January 1 through March 31, 2018, the OIG determined that staff did not document, as required by facility policy, a "Failure to Report Note" for 22 of 54 (41 percent) no-shows in the patients' EHRs. In addition, for 25 patients (46 percent), staff did not assess the need of follow-up urgency by documenting the patient's risk

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<sup>94</sup> Facility Behavioral Health Care Line Policy #1-5, *Failure to Report for Scheduled Clinic Appointments*, July 30, 2010; The classifications are: Level I (High risk of imminent harm to self or others): Submit Certificate of Evaluation and notify urgent care mental health clinic team; Level II (Moderate risk of harm to self or others or within one month of discharge from inpatient psychiatry – Ward 7): Phone patient the same day; Level III (Low risk of harm to self or others but needs ongoing mental health care): Phone within one week and/or mail a letter requesting patient to reschedule; and Level IV (Very low risk of harm to self or others and unlikely to need further mental health care): Wait for patient to reschedule as desired.

<sup>95</sup> Facility Behavioral Health Care Line Policy #1-5.

<sup>96</sup> Facility Behavioral Health Care Line Policy #1-5; DUSHM Memorandum, *Guidance on Patients Failure to Attend Appointments (no shows)*, June 25, 2013.

level (Levels I–IV) used in their present facility policy.<sup>97</sup> For 39 of the 54 (72 percent) patients, staff did not make at least three attempts to contact the patient to reschedule their behavioral health appointments as required by VHA.

## Effects of Mental Health Appointment Access Issues and Delays

The effects of delayed access and care may include an increase in patients' use of emergency departments for non-urgent care, a negative impact on patients' health outcomes, and a decrease in patient satisfaction with care experiences resulting in patient complaints.<sup>98</sup>

### *Patient Complaints*

The Patient Advocate Tracking program was established to ensure that VHA patients and their families have their complaints addressed in a convenient and timely manner. The VHA Patient Advocacy Program ensures that patient complaints are identified, resolved, classified, tracked, and used to improve overall service to patients.<sup>99</sup>

From January 11, 2016, to March 28, 2018, 110 of 328 (34 percent) complaints received by the Patient Advocate were associated with mental health access and wait times including returned emails and telephone calls. In the first two quarters of 2018, 26 of 59 (44 percent) patients' complaints included access to mental health appointments, canceled and changed mental health appointments, and mental health staff not returning patients' telephone calls and email messages. According to the Patient Advocate, appointment scheduling was the most prevalent patient complaint.

### *Low Performance VHA Comparison Data*

VHA leaders use facilities' data to compare specific measures between facilities. These measures are part of the Strategic Analytics for Improvement and Learning Value Model.<sup>100</sup> Two of the standardized measures for mental health are patient population coverage and patient experience of care. For easier comparison, VHA uses a 1 to 5 rating, whereby a lower number reflects a better performance rating in comparison to other facilities. The comparison evaluates 130 acute

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<sup>97</sup> Facility Behavioral Health Care Line Policy #1-5.

<sup>98</sup> Prentice, Julia and Pizer, Steven. Delayed Access to health Care and Mortality. *U.S. National Library of Medicine*, 2007 April; 42(2): 644-662. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1955366/>. (The website was accessed on September 13, 2018.)

<sup>99</sup> VHA Directive 1003.04, *VHA Patient Advocacy*, February 7, 2018; VHA, Patient Advocate Program, Patient Advocate. <https://www.va.gov/health/patientadvocate/>. (The website was accessed on June 27, 2018.)

<sup>100</sup> VHA, Quality of Care, Strategic Analytics for Improvement and Learning. [https://www.va.gov/qualityofcare/measure-up/strategic\\_analytics\\_for\\_improvement\\_and\\_learning\\_sail.asp](https://www.va.gov/qualityofcare/measure-up/strategic_analytics_for_improvement_and_learning_sail.asp). (The website was accessed on September 14, 2018.)

care VHA facilities. The 2018 facility measures for both standard measures reflected a 4 to 5 rating in comparison with other like facilities.

#### **Issue 4. AIB Investigation and Action Plan**

The OIG determined that the facility's AIB did not completely review or document some of the relevant items that affected outpatient mental health program scheduling practices.

An AIB is a committee or board appointed/convened by a facility director or leadership. AIB board members perform administrative investigations that use systematic processes to collect facts, and document and analyze evidence about an issue that has occurred in order to determine why the issue occurred.<sup>101</sup> The AIB makes conclusions based upon facts and evidence and may make recommendations.<sup>102</sup>

VHA leaders who convene an AIB must ensure that a sufficient investigation is conducted and take appropriate actions as needed or recommended by the AIB.<sup>103</sup> According to VHA, AIBs should perform interviews and “attempt to review all available documents, records, and other information” that are relevant to the investigation issues or may lead to other evidence that may be needed.<sup>104</sup>

After the OIG requested information and the Chief of Staff requested a review of scheduling practices, the Facility Director convened an AIB on February 22, 2018, to conduct an internal investigation concerning scheduling irregularities and practices in the mental health outpatient clinics. According to the Facility Director's charge letter, the AIB members were to seek testimony as well as gather other evidence that was determined to be “necessary and relevant.”

According to AIB members, they did not review relevant policies or data concerning the scheduling practices but did interview staff who scheduled appointments and worked within the outpatient mental health clinics. The AIB members' conclusions and recommendations were primarily based upon those interviews.

On April 30, 2018, the AIB concluded its investigation and gave their conclusions and recommendations to the Facility Director.

The AIB members made nine recommendations to facility leaders:

- Administrative action was not needed for any specific employee
- Identify root causes needed to improve the work environment and lack of communication
- Define supervisory roles

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<sup>101</sup> VA Directive 0700, *Administrative Investigations*, March 25, 2002.

<sup>102</sup> VA Handbook 0700.

<sup>103</sup> VA Directive 0700.

<sup>104</sup> VA Handbook 0700.

- Provide clear expectations and responsibilities based on the requirements for scheduling
- Develop a quality control plan for scheduling by the MSAs
- Ensure clinical reviews are completed in a timely manner (when a physician leaves, the patient's record needs to be clinically reviewed and assigned to another physician or provider)
- Evaluate the grid management process and include input from the providers; develop a staffing plan for coverage
- Provide daily clinical huddles to ensure communication; review telemental health scheduling processes
- Review same day referrals to urgent care to ensure patient continuity

Although the AIB review was conducted under the direction of facility leaders, the overall exploration of issues only included interviews with staff. The review did not include an analysis of scheduling data (including timeliness), patients' complaints, facility policies, patients' EHRs, or other records, such as schedules, related to processes that were used to schedule patients for appointments.

On May 8, 2018, the Facility Director assigned the Chief of Staff to develop an action plan based on the AIB recommendations within 30 days. The action plan was presented to the OIG on July 12, 2018.

Although the action plan addressed several concerns such as meeting with staff and provided guidance and expectations regarding a team-based approach, it did not address an exploration of root causes for identified communication issues, increased use of CHOICE and the telemental health program, MSA hiring practices, and the facility no-show policy.

In addition, if reviews of policies and patient records had been initiated or the action plan had included a more in-depth review of communication and workplace problems, these issues of access to services, including facility policy compliance with VHA requirements, may have been noted.

## **Issue 5. Consults Marked as Complete Without Scheduled Appointments**

During the inspection, the OIG determined that staff were marking consults complete without scheduling face-to-face appointments as requested by a patient's provider. Although staff called these patients, staff did not consistently document that an evaluation of the patient's mental health risk was performed.

According to VHA policy, the intent of a clinical consult is to meet the request by a sending provider for clinical services on behalf of a patient. The clinical consult includes the request by the sending provider and an answer by the receiving service. The consult process has two status

indicators that show the consult actions are concluded: complete and discontinued. Complete indicates the requested service has been accomplished and discontinued indicates the consult is no longer wanted or needed. The sending provider is electronically alerted through EHR alerts to the status used, but may interpret the complete status as having the consult order fulfilled with a requested face-to-face appointment or requested service.<sup>105</sup>

VHA policy also requires that all new patients requesting or referred for outpatient mental health services receive an initial evaluation within 24 hours by a primary care or mental health provider that includes an assessment to identify patients with urgent care needs that may indicate hospitalization or immediate initiation of outpatient care, and ensure a more comprehensive diagnostic and treatment planning evaluation is performed within 30 days.<sup>106</sup>

Facility policy indicated that outpatient clinical consults will either be face-to-face appointments or via telehealth, and that the consults will be completed by a consulting provider.<sup>107</sup> According to facility medical bylaws, a satisfactory consultation includes an interview and examination of the patient and review of the patient's EHR.<sup>108</sup>

The OIG identified 436 of 536 (81 percent) outpatient clinical consults conducted from January 1 through March 31, 2018, that had provider requests for face-to-face appointments and were marked complete rather than discontinued by the outpatient mental health staff.

When the consults and the associated EHRs were reviewed, OIG staff determined that 137 of the 436 (31 percent) consults marked complete had no face-to-face appointments as the sending provider requested, and although staff called patients, they did not document a mental health evaluation to identify urgent care needs, such as suicide risk, that may indicate an immediate need for intervention; however, staff documented instructions for the patients to use the Primary Care Mental Health Integration Team walk-in clinic.<sup>109</sup> Of the 137 patients, 118 (86 percent) did not go to the walk-in clinic and did not have appointments documented with mental health outpatient services (per assessment of visits from January 1 through September 17, 2018).

## Example 2

*A patient who had symptoms of anxiety, hypervigilance, lack of focus, lack of sleep, and paranoia wanted a referral for counseling. The patient's primary care provider prescribed medications for the patient's symptoms and placed a consult for counseling services. The consult stated that an e-consult was not appropriate,*

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<sup>105</sup> The receiving provider can also use a cancel status; however, this may not close the consult because the sending provider can send the consult back to the receiving provider with additional information and requests; VHA Directive 1232(1).

<sup>106</sup> VHA Handbook 1160.01.

<sup>107</sup> Facility Memorandum 11-29, *Consult Management*, February 24, 2017.

<sup>108</sup> Facility *Bylaws Rules and Regulations of the Medical Staff*, March 25, 2015.

<sup>109</sup> VHA Handbook 1160.01.

*and the patient needed a face-to-face visit. An outpatient mental health provider called the patient the same day, and after “some discussion,” the patient agreed the walk-in clinic may be appropriate and to receive a letter about access to the walk-in clinic. The consult was marked complete by the provider, and the patient was sent the letter with the walk-in clinic information. However, 227 days later, the patient had not been seen in the walk-in clinic or by a facility mental health provider.*

When outpatient mental health staff marked the consults complete with the instructions to present to the walk-in clinic without documentation of any other specific evaluation, the consults, and whether the patients followed through with instructions, could not be tracked with VHA patient-tracking methods, such as the EWL. In addition, patients with provider requests for mental health services might not have been evaluated by a provider for mental health urgent care needs or received needed services.

## Conclusion

The OIG determined that patients had limited access to outpatient mental health and the telemental health program. Additionally, the VHA EWL was not used as required by VHA. On August 1, 2018, the facility had 801 open consults and 191 of those consults (24 percent) had been open beyond 90 from the PID. Facility data also indicated that the mental health outpatient appointment cancellation rate was consistently higher than the VHA national rate. Other data elements for outpatient mental health appointments showed a lower rate than the national rate for completed appointments. In addition, facility data indicated long wait times (between one and four months) for new patients' access to mental health services.

Facility staff reported that reasons for these access issues included provider and scheduling staff shortages.

Upon review of patient consults and RTC orders from January 1 through March 31, 2018, the OIG determined that patients experienced delays in mental health care; however, none of these patients completed suicide. Although very few telemental health consults occurred during this timeframe, delays averaged 88 days for consults and 59 days for RTC orders. For all delays, staff stated a cause was shortage of mental health providers. The effects of delayed access and care may include an increase in patients' use of emergency departments for non-urgent care, a decrease in patient satisfaction with care, and risk of a negative impact on patients' clinical outcomes.

The OIG determined that several factors contributed to access and delay issues. These factors included a shortage of provider and scheduling staff as well as underutilizing both CHOICE and telemental health services, hiring practices that caused long delays in hiring, MSA hiring practice issues that affected employment consistency, and disproportionate provider productivity. OIG staff also identified training deficiencies and supervision issues for mental health scheduling staff. The OIG also identified issues related to facility policy compliance with VHA consult requirements and staff compliance with facility and VHA policy to follow up with no-show patients.

The OIG concluded that the February 2018 AIB investigation and action plan did not completely address or document issues that affected scheduling practices of the outpatient mental health program. In addition, the AIB review was primarily based upon interviews. Issues not addressed included staffing hiring practices, the underutilization of non-VA services and telemental health services, an in-depth review and analysis of scheduling data (including timeliness) and patients' complaints, and facility policies' compliance with VHA requirements. However, the administrative investigation addressed several issues with provider productivity, providers and scheduling staff shortages, scheduling staff training and supervisory oversight, and full implementation of Behavioral Health Interdisciplinary Program teams.

During the inspection, OIG staff identified an issue involving the consult process. Although staff called patients, they did not consistently arrange for patients' face-to-face appointments in the

outpatient mental health clinic, and if patients were called rather than receiving an appointment, staff did not document an evaluation of patients' immediate needs or the urgency of care, such as would be done with a suicide risk assessment. Rather, during the calls, patients were asked by staff to come into the walk-in clinic. The consults were marked complete regardless if the patients were seen or evaluated. If consults were marked complete, they were not tracked through VHA appointment scheduling processes, such as the EWL, and patients may not have received consistent mental health care and/or were lost in the appointment process.



## Recommendations 1–12

1. The New Mexico VA Health Care System Director ensures that outpatient mental health scheduling staff receive training to use the electronic wait list as required by Veterans Health Administration and that New Mexico VA Health Care System managers monitor compliance.
2. The New Mexico VA Health Care System Director reviews clinic cancellation rates and develops action plans to address identified issues.
3. The New Mexico VA Health Care System Director reviews open and completed consult data as well as new patient data and develops action plans to address identified issues.
4. The New Mexico VA Health Care System Director evaluates the underutilization of non-VA and telemental health services for the outpatient mental health department and develops an action plan to address identified issues.
5. The New Mexico VA Health Care System Director ensures that patients with outpatient mental health consults and return-to-clinic orders, including telemental health, are scheduled as required by Veterans Health Administration policy and within the Veterans Health Administration consult/return-to-clinic timeframe and that the scheduling process is monitored for compliance.
6. The New Mexico VA Health Care System Director and managers review provider and scheduling staffing levels and develop an action plan to address recommendations, if any, from the staffing level reviews.
7. The New Mexico VA Health Care System Director assesses hiring practices for providers and scheduling staff and ensures positions are filled timely.
8. The New Mexico VA Health Care System Director updates the New Mexico VA Health Care System policies, *Consult Management*, and *Failure to Report for Scheduled Clinic Appointments*, to meet Veterans Health Administration policy.
9. The New Mexico VA Health Care System Director ensures outpatient mental health staff follow Veterans Health Administration requirements for no-show patients and monitors compliance with this process.
10. The New Mexico VA Health Care System Director confirms that the Administrative Investigative Board recommendations and action plans are completed as required by VHA and managers monitor compliance.
11. The New Mexico VA Health Care System Director ensures the Administrative Investigative Board process includes identification of relevant documents, records, and other information pertinent to the issues of an investigation.

12. The New Mexico VA Health Care System Director evaluates the practice of marking outpatient mental health consults as complete without an appointment and without documenting a mental health risk evaluation and takes action as necessary.

## Appendix A: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: June 12, 2019

From: Director, VA Desert Pacific Healthcare Network (10N22)

Subj: Healthcare Inspection—Concerns with Access and Delays in Outpatient Mental Health Care at the New Mexico VA Health Care System, Albuquerque, New Mexico

To: Director, Office of Healthcare Inspections (54HL04)  
Director, GAO/OIG Accountability Liaison (GOAL) Office (VHA 10EG GOAL Action)

Concur

*(Original signed by:)*

Randy Quinton, Deputy Network Director

for Michael Fisher

Director, VA Desert Pacific Healthcare Network

## Appendix B: Facility Director Comments

### Department of Veterans Affairs Memorandum

Date: June 12, 2019

From: Director, New Mexico VA Health Care System (501/00)

Subj: Healthcare Inspection—Concerns with Access and Delays in Outpatient Mental Health Care at the New Mexico VA Health Care System, Albuquerque, New Mexico

To: Director, VA Desert Pacific Healthcare Network (10N22)

1. In response to your Memo dated May 29, 2019, please find attached the requested concurrence and corrective action plan from our facility.
2. If you have any questions or require additional information, please contact Carol M. Moore, Chief, Quality, Safety & Value (QSV), at 505-265-1711 (extension 3696).

(original signed by:)  
Andrew M. Welch  
Director

## Comments to OIG's Report

### Recommendation 1

The New Mexico VA Health Care System Director ensures that outpatient mental health scheduling staff receive training to use the electronic wait list as required by Veterans Health Administration and that New Mexico VA Health Care System managers monitor compliance.

Concur.

Target date for completion: Completed, April 2019

#### Director Comments

Outpatient mental health scheduling staff were realigned to Health Administration Service (HAS) in March 2018. HAS ensured that all scheduling staff completed national training per the January 2019 National MSA TMS Reconciliation which included training on the use of the Electronic Wait List (EWL). The National Scheduler Training Completion Report shows that facility wide 99.24% are trained as of April 2019. Tracking also shows that 100% of mental health scheduling staff have been trained.

Monitoring of compliance with scheduling practices, including use of the EWL, is ongoing using the Supervisory Appointment Tool (SAT). The accuracy assessment of the scheduling practice includes use of the EWL when appropriate. Accuracy has shown improvement since FY 18 Cycle 1 from 81% to 93%.

#### OIG Comment

Based on information provided by the New Mexico VA Health Care System Director, the OIG considers this recommendation closed.

### Recommendation 2

The New Mexico VA Health Care System Director reviews clinic cancellation rates and develops action plans to address identified issues.

Concur.

Target date for completion: June 2019, Completed

#### Director Comments

Monitoring of Clinic Cancellation Rates is ongoing using the VSSC Clinic Cancellation and No Show Report. In FY 2018 the NMVAHCS Cancelled by Clinic Rate was higher than the National rate, 12.42% versus 8.0% respectively. During the last year, BHCL and HAS implemented bimonthly meetings to review clinic cancellation data and provide feedback.

Compliance with clinic cancellation processes has improved with most cancellations done appropriately through supervisors, BHCL Chief and Chief of Staff when the cancellation is less than 45 days. In FY 2019 YTD the NMVAHCS cancelled by clinic rate is down to 8.86%.

### **OIG Comment**

Based on information provided by the New Mexico VA Health Care System Director, the OIG considers this recommendation closed.

### **Recommendation 3**

The New Mexico VA Health Care System Director reviews open and completed consult data as well as new patient data and develops action plans to address identified issues.

Concur.

Target date for completion: September 2019.

### **Director Comments**

The BCHL Access Coordinator and other Consult Champions review all consults sent to BHCL outpatient services and disseminate them to the appropriate location. A monthly report is shared with BHCL leadership and the report shows all consults were completed with appropriate documentation March, April and May 2019. BCHL leadership will continue to review monthly reports for sustainment.

During the past year HAS increased Mental Health MSA staffing, including a BHCL MSA lead and supervisor and has improved consult processing.

### **Recommendation 4**

The New Mexico VA Health Care System Director evaluates the underutilization of non-VA and telemental health services for the outpatient mental health department and develops an action plan to address identified issues.

Concur.

Target date for completion: January 2020

### **Director Comments**

The facility continues to refer patients for mental health services via CHOICE and with required training and full implementation of the Consult Tool Box compliance with documentation of the offer of the referral and whether or not the Veteran opts in is believed to have improved.

Veterans continue to opt in to Community Care due to the wait times BHCL outpatient has for some services. There is not, however, any data available on improved documentation of whether

Veterans opt in or not for CHOICE referrals for mental health in FY 2018 vs FY 2019. There is not any trended data available on the use of CHOICE consults for outpatient mental health. BHCL, HAS and Community Care staff will work together to develop data collection, trending and reporting to continue until progress and sustainment is achieved.

The CUSS report shows that as of May 31, 2019 the average clinic utilization for 16 TMH clinics was 62.74% from May 2018 through May 2019. Currently 8 of the 16 clinics are actively being used. Clinics not being used impacted the average negatively and so the clinic grids for non-utilized clinics were removed in March 2019. Of the 8 actively used TMH clinics 6 have clinic availability for follow-up within 1 week and two clinics have availability over 30 days. There are currently 408 Tele-mental Health RTCs open/pending from May 2018 through May 2019, this is in progress and efforts are impacted by only having two MSAs assigned to telemental health. BHCL and HAS will work to identify additional resources to help schedule the tele-mental health return to clinic orders. While improvement is noted BHCL and HAS will continue to monitor and report progress until improvement is demonstrated and sustained.

## **Recommendation 5**

The New Mexico VA Health Care System Director ensures that patients with outpatient mental health consults and return-to-clinic orders, including telemental health, are scheduled as required by Veterans Health Administration policy and within the Veterans Health Administration consult/return-to-clinic timeframe and that the scheduling process is monitored for compliance.

Concur.

Target date for completion: January 2020

### **Director Comments**

The BCHL Access Coordinator and other Consult Champions review all consults sent to BHCL outpatient services and disseminate them to the appropriate location. A monthly report is shared with BHCL leadership and the report shows all consults were completed with appropriate documentation March, April and May 2019. BCHL leadership will continue to review monthly reports for sustainment.

A Coordination Agreement was developed to outline roles responsibilities of HAS MSAs and BHCL staff. This is a living document that continues to evolve as processes changes. The MSA's scheduling processes are monitored by the SAT (see recommendation 1 above) and the accuracy assessment includes that consults are actioned appropriately. Accuracy has shown improvement since FY 18 Cycle 1.

There is not readily available trended data on compliance with VHA time frames. BHCL and HAS will work together to develop data collection, trending and reporting to continue until progress is confirmed, and sustainment is achieved.

## Recommendation 6

The New Mexico VA Health Care System Director and managers review provider and scheduling staffing levels and develop an action plan to address recommendations, if any, from the staffing level reviews.

Concur.

Target date for completion: June 2019

### Director Comments

BHCL provider staffing is monitored on an ongoing basis. One concern was the difficulty hiring psychiatric prescribers. The facility converted 2 MD positions. One MD position was converted to a mid-level (NP/PA) which has been filled and is onboard. The second MD position was converted to 2 PharmDs who have been selected with approximate start dates in July-August 2019. Psychology is fully staffed, and Social Work has 5-6 vacancies with approval to convert 6 positions from GS-11s to GS-12s with hope that it helps recruit and retain social workers. The vacancy rate in May 2018 was approximately 25% with 31 vacancies on average, the estimated current vacancy rate is 15.5%.

HAS monitors staffing levels by using the Scheduling Resource Summary VSSC report and SAT Tool report and rotates MSAs to meet the weekly needs of the clinics. In addition, HAS leadership are pursuing new FTEE approval to support additional BHCL providers. No additional review or action planning is deemed necessary at this time.

### OIG Comment

The OIG considers this recommendation open and will review documentation submitted by the New Mexico VA Health Care System Director during follow-up until evidence reflects that corrective actions were completed and effective.

## Recommendation 7

The New Mexico VA Health Care System Director assesses hiring practices for providers and scheduling staff and ensures positions are filled timely.

Concur.

Target date for completion: June 2019

### Director Comments

By converting some positions to easier to fill positions as outlined in recommendation 6 BHCL clinical positions are being filled timely. It is anticipated with the conversion of some Social Work positions to GS 12 that the remaining vacancies will be filled timely. During FY 18, a



Hiring MSA Fair was held in the Spring to hire 11 MSA vice positions. In FY 19, an MSA supervisor and lead were hired along to oversee 23/24 FTEE. No additional hiring practice changes are deemed necessary at this time.

### **OIG Comment**

The OIG considers this recommendation open and will review documentation submitted by the New Mexico VA Health Care System Director during follow-up until evidence reflects that corrective actions.

### **Recommendation 8**

The New Mexico VA Health Care System Director updates the New Mexico VA Health Care System policies, *Consult Management*, and *Failure to Report for Scheduled Clinic Appointments*, to meet Veterans Health Administration policy.

Target date for completion: September 2019

### **Director Comments**

A team with the Group Practice Manager (GPM), Mental Health GPM, Chief of HAS and BHCL will review and revise the local policies *Consult Management*, and *Failure to Report for Scheduled Clinic Appointments* to ensure compliance with VHA policy.

### **Recommendation 9**

The New Mexico VA Health Care System Director ensures outpatient mental health staff follow Veterans Health Administration requirements for no-show patients and monitors compliance with this process.

Concur.

Target date for completion: January 2020

### **Director Comments**

HAS MSAs have improved documentation in the medical record of the required phone calls and letter for patients who no-show for mental health care appointments. The bi-monthly meetings with the HAS Chief and BHCL on clinic cancellations has also focused on Failure to Report Notes and Return to Clinic Orders when patients no show and provider compliance has also improved. There is however no readily available data to demonstrate this improvement. Both HAS and BHCL will develop a method to monitor compliance and will track and trend for 6 months to ensure sustained compliance.

## **Recommendation 10**

The New Mexico VA Health Care System Director confirms that the Administrative Investigative Board recommendations and action plans are completed as required by Veterans Health Administration and managers monitor compliance.

Concur.

Target date for completion: September 2019

### **Director Comments**

The Chief of BHCL reports to the COS on a reoccurring basis on the status of the AIB Action Plan. As of June 2019, nine of the ten recommendations have been completed. A Rapid Process Improvement Event is scheduled in July 2019 to address the remaining issue.

## **Recommendation 11**

The New Mexico VA Health Care System Director ensures the Administrative Investigative Board process includes identification of relevant documents, records, and other information pertinent to the issues of an investigation.

Concur.

Target date for completion: September 2019

### **Director Comments**

The facility identified the need for improving processes related to Administrative Investigation Boards (AIB) prior to this OIG visit and provided training to over 40 people in March 2018. The AIB Workbook developed by the Office of Human Resources Management Policies and Programs Service, in collaboration with VHA, VBA, NCA, Office of General Counsel, and the VHA Employee Education System is used and it includes a checklist to prompt identification, collection and review of documents and evidence. Human Resources (HR) will continue to provide technical support to the AIBs and will monitor to ensure the boards charter clearly outlines the requirements and that the team uses the checklist appropriately. HR will provide executive leadership an assessment of compliance by AIBs with processes including identification and review of all relevant documents.

## **Recommendation 12**

The New Mexico VA Health Care System Director evaluates the practice of marking outpatient mental health consults as complete without an appointment and without documenting a mental health risk evaluation and takes action as necessary.

Concur.

Target date for completion: September 2019

### **Director Comments**

As indicated in recommendation 5 above, the Access Coordinator and Champion Team, review each consult received for BHCL Outpatient Services and makes sure each consult is completed (Scheduling and/or Clinical Documentation) appropriately. This includes making sure no consult that includes a face-to-face appointment is closed or marked as completed inappropriately. A monthly report is shared with BHCL leadership and the report shows all consults were completed with appropriate documentation March, April and May 2019. BCHL leadership will continue to review monthly reports for sustainment.

## OIG Contact and Staff Acknowledgments

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Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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