DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Inadequate Supervision of a Mental Health Provider and Improper Records Management for a Female Patient at the VA Greater Los Angeles Health Care System in California

HEALTHCARE INSPECTION | REPORT #21-03734-32 | JANUARY 24, 2023

MISSION

The mission of the Office of Inspector General is to serve veterans and the public by conducting meaningful independent oversight of the Department of Veterans Affairs.

In addition to general privacy laws that govern release of medical information, disclosure of certain veteran health or other private information may be prohibited by various federal statutes including, but not limited to, 38 U.S.C. §§ 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, the OIG adheres to privacy and confidentiality laws and regulations protecting veteran health or other private information in this report.

Report suspected wrongdoing in VA programs and operations to the VA OIG Hotline:

www.va.gov/oig/hotline

1-800-488-8244

Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess allegations related to the mental health care of a female patient at the VA Greater Los Angeles Healthcare System (facility) in California. The allegations included that a psychiatry physician resident (psychiatry trainee) was inappropriate during treatment discussions with the patient, the psychiatry trainee's treatment resulted in a decline in the patient's mental health causing decreased trust and mental functioning, the psychiatry trainee received inadequate supervision, and facility leaders did not take sufficient action to address the known "alleged inappropriate behavior" of the psychiatry trainee.[1] During the inspection, the OIG identified an additional concern related to the storage and disposition of video recordings and consent forms.

The OIG did not substantiate that the psychiatry trainee's behavior during treatment discussions with the patient was inappropriate. This finding is based on a focused review of select video recordings made during the patient's treatment that occurred between July and August 2020.[2] The psychiatry trainee utilized, and was in group supervision for, a modality called Intensive Short-Term Dynamic Psychotherapy (ISTDP).[3] ISTDP is a sequence of steps in which a therapist seeks to understand a patient's interpersonal difficulties, intensify and challenge resistance, analyze transference, explore conflict, and work through unconscious issues.[4] This approach is intended to set up a tension, which may result from challenging resistance and exploring conflict. The task of the therapist is to balance these various aspects of the treatment process, and ultimately bring about resolution in a way that promotes psychological health. Therapy sessions may be recorded to examine the therapist's work for supervisory oversight or psychotherapy education.

[1] From the allegations and interviews, the OIG interpreted "inappropriate" as sexualized interactions that violated boundaries. VHA Directive 1400.01, *Supervision of Physician, Dental, Optometry, Chiropractic, and Podiatry Residents*, November 7, 2019. Residents may also be enrolled in an additional residency training program as a fellow. The OIG refers to this provider as "psychiatry trainee" throughout the report regardless of status as a resident or fellow.

[2] Video recordings of select sessions were reviewed by two OIG psychiatrists, one with a background in supervising residents performing psychodynamic psychotherapies. The entire video recording was reviewed for the session specifically identified by the complainant, as well as those immediately preceding and following the identified session. In addition, five sessions from the weeks prior to the identified session were reviewed; sampling was done at 10-minute intervals to identify the topic of discussion, including the opening and closing of the session. The video recordings consisted of 47 treatment sessions with a total of 50 hours and 52 minutes.

[3] The supervisor told the OIG that supervision for ISTDP was conducted in a weekly small group with at least one supervisor and a maximum of four trainees.

[4] Kaplan and Sadock, "Intensive Short-Term Dynamic Psychotherapy—Habib Davanloo," in *Kaplan & Sadock's Comprehensive Textbook of Psychiatry, 10th ed.*, eds. Benjamin J. Sadock, Virginia A. Sadock, and Pedro Ruiz (Philadelphia: Lippincott Williams & Wilkins, 2017), 2801-2804.

The OIG's focused review determined that the psychiatry trainee did not demonstrate behavior that overtly violated boundaries, deviated from ISTDP intervention protocols noted in literature, or diverged from instructions reportedly given by the supervisor for the psychiatry trainee.[5] Although a conversation related to sensitive topics was observed, the psychiatry trainee allowed the patient to choose whether to discuss them. In addition, the OIG did not observe any conduct by the psychiatry trainee that was exploitative or against the patient's interests.

The OIG found that the psychiatry trainee did not always engage in effective therapeutic intervention and, at times, elicited negative feelings in a context that was disruptive to the therapeutic process. For example, during one session, the psychiatry trainee made a statement that elicited a strong negative reaction from the patient that resulted in the psychiatry trainee apologizing at the beginning of the next session. After apologizing, the psychiatry trainee ultimately proceeded to engage the patient in another intense exercise that elicited a similar strong negative response and was further disruptive to the therapeutic process. However, the OIG was unable to determine that the treatment by the psychiatry trainee resulted in a decline in the patient's mental health causing decreased trust and mental functioning. Even when correctly implemented, ISTDP carries a known risk of therapeutic failures or delays resulting in worsening symptoms. Additionally, the OIG found documentation in the patient's medical record related to the patient's medical history, and other concurrent therapeutic interventions, that may have exacerbated the patient's symptoms.

The OIG substantiated that the supervisor did not provide adequate supervision to the psychiatry trainee through either structured group supervision for trainees of ISTDP or individual supervision. After completing the psychiatric residency and starting a fellowship, the psychiatry trainee could no longer attend ISTDP group supervision sessions due to schedule conflicts, and began an "as-needed" supervisory arrangement. The supervisor reported to the OIG of providing supervision on only one occasion during the treatment that was performed by the psychiatry trainee as a fellow. No other supervision, including a review of treatment videos, was provided by the supervisor until after the patient terminated therapy. Appropriate supervision may have provided the psychiatry trainee an opportunity to apply more effective or alternative approaches to achieve a more desirable therapeutic outcome.

The OIG also determined that the psychiatry trainee's documentation and the supervisor's documented oversight did not meet facility timeliness expectations or completeness requirements. The OIG found that approximately 76 percent (32 of 42) of the psychiatry trainee's electronic health record (EHR) documentation reviewed did not meet the Mental Health Department's expectation to be completed within 24 hours of the encounter, and that documentation timeliness deteriorated after becoming a fellow, despite no change in the

[5] Due to identified deficiencies associated with the psychiatry resident's documentation, the OIG could not verify that all of the patient's appointments were documented and therefore, that all video recordings were present.

expectation. The psychiatry trainee told the OIG that due to the fellowship workload there was limited time to write notes but did not recall receiving feedback from the supervisor regarding documentation. The supervisor did not meet the timeliness standard of co-signature within 24 hours (or the next business day) approximately 70 percent (29 of 42) of the time. It is unclear to the OIG why the supervisor did not timely cosign the notes as required. The OIG concluded that the psychiatry trainee's delayed documentation, along with the supervisor's delayed review and co-signature, impeded the supervisor's ability to timely review the care provided to the patient. As a result, the supervisor was unable to inform the subsequent therapy, amounting to insufficient supervisory oversight.

The OIG also determined that the psychiatry trainee did not document all treatment sessions, and stopped entering return-to-clinic orders and scheduling appointments for the patient in May 2020, even though the psychiatry trainee continued to consistently see the patient.[6] This was inconsistent with the expectation that trainees place return-to-clinic orders and schedule weekly ISTDP patients into clinic schedules for hour-long appointments throughout the patients' care. The psychiatry trainee told the OIG that as time went on and the patient continued to show up consistently, the placement of orders and regular scheduling of therapy was not a priority.

Following termination of treatment, the patient reached out to multiple facility and Mental Health leaders during separate occasions to discuss her treatment concerns and request the video recordings. The OIG substantiated that Mental Health Department leaders were not adequately responsive to the patient's concerns regarding the psychiatry trainee's treatment behavior or to her requests for the treatment video recordings. Although some of the leaders reported to the OIG they had conducted informal EHR reviews, the OIG did not find evidence that the supervisor or other leaders completed a structured review of the patient's complaints or an evaluation of the psychiatry trainee's treatment of the patient, as required. During interviews, supervisors and leaders did not give a clear explanation as to why the required review of the psychiatry trainee's treatment was not completed.

In April 2021, following notification of the patient's complaints, facility leaders began a peer review. However, the peer review coordinated by Quality Management staff did not include a review of the trainee's supervisor, the provider ultimately responsible for the patient's care. The chief of Quality Management reported believing that the psychiatrist who was reviewed was providing coverage for the supervisor. The risk manager explained to the OIG that when determining which provider to review through the peer review process, the supervisor's title was incorrectly listed as a fellow (trainee) in the EHR and that it was not common practice to conduct

[6] VA Deputy Under Secretary for Health for Operations and Management, "Deployment of National Return To Clinic Order," December 7, 2017. Return-to-clinic orders are placed through the EHR and required of all clinicians when a patient requires follow-up treatment. The psychiatry resident began online appointments in March 2020 and stopped putting in orders in May 2020.

peer reviews on trainees. Therefore, the risk manager did not inquire further regarding a review of the supervisor.

In addition, the patient advocate did not address the patient's request for the video recordings or report treatment concerns that were submitted. Although the patient advocate documented the patient's contact, the OIG did not find evidence that the patient advocate addressed the patient's concerns. The OIG would have expected a direct response from the patient advocate, including consultation with appropriate staff, and documentation of completion of the request. As a result of the absence of further communication or resolution, the patient was unable to obtain the assistance and advocacy she was seeking.

During the inspection, the OIG identified an additional concern related to the improper creation, storage, and disposition of video recordings and consent forms. The OIG discovered that one month after the conclusion of the residency and fellowship, and separation from the facility as an 'employee,' the psychiatry trainee was in possession of "a password protected flash drive containing audio and video of treatment sessions." The supervisor had not ensured that the psychiatry trainee created, stored, and dispositioned video recordings on VA accessible equipment, as required by Veterans Health Administration (VHA) policy. It was unclear to the OIG how long this practice was in place, and whether the psychiatry trainee was informed to delete video recordings, due to conflicting information provided to the OIG during interviews. In addition, the OIG found the psychiatry trainee retained the patient's signed consent form against VHA policy, which put the patient's health information at risk for a breach of security and privacy.[7] It is unclear to the OIG why the Mental Health Department was using this practice; however, the supervisor and a resident trainee told the OIG that the practice was to have residents retain the consent form at that time. The OIG concluded that discrepancies between facility staffs' understanding regarding video recordings as federal records, and the required records management, contributed to the deficiencies. The extent of these issues is unknown as records management across all mental health residency and fellowship programs was beyond the scope of this inspection. The OIG is concerned that the records management issues identified during this review may reflect a more widespread problem.

The OIG made one recommendation to the Under Secretary for Health to conduct a review to assess the possible scope of current and former VA psychiatry residents being in possession of patients' personal health information, to include video recorded treatment sessions and consent forms, and consult with the appropriate organizational leaders such as the Office of General Counsel on the required disposition of the recordings and forms, and take action as needed.

[7] The psychiatry resident provided an electronic copy of the patient's signed consent form to the OIG, indicating the psychiatry resident retained the paper form after separation from the VA.

The OIG made two recommendations to the Veterans Integrated Service Network Director related to reviewing the supervision provided to the psychiatry trainee regarding the patient's treatment, documentation, and document control; determining if standards were met, and taking action as indicated; and evaluating treatment protocols for video recorded therapy, specifically the management of patient access to the recordings.

The OIG made three recommendations to the Facility Director related to reviewing facility leader and staff responses to the patient's concerns; ensuring records control schedules are appropriately completed for the Mental Health Department; and reviewing processes for utilization of video recordings, in consultation with appropriate staff, to ensure compliance with VHA requirements.

Comments

The Under Secretary for Health and Veterans Integrated Service Network and Facility Director concurred with five recommendations and concurred in principle with one recommendation, and provided acceptable action plans (see appendixes A, B, and C). The OIG will follow up on the planned actions until they are completed.

During VHA's review of an OIG draft report, it is usual practice for VHA to submit comments for consideration and discussion. For this report, VHA provided the OIG comments during the review of the draft. The OIG considered and reviewed the comments. Based on the review, some changes were made to the report for clarification, but no changes were made to the OIG findings.

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

Contents

Abbreviations

EHR	electronic health record
ISTDP	Intensive Short-Term Dynamic Psychotherapy
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess allegations related to the mental health care of a female patient at the VA Greater Los Angeles Healthcare System (facility) in California. The allegations included that a psychiatry physician trainee (psychiatry trainee) was inappropriate during treatment discussions with the patient, the psychiatry trainee's treatment resulted in a decline in the patient's mental health causing decreased trust and mental functioning, the psychiatry trainee received inadequate supervision, and facility leaders did not take sufficient action to address the known "alleged inappropriate behavior" of the psychiatry trainee.[1] During the inspection, the OIG identified an additional concern related to the storage and disposition of video recordings and consent forms.

Background

The facility is part of Veterans Integrated Service Network (VISN) 22, and consists of the Medical Center in West Los Angeles, two ambulatory care centers, and eight community-based outpatient clinics in Kern, Los Angeles, San Luis Obispo, Santa Barbara, and Ventura counties. In fiscal year 2021, the facility completed approximately 1.3 million outpatient visits and served roughly 90,000 patients, including around 7,200 women. The facility is affiliated with the University of California Los Angeles and the University of Southern California.

The facility provides psychotherapy in different modalities, including supportive psychotherapy, cognitive behavioral therapy for anxiety disorders, and prolonged exposure and cognitive processing therapy for trauma recovery. The facility trains residents and fellows, who provide supervised psychotherapy to patients. Intensive Short-Term Dynamic Psychotherapy (ISTDP) is one type of therapy provided by residents as part of the residency program.

Psychiatry Residency Training Program

Following initial medical education, a physician may participate in a residency program to train in a medical specialty. The VA Office of Academic Affiliations oversees health professions education and training within VA, including graduate medical education programs through affiliated universities, to provide physicians a mentored educational and practical experience to develop specific clinical and leadership skills.[2] Supervising providers are licensed independent

[1] The OIG refers to this psychiatry physician trainee as "psychiatry trainee" throughout the report regardless of status as a resident or fellow.

[2] "To Educate for VA and the Nation," VA Office of Academic Affiliations, accessed October 1, 2021, https://www.va.gov/oaa/. "Medical and Dental Education," VA Office of Academic Affiliations, accessed October 1, 2021, https://www.va.gov/oaa/medical-and-dental.asp.

practitioners who are credentialed and privileged at a facility. Supervision must follow the Accreditation Council for Graduate Medical Education standards, "providing residents with direct experience in progressive responsibility" for patient care.[3]

The psychiatry residency training program offers residents a choice of four concentrations, including psychodynamic psychotherapy.[4] Training in psychotherapy includes "clinical, didactic, and experiential learning modalities" and covers short to long-term and individual to group psychotherapy.[5] Residents receive didactic education with an introduction to therapy in the first year, and short-term psychodynamic psychotherapy in the second year. The third year focuses on outpatient care settings continuing with short-term psychodynamic psychotherapy, as well as women's mental health. Core psychotherapy techniques are taught in the third and fourth years of the residency, with residents choosing elective courses during the fourth year that align with their career goals.[6] Throughout the residency program, residents receive clinical training at a variety of sites, including the facility's Women's Comprehensive Healthcare Center clinic.[7]

Psychotherapy and Transference

In psychotherapy, transference occurs between the patient and therapist, in which feelings and attitudes directly tied to early life experiences are directed toward the therapist. Transference may be positive, negative, or sexualized.[8] The therapist observes the transference to learn about the nature of the patient's unconscious conflicts, and eventually makes interpretations that allow the patient to gain insights that have the power to lead to resolution of the conflicts and thus improve psychological health.

[3] VHA Directive 1400.01, Supervision of Physician, Dental, Optometry, Chiropractic, and Podiatry Residents, November 7, 2019.

[4] American Psychological Association, "psychodynamic psychotherapy," accessed October 4, 2021, https://dictionary.apa.org/psychodynamic-psychotherapy. Psychodynamic psychotherapy is therapy with an "emphasis on dealing with the unconscious in treatment and on analyzing transference."

[5] *Merriam-Webster.com Dictionary*, "didactic," accessed October 4, 2021, https://www.merriam-webster.com/dictionary/didactic. In this context, didactic refers to learning through lecture and textbook, rather than through demonstration or hands-on learning. "Psychotherapy," Semel-UCLA Psychiatry Residency Training Program, accessed October 1, 2021, https://residency.semel.ucla.edu/psychotherapy/.

[6] "Didactics," Semel-UCLA Psychiatry Residency Training Program, accessed October 1, 2021, https://residency.semel.ucla.edu/clinics/. "Psychotherapy," Semel-UCLA Psychiatry Residency Training Program.

[7] "Training Sites," Semel-UCLA Psychiatry Residency Training Program, accessed October 1, 2021, https://residency.semel.ucla.edu/training-sites/. "Clinics," Semel-UCLA Psychiatry Residency Training Program, accessed October 1, 2021, https://residency.semel.ucla.edu/clinics/.

[8] Darnell Ladson, DO and Randon Welton, MD, "Recognizing and Managing Erotic and Eroticized Transferences," *Psychiatry*, April 2007.

Intensive Short-Term Dynamic Psychotherapy

Psychodynamic therapy is a complex process that can take years to achieve results. Short-term therapies such as ISTDP were derived from traditional psychodynamic therapy to relieve suffering more efficiently and serve populations with limited resources. ISTDP focuses on the processing of the patient's emotions as they arise during therapy and these breakthroughs are believed to enhance therapeutic effectiveness.[9]

ISTDP is conducted by a sequence of steps in which the therapist seeks to understand the patient's interpersonal difficulties, intensify and challenge resistance, analyze transference, explore conflict, and work through unconscious issues.[10] Sessions may be recorded to examine the therapist's work, such as for supervisory oversight and psychotherapy education.[11]

When challenging the patient during ISTDP, the therapist should maintain an attitude of sympathy and respect for the patient but convey considerable disrespect for the resistance. This approach can lead to the patient developing angry feelings and is intended to set up a tension in the patient between resistance and therapeutic alliance. In certain types of patients, sexualized feelings, when present, can be fused with feelings of rage. The task of the therapist is to balance these various forces and ultimately bring about dominance of the therapeutic alliance.[12]

Allegations and Related Concerns

Prior to conducting this inspection, the OIG requested information from the facility regarding the allegations but did not find evidence that an adequate review of the patient's concerns or the psychiatry trainee's care had occurred. In June 2021, the VISN 22 Director responded to an OIG inquiry regarding the patient's allegations related to distress symptoms, and reported interviewing facility Mental Health Department leaders and reviewing the patient's electronic health record (EHR). The VISN 22 Director reported to the OIG that the review "determined that Greater Los Angeles VA Healthcare [sic] system provided appropriate services and levels of care."

In August 2021, the VISN responded to an additional OIG inquiry regarding the allegations. Specifically, the OIG asked about facility policies related to the review of patient allegations, and therapy session video recordings. In addition, the OIG requested information on the status of the

[9] Johansson, R., Town, J. M., and Abbass, A., "Davanloo's Intensive Short-Term Dynamic Psychotherapy in a tertiary psychotherapy service: overall effectiveness and association between unlocking the unconscious and outcome," *PeerJ, 2014*; 2: e548, August 28, 2014.

[10] Davanloo, "Intensive Short-Term Dynamic Psychotherapy," 2801-2804.

[11] Johansson, "Davanloo's Intensive Short-Term Dynamic Psychotherapy in a tertiary psychotherapy service: overall effectiveness and association between unlocking the unconscious and outcome."

[12] Davanloo, "Intensive Short-Term Dynamic Psychotherapy Extended Major Direct Acess [*sic*] to the Unconscious."

patient's therapy session video recordings, the mental health chain of command, the role of the supervisor for the psychiatry trainee, and all actions taken in response to the allegations. The VISN response reported an informal review "did not yield any findings of concern;" that an "SOP [standard operating procedure] on audio and video recordings" had been developed; and "the existence of any audio video recordings cannot be confirmed." Based on continuing concerns regarding the patient's treatment and that the response(s) did not adequately address the concerns, the OIG initiated an inspection.

The OIG conducted the inspection to evaluate the following allegations

- the psychiatry trainee's behavior "was inappropriate in [the] treatment discussions" with the patient;
- the psychiatry trainee's treatment resulted in a decline in the patient's mental health, specifically causing her to experience decreased trust and mental functioning;
- the psychiatry trainee received inadequate supervision; and
- facility staff and leaders did not take sufficient action to address the known "alleged inappropriate behavior" by the psychiatry trainee.

During the inspection, the OIG identified an additional concern related to the storage and disposition of video recordings and consent forms.

Scope and Methodology

The OIG initiated the inspection on September 14, 2021, and conducted a virtual site visit from November 2–4, 2021, with additional interviews November 5, 2021, through January 5, 2022. The OIG interviewed the patient; Facility Director; Chief of Staff; associate chief of staff for Mental Health; chief of Health Administration Service; chief of Quality Management; psychiatrists, including the psychiatry trainee, the supervisor, referring psychiatrist, and a Women's Health psychiatry resident; privacy officer; Information Systems Security officers; and the records management officer.[13]

The OIG reviewed relevant Veterans Health Administration (VHA) directives; facility bylaws, policies, and procedures; and the psychiatry trainee's and supervisor's training records. Additionally, the OIG reviewed information specific to the patient's care including EHRs from

[13] The associate chief of staff for Mental Health is also the chief of Psychiatry.

November 2019 through October 2021, quality management reviews and action plans, selected video recordings, patient advocate data, and email correspondence.[14]

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 substantiates an allegation when the available evidence indicates that the alleged event or action more likely than not took place. The OIG does not substantiate an allegation when the available evidence indicates that the alleged event or action more likely than not did not take place. The OIG is unable to determine whether an alleged event or action took place when there is insufficient evidence.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, Pub. L. No. 95-452, 92 Stat. 1101, as amended (codified at 5 U.S.C. App. 3). The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

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.

Patient Case Summary

The patient is a woman in her thirties with a history of service-connected post-traumatic stress disorder, major depressive disorder, panic disorder, social anxiety disorder, and substance use disorders. In September 2019, the patient sent a secure message to her primary care provider requesting to see a psychologist, and the provider placed a Women's Health psychiatry consult for evaluation of anxiety. In October 2019, a Women's Health psychiatry resident evaluated the patient. The visit was supervised by the referring psychiatrist from the facility Trauma Recovery Service. The patient reported anxiety symptoms, a history of childhood trauma, "problems with men," stressors including a new job that worsened her social anxiety, and the breakup of a long-term relationship. The Women's Health psychiatry resident noted the patient had received psychotherapy and medication management at the facility in the past. The patient declined medication management at the visit, but agreed to a referral for ISTDP with a male provider.

[14] Video recordings of select sessions were reviewed by two OIG psychiatrists, one with a background in supervising residents performing psychodynamic psychotherapies. The entire video recording was reviewed for the session specifically identified by the complainant, as well as those immediately preceding and following the identified session. In addition, five sessions from the weeks prior to the identified session were reviewed; sampling was done at ten-minute intervals to identify the topic of discussion, including the opening and closing of the session. The video recordings consisted of 47 treatment sessions with a total of 50 hours and 52 minutes.

Later that month, the psychiatry trainee discussed the therapy with the patient and explained the "goal of experiencing deeply repressed or otherwise defended emotions as well as the need to video-record sessions." The patient voiced interest in participating in the treatment and attended appointments with the psychiatry trainee from November 2019 to December 2020. During that time, the psychiatry trainee documented that feelings that came up during therapy were examined, including feelings about coworkers, family, and "this provider." In November 2020, prior to terminating her therapy with the psychiatry trainee, the patient reengaged in medication management for her depressive and anxiety symptoms.

In December 2020, the patient attended an appointment with the psychiatry trainee who documented that the patient reported an "incredible amount of distress regarding therapy today notwithstanding that a few weeks ago she had reported feeling considerably improved." The patient indicated "dissatisfaction with the path our efforts at therapy had taken" and that she was seeing an outside therapist and did not wish to continue therapy with the psychiatry trainee.

The referring psychiatrist spoke with the patient after therapy ended and made efforts to connect her to continued treatment by placing a Community Care consult for therapy and a referral to a VA trauma group in February 2021. The patient attended a VA Community Care therapy appointment, but the EHR indicates she chose to continue therapy with a different non-VA provider. She briefly attended the trauma group, but stopped in March 2021, citing difficulties with VA.

In May 2021, a Women's Health psychiatrist documented medical and psychosocial factors that contributed to the patient's ongoing symptoms and noted "she is discussing attachment and trauma issues in therapy [with non-VA therapist], specifically related to her previous male therapist [psychiatry trainee]. She still feels pretty upset about that experience that ended in December." In early June 2021 the Women's Health psychiatrist also documented the patient felt "unsafe seeing VA doctors, specifically psychiatry, because of her previous negative experiences." The patient continued to attend psychiatry appointments for medication management through July 2021, and transferred care to a different facility clinic location.

In October 2021, the patient's primary care physician documented that the patient did not like the way her antidepressant made her feel and that she was no longer taking it. The patient further reported a previous traumatic experience with a provider and declined to continue psychiatric treatment at the facility. The patient reported she only wished to follow up with her non-VA therapist.

Inspection Results

The OIG did not substantiate that the psychiatry trainee's behavior during treatment discussions with the patient was inappropriate. While the psychiatry trainee's behavior did not appear to violate boundaries or deviate from standard ISTDP interventions, the OIG determined that the

treatment was not successfully executed and identified deficiencies in the psychiatry trainee's treatment that may have contributed to the treatment failure. The determination of whether treatment by the psychiatry trainee resulted in a decline in the patient's trust and mental functioning was complicated by the presence of other factors that may have also contributed to the patient's decline in mental health. The OIG substantiated that the supervisor did not provide adequate supervision to the psychiatry trainee to manage the patient's needs as required.

The OIG also substantiated that the response of facility and Mental Health Department leaders, including the supervisor, failed to address the patient's treatment concerns and evaluate the psychiatry trainee's behavior. During the course of the review, the OIG identified an additional concern related to Mental Health Department providers', including the trainees', storage and disposition of video recordings and consent forms outside the VA's system of records, in violation of VA policy.

1. Alleged Inappropriate Behavior During Treatment Discussions

The OIG did not substantiate that the psychiatry trainee's behavior during treatment discussions with the patient was inappropriate.[15] This finding is based on a focused review of select video recordings made during the patient's treatment that occurred between July and August 2020. The psychiatry trainee's behavior did not appear to violate boundaries or deviate from standard ISTDP interventions.[16] However, the OIG determined that the treatment was not successfully executed and identified deficiencies in the psychiatry trainee's treatment that may have contributed to the treatment failure.

Boundaries define appropriate professional behavior and "the expected and accepted psychological and social distance between practitioners and patients." Maintaining professional boundaries creates safety for both patients and physicians and establishes clear roles so providers act in a patient's best interest.[17] Boundary crossings and boundary violations "may arise from the therapist or from the patient." A boundary *crossing* can be either a deviation from therapy or intentional for a therapeutic purpose, but it is harmless and does not exploit the patient. In contrast, a boundary *violation* is exploitative of the patient and can be harmful to the patient and the therapy.[18]

[15] From the allegations and interviews, the OIG interpreted "inappropriate" as sexualized interactions that violated boundaries.

[16] Ladson, "Recognizing and Managing Erotic and Eroticized Transferences," 2007. While transference may be unavoidable, a boundary violation is not appropriate as a response.

[17] V. K. Aravind, V. D. Krishnaram, and Z. Thasneem, "Boundary Crossings and Violations in Clinical Settings," *Indian Journal of Psychological Medicine*, Jan - Mar 2012, accessed October 4, 2021, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3361837/pdf/IJPsyM-34-21.pdf.

[18] Aravind, "Boundary Crossings and Violations in Clinical Settings," 2012.

Addressing sexualized transference in therapy is challenging as it "may be mistaken as an invitation for further flirtation or a sexual relationship." It is unethical, and a boundary violation, for a therapist to use the discussion of the intense feelings for their own self-gratification.[19] Management of transference is a crucial component in psychotherapy education, and should be carefully addressed in supervision "so that therapy can progress while appropriate boundaries are carefully maintained, and no serious boundary violations occur."[20]

During an interview, a facility psychiatrist described to the OIG that sexualized transference was one of the most difficult situations that could occur in psychotherapy treatment. Further, the psychiatrist warned that residents should recognize the risks and quickly seek supervision, stating:

> [T]he danger is sometimes as a resident you don't know what you don't know. And that's why we want people to just have the structure of weekly … or (again, if you miss, conflict comes up) pretty regular supervision because the problem often is that you don't know what you don't know. And so, you don't know that a particular type of situation has the potential to be very disruptive or even destructive to the treatment.

The OIG learned that over the course of ISTDP therapy, the patient developed romantic feelings for the psychiatry trainee (sexualized transference) and in July 2020, expressed being in love with, and attracted to, the psychiatry trainee. The patient told the OIG that sexual feelings were discussed in almost half of the sessions.

The supervisor reported to the OIG that in response to the patient's expression of romantic feelings (July 2020), the psychiatry trainee consulted with the supervisor in the beginning of August 2020. The supervisor reportedly viewed the video recording from the August 2020 session and recommended inviting the patient to face the transference directly to explore the deep underlying feelings. The supervisor described the recommendation as a technique consistent with ISTDP methods.

The psychiatry trainee reported following a treatment plan that had been agreed upon by the psychiatry trainee and the supervisor. After discussing the concerns with the supervisor in August 2020, the psychiatry trainee did not request further guidance despite moving away from ISTDP techniques in November 2020 to allow the patient time to recover, as her progress had halted.

The OIG's focused review determined that the psychiatry trainee did not demonstrate behavior that overtly violated boundaries, deviated from ISTDP intervention protocols noted in literature, or diverged from instructions reportedly given by the supervisor. Although a conversation related

[19] Ladson, "Recognizing and Managing Erotic and Eroticized Transferences," 2007.
[20] Ladson, "Recognizing and Managing Erotic and Eroticized Transferences," 2007.

to sensitive topics was observed, the psychiatry trainee allowed the patient to choose whether to discuss them. In addition, the OIG did not observe any conduct by the psychiatry trainee that was exploitative or against the patient's interests.[21]

While all of the reviewed interactions appeared to be intended for the benefit of the patient, there were identified deficiencies in the psychiatry trainee's therapeutic interventions. Specifically, the OIG determined that the psychiatry trainee did not always engage in effective therapeutic intervention, and, at times, elicited negative feelings in a context that was disruptive to the therapeutic process. For example, following a session in which the psychiatry trainee made a statement that elicited a strong negative reaction from the patient and required a necessary apology from the psychiatry trainee, the psychiatry trainee allowed the next session to progress to another exercise despite the high likelihood of it leading to another problematic scenario, which did occur. The patient was left with unresolved negative feelings that continued the distress that began in the previous session. The OIG would expect a more experienced therapist would have avoided allowing such a scenario to unfold at such an inopportune time, or alternatively would have used the new scenario to further the therapeutic process by exploring the feelings on a deeper level, rather than minimizing them.

In addition, during interviews the OIG learned that the patient had access to the video recordings made during treatment sessions for 30 days following each session.[22] The OIG was told and observed that the patient and psychiatry trainee discussed reviewing video recordings and interactions from previous sessions. The patient's understanding was that the videos were available for treatment purposes to see how she was responding to therapy. The OIG did not evaluate the reported practice of allowing, or advising, the patient to view the recordings in between sessions without the presence of a provider. However, it was unclear to the OIG whether the review of previous sessions was an intentional, or incidental, part of the treatment. The facility should assess the therapeutic value of the practice, and whether the facility has adequate controls related to such a practice.

2. Alleged Decline in the Patient's Mental Health as a Result of the Psychiatry Trainee's Treatment

The OIG was unable to determine whether the treatment by the psychiatry trainee resulted in a decline in the patient's mental health. While treatment deficiencies were noted and the patient reported worsened mental status, the OIG found documentation of other factors that may have also contributed to a decline in the patient's mental health. In addition, the OIG acknowledges that properly implemented psychotherapy carries an inherent risk of failure; known

[21] Due to identified deficiencies associated with the psychiatry resident's documentation (see Issue 3 below), the OIG could not verify that all of the patient's appointments were documented and therefore, that all video recordings were present.

[22] The OIG determined that the psychiatry resident began virtual sessions with the patient in late March 2020.

complications of ISTDP techniques include stagnating progress or worsening mental health symptoms.[23]

The OIG reviewed the patient's EHR and found that following termination of the therapy in December 2020, the patient received care from a non-VA provider. The patient told the OIG that the request to receive care from a non-VA provider was due to distress specifically related to treatment by the psychiatry trainee.

Additionally, multiple providers documented the patient feeling retraumatized and experiencing physical symptoms, or as feeling unsafe with VA mental health providers due to her "negative experiences." At the beginning of March 2021, the patient attended a group therapy appointment and reported that therapy provided by the psychiatry trainee was "detrimental to her." About a month later, a non-VA therapist documented that the patient was traumatized by a VA therapist. In the beginning of May 2021, a Women's Health psychiatrist documented that she reported "deep depression" as a result of several factors including a reference to working through issues with her previous therapist. At the beginning of June 2021, the patient reported to a Women's Health psychiatrist that she felt unsafe with VA providers. Subsequently, at the end of October 2021, the patient advised her primary care provider that she no longer wished to receive mental health treatment at the VA. Ultimately, the patient declined all VA mental health care and opted for non-VA care.[24]

A Women's Health psychiatrist told the OIG that "she was receiving psychotherapy through this resident [psychiatry resident] and there was some kind of rupture or some kind of conflict which made her feel worse…She said that afterwards, it was hard to trust in general any providers at West LA." The Facility Director acknowledged to the OIG that, although Mental Health Department leaders found that "the treatment wasn't inappropriate and that the therapy didn't cause an increase in distress…one could possibly argue that that's not necessarily true cause it probably did cause distress, whether it was causative as a result of inappropriateness is a different question." In interviews with the OIG, the referring psychiatrist and the supervisor indicated that some patients are better candidates for ISTDP than others, though they initially felt this patient was an appropriate candidate. During the last video session at the beginning of December 2020, the OIG noted the psychiatry trainee confirmed treatment failure to the patient and apologized for it.

Although the OIG identified treatment deficiencies that might have contributed to the patient's worsening symptoms, other factors could not be ruled out. For instance, even when correctly implemented, ISTDP carries a known risk of therapeutic failures or delays, resulting in

[23] Kaplan, "Intensive Short-Term Dynamic Psychotherapy—Habib Davanloo," 2803.

[24] Initially the patient received medication management through July 12, 2021, and transferred care to a different facility clinic location.

worsening symptoms.[25] In addition, factors that are external to the ISTDP can also affect a patient's underlying mental condition or symptoms. The OIG did find documentation in the patient's medical record related to the patient's medical history, and other treatment that the patient was receiving, that may have exacerbated the patient's symptoms.

The OIG recognizes that the patient experienced negative outcomes following the psychiatry trainee's treatment efforts, and that there were identified deficiencies in psychotherapeutic technique. However, the OIG is unable to determine that the treatment alone resulted in the patient's worsening symptoms or that a negative outcome could have been avoided by more skillful application of therapeutic techniques.

3. Inadequate Supervision of the Psychiatry Trainee

The OIG substantiated that the supervisor did not provide adequate supervision to the psychiatry trainee through either structured group supervision for trainees of ISTDP or individual supervision.[26] The OIG also determined that the supervisor did not provide adequate oversight of the psychiatry trainee's documentation related to the patient's care.

Inadequate Psychotherapy Supervision

All VA residents "must function under the supervision of supervising practitioners at all times."[27] VHA defines supervision as "an intervention provided by a supervising practitioner (attending) that occurs as residents provide patient care."[28] Resident supervision within VHA is inclusive of "oversight" and intended to "inform and guide" the resident's patient care within a time frame relevant to the patient's treatment.[29] A fellow is a post-residency physician pursuing study in a specialized field of medicine. However, the term "resident" is inclusive of the term "fellow," and both are subject to supervisory requirements.[30] The level of supervision provided is determined by the supervising attending and is dependent on such factors as the experience and capability of the resident or fellow.[31] Most importantly, the supervision should assure high-quality and safe patient care.[32]

[25] Kaplan, "Intensive Short-Term Dynamic Psychotherapy—Habib Davanloo," 2803.

[26] The supervisor told the OIG that supervision for ISTDP was conducted in a weekly small group with at least one supervisor and a maximum of four trainees.

[27] VHA Directive 1400.01.

[28] VHA Directive 1400.01.

[29] VHA Directive 1400.01.

[30] VHA Directive 1400.01. Residents may also be enrolled in an additional residency training program as fellows.

[31] VHA Directive 1400.01. The "[l]evel of supervision refers to the type of involvement of the supervising practitioner with the resident during the patient encounter, procedure, or episode of care."

[32] VHA Directive 1400.01.

One approach used to facilitate supervision of residents participating in the facility ISTDP training includes conducting, video recording, and presenting treatment sessions at group supervision weekly.[33] "Psychotherapy instructors have used video technology to train residents for over 40 years," believing it "is essential for…accurate psychotherapy supervision."[34] The use of video recordings in a group-supervision setting is not only common in the training of ISTDP, but is a requirement for residents in the facility's ISTDP clinic.[35]

The supervisor, who taught ISTDP at the facility, told the OIG that the psychiatry trainee participated in ISTDP training for the 2019 academic year as a fourth-year resident and continued into the 2020 academic year as a fellow, providing therapy to the patient from the beginning of November 2019 to December 2020.[36] The supervisor explained to the OIG that when the psychiatry trainee became a fellow (July 2020), the psychiatry trainee could no longer attend ISTDP group supervision due to conflicting obligations related to the fellowship. Although the ISTDP group-supervision colleagues would no longer view the psychiatry trainee's video recordings, the psychiatry trainee began an "as-needed" supervisory agreement. The supervisor stated this supervision arrangement was appropriate given the psychiatry trainee's experience and capability. The psychiatry trainee confirmed the supervision arrangement, telling the OIG that supervision during the fellowship was less structured than the ISTDP group supervision and dependent on when the psychiatry trainee and supervisor had time to meet.

The supervisor reported to the OIG that after the psychiatry trainee became a fellow, supervision was provided on one occasion during the patient's treatment that was performed by the psychiatry trainee as a fellow, after an August 2020 consultation with the psychiatry trainee. No other supervision, including a review of treatment videos, was provided by the supervisor until after the patient terminated therapy in December 2020. The supervisor told the OIG that the supervisory session occurred in mid-August 2020, following a request from the psychiatry trainee, three days after a treatment session with the patient. In that supervisory session, the supervisor reviewed the treatment session video recording and ISTDP therapeutic techniques

[33] For the 2019–2020 academic year, residents presented video recordings every six to eight weeks at group supervision; in contrast, for the academic year 2020–2021, residents presented video recordings weekly beginning the seventh week of group supervision.

[34] Allan Abbass, "Small-Group Videotape Training for Psychotherapy Skills Development," *Academic Psychiatry* 28, 2004 (January 9, 2014): 151-155.

[35] Johansson, "Davanloo's Intensive Short-Term Dynamic Psychotherapy in a tertiary psychotherapy service: overall effectiveness and association between unlocking the unconscious and outcome," 2014.

[36] The psychiatry resident participated in the psychiatry residency at the facility from July 1, 2016, through June 30, 2020, and the psychiatry fellowship from July 1, 2020, through June 30, 2021. The psychiatry resident was not authorized to provide patient care unsupervised during the residency or fellowship. The associate chief of staff for Mental Health, deputy chief of Mental Health for education, director of psychotherapy training, and the referring psychiatrist and the supervisor, who were the clinical supervisors of the ISTDP clinic, agreed that video-based review is the standard in ISTDP training.

with the psychiatry trainee.[37] The supervisor informed the OIG that although this was the second instance of the patient expressing feelings of attraction toward the psychiatry trainee, the supervisor did not view any subsequent video recordings of the psychiatry trainee and patient prior to the patient terminating therapy. The supervisor reported to the OIG that it was almost four months following the August 2020 supervision that the psychiatry trainee again received supervision. The second supervisory session occurred in the beginning of December 2020, which was two days after the patient terminated therapy.

When the psychiatry trainee became a fellow, supervisory requirements remained. The allowed flexibility to determine the needed level of supervision, as decided by the supervisor, also remained in place. The OIG concluded that a timely and thorough review of relevant video recordings may have benefited the treatment in the event that treatment stagnated or was not benefiting the patient. The therapy techniques could have been revised with follow-up monitoring, or care could have been transferred prior to therapeutic failure.

Inadequate Supervision of the Psychiatry Trainee's Documentation

The OIG determined that the supervisor did not provide adequate supervision of the psychiatry trainee's documentation. Specifically, the OIG determined that the psychiatry trainee's documentation, as well as the supervisor's documentation related to the provision of supervision, did not meet timeliness standards. The OIG also determined that the psychiatry trainee did not document all treatment sessions, and stopped entering return-to-clinic orders and scheduling appointments for the patient.[38] In addition, the supervisor did not adequately review the psychiatry trainee's documentation to ensure completeness and accuracy of the patient's care.

VHA requires that providers adhere to "generally-accepted" practices for the timeliness and completeness of EHR documentation and that the supervising attending is "ultimately

[37] The supervisor told the OIG of reviewing, in December 2020, the video recording of a treatment session following this supervision and that it showed that the psychiatry resident applied the therapeutic techniques they had discussed "relatively well" and achieved "a successful outcome."

[38] VA Deputy Under Secretary for Health for Operations and Management, "Deployment of National Return To Clinic Order," December 7, 2017. Return-to-clinic orders are placed through the EHR and required of all clinicians when a patient requires follow-up treatment. The psychiatry resident began online appointments in March 2020 and stopped putting in orders in May 2020.

responsible for the accuracy of the health record for each patient."[39] VHA also requires "[t]he health record must clearly demonstrate the involvement of the supervising [attending] in each type of resident-patient encounter."[40] "Allowable documentation include[s]" a co-signature of the supervising attending, which "signifies that the supervising [attending] has reviewed the resident note, and…concurs with the content of the resident note or entry."[41]

Delayed Documentation

The OIG determined that the psychiatry trainee's documentation did not meet facility timeliness expectations. VHA states the frequency of documentation depends on the care setting and the patient's needs, and should follow agreed upon standards set within the facility.[42] Facility Mental Health Department leaders, including the supervisor, reported to the OIG that the expectation for timely documentation of treatment sessions was the same day or within 24 hours.[43]

The OIG reviewed the patient's EHR for all encounters documented by the psychiatry trainee and found that approximately 76 percent (32 of 42) did not meet the Mental Health Department's expectation to be completed on the same day or within 24 hours of the encounter. Of the EHR entries that did meet the timeliness standards, 60 percent (6 of 10) occurred before the psychiatry trainee became a fellow and discontinued ISTDP group supervision.

Upon further review of the documented patient encounters after the psychiatry trainee became a fellow in July 2020, the OIG found the psychiatry trainee's timeliness of documentation deteriorated, despite no change in requirement. For example, the psychiatry trainee completed documentation for six treatment sessions that occurred between the beginning of August 2020 and the end of September 2020 on the same day in early October 2020. This block of documentation included the treatment session in mid-August 2020 when, according to what the

[39] VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015. This handbook was in place during the time of events discussed in this report. It was rescinded and replaced by VHA Directive 1907.01, *VHA Health Information Management and Health Records*, April 5, 2021. Both the handbook and directive contain the same or similar language regarding the requirements for timeliness and completeness of EHR documentation. *Bylaws and Rules of the Medical Staff of the VA Greater Los Angeles Healthcare System*, December 31, 2018. The procedure outlined in this policy is written as "VHA Handbook 1400.1, Resident Supervision," which references VHA Handbook 1400.01, *Resident Supervision*, December 19, 2012. This Handbook was rescinded and replaced by VHA Directive 1400.01, *Supervision of Physician, Dental, Optometry, Chiropractic, and Podiatry Residents*, November 7, 2019. The Handbook and Directive contain the same or similar language regarding resident supervision and oversight.

[40] VHA Directive 1400.01. VHA Handbook 1907.01. VHA defines patient encounters as the contact between a patient and provider, where the patient receives diagnosis, evaluation, and treatment. Encounter forms are mandatory and document the patient care provided, linking to the visit's progress note. Within VHA, health records document and ensure high quality patient care.

[41] VHA Directive 1400.01.

[42] VHA Directive 1400.01.

[43] Facility mental health leaders include the associate chief of staff for Mental Health, the deputy chief of Mental Health for education, and the director of psychotherapy training.

supervisor reported to the OIG, the psychiatry trainee indicated that a significant interaction occurred between the patient and the psychiatry trainee. The OIG found that the session was not documented in the EHR until 54 days after the treatment session.

The associate chief of staff for Mental Health and the deputy chief of Mental Health for Education told the OIG that an attending supervisor's co-signature on the trainee's EHR documentation is expected within 24 hours.[44] The OIG reviewed the supervisor's documented review of the psychiatry trainee's documentation and found that all of the patient encounters documented by the psychiatry trainee contained a co-signature from the supervisor demonstrating the required supervisory oversight. The encounter notes were generally co-signed within one to seven days of completion. However, the supervisor did not meet the expected timeliness standard of co-signature within 24 hours (or the next business day) approximately 70 percent (29 of 42) of the time. It is unclear to the OIG why the supervisor did not timely cosign the notes as required.

When the OIG asked the supervisor if there were any issues with the psychiatry trainee's documentation, the supervisor said, "not that I recall. I think it was pretty good." The psychiatry trainee told the OIG that due to the fellowship workload there was limited time to write notes, but did not recall receiving feedback from the supervisor regarding documentation.

The OIG concluded that the psychiatry trainee's delayed documentation, along with the supervisor's delayed review and co-signature, impeded the supervisor's ability to timely review the care provided to the patient. As a result, the supervisor was unable to inform the subsequent therapy, amounting to insufficient supervisory oversight.

Incomplete Documentation

The OIG determined that the psychiatry trainee's documentation did not meet completeness requirements by failing to document all patient encounters and return-to-clinic orders. VHA requires "that all required data is present and authenticated" and each entry of patient care contains relevant information such as the assessment, clinical impression, and plan of care.[45] Complete documentation provides an accurate account of the treatment provided to the patient.

VHA also requires the use of return-to-clinic orders for all clinics providing direct patient care and that "appointments are scheduled timely, accurately, and consistently" to provide high-quality care. In order to prevent scheduling errors, return-to-clinic orders are placed in the EHR by healthcare providers to indicate an appropriate date for scheduling a patient's follow-up

[44] The deputy chief of Mental Health for Education clarified that EHR entries do not require monitoring over weekends, so for entries completed on Friday or the weekend, timely would be the next business day.

[45] VHA Handbook 1907.01.

treatment.[46] Within the facility ISTDP clinic, it is the expectation that residents place return-to-clinic orders and schedule weekly ISTDP patients into clinic schedules for hour-long appointments.

In order to assess the psychiatry trainee's documentation for completeness, the OIG compared the dates of the video recordings to documentation in the patient's EHR. A total of 47 sessions were recorded between November 2019 and December 2020. The OIG found that nearly 13 percent (6 of the 47) recorded sessions did not have a corresponding note in the patient's EHR.[47] Additionally, the OIG found 10 of the video recorded treatment sessions lasted around 90 minutes; however, the psychiatry trainee's documentation in the EHR represents that the treatment sessions included 45 minutes of psychotherapy.

The OIG also reviewed the psychiatry trainee's documented encounters with the patient for the content of each treatment session and found all of the EHR entries followed a template and contained relevant information per VHA requirements, including diagnosis, assessment, and treatment plan. However, the OIG did not find EHR documentation of the November 2020 change in techniques relayed to the OIG by the psychiatry trainee. When asked about the psychiatry trainee's documentation, the associate chief of staff for Mental Health stated the content of psychiatry trainee's documentation of the patient's care was as expected.

In addition, the OIG examined the psychiatry trainee's documented encounters to assess the presence of return-to-clinic orders for the scheduling of appointments. The OIG found that the psychiatry trainee stopped placing return-to-clinic orders and that appointments for treatment sessions went unscheduled starting in early May 2020, even though the psychiatry trainee continued to see the patient regularly. When asked, the psychiatry trainee told the OIG that as time went on and the patient continued to show up consistently, the placement of orders and regular scheduling of therapy was not a priority. The OIG determined that the psychiatry trainee's failures in documentation, including undocumented treatment sessions and return-to-clinic orders, led to an inaccurate account of the treatment provided to the patient.

The OIG concluded that the psychiatry trainee's delayed and incomplete documentation reflects inadequate supervisory involvement ultimately resulting in insufficient supervision to manage the patient's care needs. The OIG would have expected the supervisor to identify unmet standards in documentation and, in response, initiate supervision or guidance. However, the

[46] VA Deputy Under Secretary for Health for Operations and Management memo. VHA Directive 1230(5), *Outpatient Scheduling Processes and Procedures*, July 15, 2016, amended September 24, 2021. The amendments made to this directive took place after the events discussed in this report; however, the directive contains the same or similar language regarding requirements for return-to-clinic orders.

[47] The OIG found inconsistency in the documentation and report of how many treatment sessions occurred between November 4, 2019, and December 8, 2020. Forty-two sessions were documented in the patient's EHR; the Psychiatry Resident provided 47 video recorded sessions, including three undated sessions; and the patient recalled about 53 sessions.

supervisor only provided supervision for the patient's care when requested by the psychiatry trainee.

4. Inadequate Facility Response to the Patient's Treatment Concerns

The OIG substantiated that

- Mental Health Department leaders were not adequately responsive to the patient's concerns regarding the psychiatry trainee's treatment behavior or to her requests for the video recordings;
- the peer review initiated by Quality Management staff did not include the supervisor, the provider ultimately responsible for the patient's care; and
- the patient advocate's responses were not timely or complete.

VA is committed to "world-class customer service" and a fundamental element is service recovery, which is based on the principle "that staff at the point-of-service" recognize "service failure, effectively resolves a service problem, identifies root causes(s) and solutions based upon them as soon and effectively as possible."[48] VHA provides several avenues for identifying root causes and solutions, including management and focused performance reviews.[49] For residents, peer reviews are not appropriate; however, facilities are required to ensure a "monitoring process exists for resident supervision" that would capture patient complaints and incident reports involving residents. VHA requires that "[w]hen a resident's performance or conduct is judged to be detrimental to patient care, evaluation of the resident, in mutual consultation with the faculty, must be completed."[50]

Inadequate Response of Mental Health Department Leaders Regarding the Patient's Treatment Concerns and Requests for the Video Recordings

The OIG substantiated that Mental Health Department leaders did not adequately address the treatment concerns the patient began reporting in December 2020. Following termination of therapy in December 2020, the patient expressed her concerns to multiple Mental Health Department leaders. The patient told the OIG that the concerns included "distress, increased anxiety, depression, suicidal ideation, helplessness and trauma." In addition, the patient reported

[48] VHA Directive 1003, *VHA Veteran Patient Experience*, April 14, 2020.
[49] VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018.
[50] VHA Directive 1400.01.

making several requests for the video recordings created during treatment sessions with the psychiatry trainee.[51]

For example, the patient reported communicating with the referring psychiatrist at least six times between December 2020 and March 2021, and reported treatment concerns.[52] The patient told the OIG that, in mid-December 2020, she reported to the referring psychiatrist the "extremely distressing" circumstances related to the treatment. At that time, the patient accepted the referring psychiatrist's offer for another therapist. However, the patient reported that the referring psychiatrist did not follow up with a referral until the patient reached out at the end of January 2021, a month and a half later. At that point, a consult for a community provider was initiated. The patient reported to the OIG that after further discussions with the referring psychiatrist in March 2021, she felt "blamed" by the referring psychiatrist after being told that the concerns should have been worked out in the therapy. During an interview with the OIG, the referring psychiatrist stated that the patient initially declined a referral to a VA provider; however, in contrast, the referring psychiatrist's documentation in the EHR noted the patient's desire for a referral to a new therapist in mid-December 2020. Ultimately, a community consult was not placed until early February 2021. The OIG concluded that the referring psychiatrist did not adequately address the patient's concerns and did not follow up to ensure referrals were completed.

The OIG also found that the supervisor was informed about the patient's concerns but did not complete an adequate review of the psychiatry trainee's care in relation to the concerns. The patient reported contacting and speaking with the supervisor twice, once at the end of March 2021 and once at beginning of April 2021. The patient described telling the supervisor of feeling the psychiatry trainee "was having countertransference emotions" toward her that caused "harm and major distress." The patient reported to the OIG that the supervisor discussed her concerns, verbalized concern for her worry and a need for her "to move on from this one way or another." The supervisor told the OIG of believing the patient's treatment was going well until she terminated therapy. Although the supervisor reported addressing the clinical issue regarding the patient, the OIG did not find evidence that the supervisor completed a thorough review of the care and treatment provided by the psychiatry trainee when it was warranted to evaluate the complaints about the psychiatry trainee.

Additionally, five facility and Mental Health Department leaders were made aware of the patient's treatment concerns, but the OIG did not find evidence of actions taken, either to resolve the patient's concerns or to review the care provided by the psychiatry trainee.[53] Although some

[51] The patient reported speaking to the referring psychiatrist, supervisor, and a mental health supervisor, and contacting the associate chief of staff for Mental Health.

[52] The referring psychiatrist documented in the EHR five discussions with the patient.

[53] The leaders were the deputy chief of Mental Health for education, associate chief of staff for Mental Health, director of psychotherapy training, chief of innovation for Mental Health, and chief of Quality Management.

of the leaders reported conducting informal EHR reviews, the OIG did not find evidence that the supervisor or other leaders completed a structured review of the patient's complaints related to the psychiatry trainee's treatment, or an evaluation of the psychiatry trainee's treatment of the patient, as required. During interviews, the ISTDP supervisors and leaders did not give a clear explanation as to why the required review of the psychiatry trainee's treatment was not completed.

Ultimately, because the patient's complaints were not addressed by Mental Health Department leaders at the point of service when the patient raised the concerns, the patient continued to seek resolution through other avenues. In addition, during interviews the OIG observed that Mental Health Department leaders did not directly address and resolve the patient's concerns.

Incomplete Peer Review

The OIG determined that the risk manager initiated a peer review of the patient's care; however, the review was conducted on the referring psychiatrist rather than the supervisor who was responsible for the patients care.

According to VHA, peer review for quality is an organized process for evaluating the quality of care provided to a patient by a provider and is intended to improve the quality of health care by promoting "confidential and non-punitive assessments of care."[54] Trainees, including residents and fellows, practice under the supervision of a licensed clinician.[55] Therefore, in cases where care was provided by a trainee, peer reviews are conducted to review the supervisor rather than the trainee.[56]

The OIG found that at the end of April 2021, the Facility Director was consulted by the associate chief of staff for Mental Health and the Chief of Staff, who determined that a peer review of the patient's care was advisable. The risk manager initiated a peer review of the referring psychiatrist, which was completed and reviewed in May 2021. The OIG found that although the referring psychiatrist reported providing co-supervision for the ISTDP group supervision, the supervisor co-signed all of the psychiatry trainee's EHR documentation for the time the patient was in therapy.

When asked by the OIG why the care or the supervision provided by the supervisor was not reviewed, the chief of Quality Management reported believing that the referring psychiatrist was providing coverage for the supervisor. The risk manager explained to the OIG that when determining which provider to review through the peer review process, the supervisor's title was incorrectly listed as a fellow (trainee) in the EHR and that it was not common practice to conduct

[54] VHA Directive 1190.
[55] VHA Directive 1190. VHA Directive 1400.01.
[56] VHA Directive 1190.

peer reviews on trainees. Therefore, the risk manager did not inquire further regarding a review of the supervisor.[57] The risk manager also noted that the referring psychiatrist had been the provider listed in legal documents related to the treatment; however, the OIG found that both the referring psychiatrist and the supervisor were listed on the documents. Although, at the time, the risk manager believed the correct provider was reviewed, a review of the supervisor's care was not considered even when the supervisory involvement was confirmed. The chief of Quality Management conceded that "in hindsight, we should have peer reviewed both of them."

As of November 2021, the facility had still not completed a review of the supervisor. The OIG concluded that the decision to not conduct a peer review on the supervisor's involvement impeded facility leaders' ability to determine if the supervisor's oversight for the care of the patient was adequate.

Inadequate Patient Advocate Responses

The OIG determined that the patient advocate did not address the patient's request for the video recordings or reported treatment concerns that were submitted by the patient to the patient advocate. Patient advocates are designated employees who "manage the complaint…process" and "ensur[e] documentation of events" to improve a patient's "health and healthcare delivery." Patient advocates must ensure "timely resolution of Veteran complaints" within seven business days.[58]

At the end of March 2021, the patient contacted a patient advocate requesting the treatment-related video recordings. In response, the patient advocate documented in the patient complaint database that the patient had left a detailed message for the associate chief of staff for Mental Health requesting a follow-up call. The OIG would have expected a direct response from the patient advocate, including consultation with appropriate staff, and documentation of completion of the request.[59] The OIG did not find evidence in the patient complaint database that the patient advocate addressed the patient's concerns or that the associate chief of staff for Mental Health contacted the patient. As a result, in the absence of further communication or resolution regarding the video recordings, the patient continued to escalate her request.

In late July 2021, an administrative staff member who was responsible for assigning and tracking patient advocate program complaints and inquiries, received notification that the patient had filed a complaint with the White House VA Hotline. The patient reported having difficulties filing and not receiving responses to a patient advocate complaint regarding treatment by the psychiatry

[57] A response to an OIG inquiry received in August 2021 indicated the supervisor was a staff psychiatrist and not a fellow during supervision of the psychiatry resident and the care of the patient.

[58] VHA Directive 1003.04, *VHA Patient Advocacy*, February 7, 2018.

[59] The OIG was unable to interview the patient advocate; the facility veteran experience officer told the OIG that the patient advocate was no longer employed at VHA.

trainee and appointment scheduling. The complaint included concerns that the patient was "dealing with serious issues several months ago with a Doctor who acted inappropriately and she was given a run around being told to call numerous people who did not want to deal with the issue." The complaint also reflected that an additional complaint was filed with the Inspector General, "but it should not have come to this." The administrative staff member told the OIG of assigning the complaint to the scheduling supervisor, who then documented resolution of the clinic appointment concern. The OIG found that a scheduling supervisor contacted the patient 12 business days later regarding a clinic appointment. However, the reported issue of inappropriate behavior was not addressed.

At the request of the OIG in June 2022, the facility's veteran experience officer, who supervises the patient advocates, reviewed the patient's complaints and associated patient advocate responses.[60] Based on the review, the veteran experience officer confirmed that the patient advocate should have referred the complaint to the service line employee who was responsible for contacting the patient within seven days to address and resolve concerns. The veteran experience officer also confirmed that the patient's complaint regarding treatment by the psychiatry trainee was not addressed. The OIG concluded that the patient was unable to obtain the assistance and advocacy she was seeking.

5. Improper Creation, Storage and Disposition of Video Recordings and Consent Forms

During the inspection, the OIG identified an additional concern related to the improper creation, storage, and disposition of video recordings and consent forms. The OIG found that the psychiatry trainee recorded the video recordings on a personal computer, and stored and retained the video recordings throughout the residency and after separation from the facility. The OIG initially found that one month after the conclusion of the residency and fellowship, and separation from the facility as an 'employee,' the psychiatry trainee was in possession of a personal "password protected flash drive containing audio and video of treatment sessions" and had retained the patient's signed consent form.

The OIG also learned that, due to staffing changes, the Mental Health Department did not have a VHA records control schedule and file plan to assist with determining record disposition requirements.[61] The facility's records management officer told the OIG that each staff member is responsible for their records, and supervisors and service chiefs have ultimate responsibility for

[60] VHA Directive 1003.04. The veteran experience officer oversees the department supporting the facility's goal of ensuring positive interactions between patients and employees, that are intentional and appropriate.

[61] VHA Directive 6300(1), *Records Management*, October 22, 2018, amended September 22, 2020. The amended version contains the same or similar language regarding records management requirements.

properly maintaining records. VHA is required to protect and safeguard individually-identifiable information that is

> a subset of health information, including demographic information collected from an individual, that: (1) is created or received by a health care provider, health plan, or health care clearinghouse (e.g. a HIPAA-covered entity, such as VHA); (2) relates to the past, present, or future physical or mental condition of an individual, or provision of or payment for health care to an individual; and (3) identifies the individual or where a reasonable basis exists to believe the information can be used to identify the individual.[62]

Relatedly, personally identifiable information (PII) "is any information about an individual that can be used to distinguish or trace an individual's identity." Protected health information (PHI), considered a subcategory of PII, is "health (including demographic) data that is transmitted by, or maintained in, electronic or any other form or medium" under the control of VHA.[63]

VHA requires that PII and PHI must remain under control of the originating agency. VHA employees "should not place records material on personal drives outside the control of VHA or O&IT [Office of Information & Technology]."[64] For example, "the employee's supervisor must be able to have access to these file folders and the records within [*sic*] via network storage."[65] Facility policy requires that staff maintain audio video files electronically with a method for all users to retrieve the documents and provide an appropriate level of security.[66]

Records management is the "activities involved with respect to records creation, maintenance and use, and disposition of records to achieve adequate and proper documentation."[67] An important aspect of records management is the proper identification of material as a federal record or non-record. Federal records "include all records information, regardless of form or characteristics, made or received by a Federal agency." Non-record material "includes informational materials preserved solely for purposes of reference…that do not contain unique information" such as extra copies of official documents and uncirculated drafts and worksheets.[68]

---

[62] VHA Directive 1907.08, *Health Care Information Security Policy and Requirements*, April 30, 2019. According to VHA, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) required development of "regulations to ensure that covered entities make secure the electronic protected health information (e-PHI) of individuals."

[63] VA Directive 6066, *Protected Health Information (PHI) and Business Associate Agreements Management*, September 2, 2014.

[64] VHA Directive 6300(1).

[65] VHA Directive 6300(1).

[66] Facility Policy 00-002-EI-15, *"Electronic Records Management Policy,"* April 2016.

[67] VHA Directive 6300(1).

[68] VHA Directive 6300(1).

Through records control schedules, VHA determines how long records, including paper and electronic, are to be kept.[69]

Additionally, removing records unlawfully, or without appropriate authorization can result in criminal or civil penalties and may require notification of the National Archives and Records Administration, including the accidental removal of records.[70] VHA requires employees to "ensure, upon leaving government service, that all federal records related to their position within the federal government are placed in the proper electronic folders."[71] The facility bylaws required that "[a]ll medical records are confidential and the property of the Facility and shall not be removed from the premises without permission."[72]

The OIG determined that the video recordings and consent forms, because they contain unique information obtained through VA patient care, are subject to the protection requirements for PHI and PII.[73] They are also subject to requirements for the storage and disposition of federal records, even though they were not created as part of the EHR.

For the purpose of this review, the OIG focused on the VHA records management practices and supervision of the psychiatry trainee. However, the extent of these issues is unknown as records management across all Mental Health Department residency and fellowship programs was beyond the scope of this inspection. The OIG is concerned that the records management issues identified during this review may reflect a more widespread problem.

Improper Creation, Storage and Disposition of Video Recordings

The OIG found that the supervisor did not ensure that the psychiatry trainee created and stored video recordings on VA accessible equipment, as required, and that the psychiatry trainee created and stored the video recordings on a personal computer instead.

---

[69] VHA Directive 1078(1), *Privacy of Persons Regarding Photographs, Digital Images and Video or Audio Recordings*, November 4, 2014, amended November 19, 2014. This directive was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1078, *Privacy of Persons Regarding Photographs, Digital Images, and Video or Audio Recordings*, November 29, 2021. Both directives contain the same or similar language regarding requirements of electronic record keeping.

[70] 18 U.S.C. §2071, accessed June 6, 2022, 18 U.S.C. 2071 - Concealment, removal, or mutilation generally - Content Details - USCODE-2014-title18-partI-chap101-sec2071 (govinfo.gov);18 U.S.C. §641, accessed June 6, 2022, USCODE-2020-title18-partI-chap31-sec641.pdf (govinfo.gov); 44 U.S.C. § 3106, accessed June 6, 2022, USCODE-2020-title44-chap31-sec3106.pdf (govinfo.gov). National Archives and Records Administration, 36 C.F.R. §1230.10 and §1230.12, accessed June 6, 2022, CFR-2021-title36-vol3-sec1230-10.pdf (govinfo.gov). Federal regulations prohibit removal of government records and violation may result in "a fine, imprisonment, or both."

[71] VHA Directive 6300(1). Employees are required to complete annual *VA Privacy and Information Security Awareness and Rules of Behavior* training with requirements for handling of records containing sensitive information.

[72] Bylaws and Rules of the Medical Staff of the VA Greater Los Angeles Healthcare System, December 31, 2018.

[73] VHA Directive 6300(1).

The OIG was unable to determine what transpired in the discussions for determining whether the video recordings are federal records; there is no clear documentation of the discussions. The OIG heard conflicting information about staffs' understanding of the rules regarding the video recordings as federal records. The facility records management officer confirmed with the OIG that the video recordings were federal records subject to proper storage and records control schedules for disposition. However, the privacy officer told the OIG of consulting with the chief of innovation for Mental Health and mental health providers, and that the patient's video recordings were determined to not be federal records. The associate chief of staff for Mental Health told the OIG that the video recordings were a "teaching tool" akin to "psychotherapy notes" that have a different "standard of custody" than federal records.[74]

The OIG also found the supervisor did not ensure the psychiatry trainee dispositioned the video recordings as required.[75] The psychiatry trainee told the OIG of not receiving instruction for disposition of the video recordings. The supervisor told the OIG the psychiatry trainee was instructed to destroy the video recordings at the completion of ISTDP patient cases, and the supervisor understood that the psychiatry trainee had done so. However, a former mental health resident told the OIG of being involved in the ISTDP group supervision at the same time as the psychiatry trainee and that it was the residents' impression that the video recordings were to be kept indefinitely by the residents, but was informed within the past year to delete the video recordings. It was unclear to the OIG how long this practice was in place, and whether the psychiatry trainee and other former residents were informed to delete video recordings.

The OIG concluded that the discrepancies between facility staff's understanding of what constitutes a federal record, and required records management, contributed to deficiencies in the creation, storage, and disposition of the video recordings. In addition, the group supervisors' practices directly contradicted VHA policy and did not facilitate the required creation, storage, and disposition of the patients' video recordings within VA systems. Thus, facility record practices resulted in security concerns and an inability for VA staff to appropriately disposition the video recordings.

Improper Storage and Disposition of Consent Forms

The OIG found that the psychiatry trainee completed a consent form with the patient prior to video recording the therapy, as required; however, the psychiatry trainee retained the consent form against VHA policy.[76] VHA allows staff to "overtly produce photographs, digital images or video or audio recordings for official or treatment purposes, including but not limited to

[74] VHA Directive 1605.01, *Privacy and Release of Information*, August 31, 2016. "Psychotherapy notes are the personal session notes of the mental health professional for use in composing progress notes for the official VHA health record" and "are not considered protected health information."

[75] VHA Directive 6300(1).

[76] VHA Directive 1078(1); VHA Directive 6300(1).

treatment, staff education and development" but consent must be obtained.[77] VHA requires that all personnel comply with security, privacy, and confidentiality of individually-identifiable health information, such as a signed consent form.[78]

The supervisor told the OIG that, at the time, they were having residents retain the consent form. It is unclear to the OIG why the Mental Health Department was using this practice. The psychiatry trainee provided an electronic copy of the patient's signed consent form to the OIG, indicating the psychiatry trainee retained the paper form after separation from the VA.[79] The removal of the consent form put the patient's health information at risk for a breach of security and privacy, may have violated the National Archives Act, and ensured it was not available for the required federal records disposition.[80]

The OIG learned from a facility staff member that actions had been taken after the patient's request for the video recordings, including establishment of a related standard operating procedure. However, the OIG would have expected, but did not see evidence of or reports to the OIG, that the appropriate facility subject matter experts, such as the privacy, records management, and information systems security officers, had been involved in developing or reviewing the updated processes.

The OIG concluded that at the time of the patient's treatment, mental health staff did not adhere to VHA requirements for the storage and disposition of video recordings and consent forms, and the Mental Health Department did not have proper federal records control processes in place. It is unclear to the OIG whether the failure to properly store and disposition video recordings and consent forms was due to an oversight in the group supervision, or whether it was standard practice for the Mental Health Department. Review and consultation with the records management officer or the Office of General Counsel may have offered the opportunity for facility leaders to determine the requirements for the records and address the storage and disposition deficiencies.

Conclusion

The OIG did not substantiate that the psychiatry trainee's behavior during treatment of the patient was inappropriate. Treatment interactions reviewed in video recordings appeared to be intended for the patient's benefit and did not demonstrate behavior that overtly violated

[77] VHA Directive 1078(1).

[78] VHA Directive 1907.08.

[79] The associate chief of staff for Mental Health told the OIG that the consent form could not be located at the facility.

[80] 44 U.S.C. § 3106(a), 18 U.S.C. §2071(a)(b), 18 U.S.C. §641. 36 C.F.R. Part 1230.10(d) and 1230.12, Federal regulations prohibit removal of government records and violation may result in "a fine, imprisonment, or both."

boundaries. However, the treatment failed in the end, and the OIG concluded there were aspects of the psychiatry trainee's execution of ISTDP interventions during the fellowship that would have likely benefited from additional supervisory oversight.

The OIG was unable to determine if the psychiatry trainee's treatment resulted in a decline in the patient's mental health. While the treatment was not successful and the patient reported decreased trust and mental functioning, other non-treatment factors may have contributed to the patient's mental health decline.

The OIG substantiated that the supervisor did not provide adequate supervision to the psychiatry trainee and did not provide adequate oversight for documentation. Despite considering the review of treatment video recordings an essential component of ISTDP training, the supervisor permitted the psychiatry trainee to change from regular group supervision to individual supervision on an "as-needed" basis beginning in July 2020. As a result, the psychiatry trainee reached out, and the supervisor provided supervision, on only one occasion during the patient's treatment that was performed by the psychiatry trainee as a fellow. The OIG concluded that the supervisory arrangement was not sufficient to manage the patient's care needs.

The OIG found that the psychiatry trainee's documentation was not timely nor complete. Key deficits in documentation included that the psychiatry trainee did not document all treatment sessions with the patient, did not accurately document treatment session times, and did not document treatment changes. In addition, the psychiatry trainee stopped entering return-to-clinic orders and scheduling the patient's appointments beginning in early May 2020, even though the psychiatry trainee continued to see the patient. The supervisor failed to provide adequate supervision of the psychiatry trainee's documentation, facilitating an inaccurate account of treatment.

The OIG substantiated that facility leaders' response failed to resolve the patient's treatment concerns and address the psychiatry trainee's alleged behavior. Although some facility leaders reviewed the patient's EHR, the OIG did not find evidence that the leaders adequately reviewed the care to resolve the patient's concerns, which she began reporting in December 2020. While Quality Management staff initiated a peer review, it was not conducted on the provider responsible for the patient's care—the psychiatry trainee's direct supervisor. In addition, the patient advocate did not address the patient's request for the video recordings or reported treatment concerns that were submitted.

The OIG found deficiencies in the creation, storage, and disposition of video recordings containing protected patient information, as well as a consent form. The psychiatry trainee created and stored video recordings of treatment sessions on a personal computer which, although consistent with reported practices by other residents, was against VA requirements. The video recordings were also not properly dispositioned. The OIG learned that although no longer a VA resident or fellow, the psychiatry trainee was in possession of the patient's signed consent form and video recordings of treatment sessions. Facility supervisors noted the practice at the

time was to have residents retain copies of patients' signed consent forms, a process that put the patients' health information at risk for a breach of security and privacy. The extent of these issues is unknown as records management across all Mental Health Department residency and fellowship programs was beyond the scope of this inspection. The OIG is concerned that the records management issues identified during this review may reflect a more widespread problem.

Recommendations 1–6

1. The Veterans Integrated Service Network Director reviews the supervision provided to the psychiatry trainee regarding the patient's treatment, documentation, and document control, to include electronic health records and video recordings, and determines if standards were met, and takes action as indicated.

2. The Veterans Integrated Service Network Director reviews treatment protocols for video recorded therapy, specifically the management of patient access to recordings, and takes action as indicated.

3. The Greater Los Angeles Healthcare System Director reviews the facility leader and staff responses, including those of the supervisor and patient advocate, to ensure the patient's concerns were adequately addressed, and takes action as indicated.

4. The Under Secretary for Health conducts a review to assess the possible scope of current and former VA psychiatry residents being in possession of patients' personal health information, to include video recorded treatment sessions and consent forms, and consults with the appropriate organizational leaders such as the Office of General Counsel on the required disposition of the recordings and forms, and takes action as needed.

5. The Greater Los Angeles Healthcare System Director ensures records control schedules, including one for video recordings, are completed for the Mental Health Department as required by Veterans Health Administration policy.

6. The Greater Los Angeles Healthcare System Director reviews processes related to the utilization of video recordings, in consultation with appropriate staff, to ensure compliance with Veterans Health Administration requirements.

Appendix A: Office of the Under Secretary for Health Memorandum

Department of Veterans Affairs Memorandum

Date: October 27, 2022

From: Under Secretary for Health

Subj: OIG Draft Report, Inadequate Supervision of a Mental Health Provider and Improper Records Management for a Female Patient at the VA Greater Los Angeles Health Care System in California

To: Director, Office of Healthcare Inspections (54WH00)

1. Thank you for the opportunity to review and comment on the Office of Inspector General draft report, Inadequate Supervision of a Mental Health Provider and Improper Records Management for a Female Patient at the VA Greater Los Angeles Health Care System in California. The Veterans Health Administration concurs in principle with recommendation 4 and provides an action plan in the attachment.

2. Comments regarding the contents of this memorandum may be directed to the GAO OIG Accountability Liaison Office at VHA10BGOALACTION@va.gov.

(*Original signed by*:)

Shereef Elnahal M.D., MBA

Office of the Under Secretary for Health Response

VETERANS HEALTH ADMINISTRATION (VHA)

Action Plan

Veterans Health Administration: Inadequate Supervision of a Mental Health Provider and Improper Records Management for a Female Patient at the VA Greater Los Angeles Health Care System in California

(OIG 2021-03734-HI-1220)

Recommendation 4. The Under Secretary for Health conducts a review to assess the possible scope of current and former VA psychiatry trainees being in possession of patients' personal health information, to include video recorded treatment sessions and consent forms, and consults with the appropriate organizational leaders such as the Office of General Counsel on the required disposition of the recordings and forms, and takes action as needed.

VHA Comments: Concur in Principle

VHA Privacy and Health Records Management, in partnership with subject matter experts in health professions education, Office of Academic Affiliations (OAA), will develop guidance regarding the management of health records by health care providers or health profession trainees (HPTs) in any clinical service, including the psychiatry residency training program at the VA Greater Los Angeles Healthcare System in California. The guidance will be issued through the Office of the Assistant Under Secretary for Health for Operations. To ensure that all HPTs (not just physician residents) receive clear guidance, OAA will add relevant content to the Mandatory Training for Trainees course.

The practice identified by the Inspector General became particularly important during the early days of the COVID-19 pandemic when protecting patient safety by avoiding any unnecessary in-person contact was high priority for VA. Using video encounters, especially when a physical exam was not needed, gave patients the ability to receive treatment while limiting possible viral exposure during transportation or in clinic environments. Now that the country has entered a new norm for managing COVID-19, this is an opportune moment to look back at early emergency practices and determine whether corrective actions are needed. This action plan is a concur in principle response because VHA believes these actions should apply to any clinical service and not just in the psychiatry setting.

Status: In Progress Target Completion Date: October 2023

OIG Comment

The OIG will ensure that the guidance and actions taken by VHA will impact prior residents that are no longer affiliated with VHA prior to the closure of this recommendation.

Appendix B: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: October 13, 2022

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

Subj: Healthcare Inspection—Inadequate Supervision of a Mental Health Provider and Improper Records Management for a Female Patient at the VA Greater Los Angeles Health Care System in California

To: Office of the Under Secretary for Health (10)
Director, Office of Healthcare Inspections (54WH00)
Director, GAO/OIG Accountability Liaison Office (VHA 10BGOAL Action)

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) report, Inadequate Supervision of a Mental Health Provider and Improper Records Management for a Female Patient at the VA Greater Los Angeles Health Care System in California.

2. Based on the thorough review of the report by VISN 22 Leadership, I concur with the recommendations and submitted action plans of the VA Greater Los Angeles Health Care System.

3. If you have additional questions or need further information, please contact the VISN 22 Quality Management Officer.

(*Original signed by*:)

Michelle L. Dorsey
Chief Medical Officer
for
Michael W. Fisher
VISN 22 Network Director

VISN Director Response

Recommendation 1

The Veterans Integrated Service Network Director reviews the supervision provided to the psychiatry trainee regarding the patient's treatment, documentation, and document control, to include electronic health records and video recordings, and determines if standards were met, and takes action as indicated.

Concur.

Target date for completion: December 31, 2022

Director Comments

The Veterans Integrated Service Network (VISN) 22 Chief Mental Health Officer will conduct a review of the supervision provided to the psychiatry trainee regarding the patient's treatment, documentation, and document control, to include electronic health records and video recordings. The review will determine if provisions of care were met as per VHA Handbook 1400.01, VHA Handbook 1160.01 (1), VHA Handbook 1605.1, VHA Directive 6300(1), VHA Directive 1907.01, VHA Directive 1907.08 and other applicable VHA and VA Greater Los Angeles Healthcare System policies. VISN 22 will also consult with Office of Academic Affiliations. Upon completion of the review, the VISN Director will ensure corrective actions are implemented until completed.

Recommendation 2

The Veterans Integrated Service Network Director reviews treatment protocols for video recorded therapy, specifically the management of patient access to recordings, and takes action as indicated.

Concur.

Target date for completion: December 31, 2022

Director Comments

The Veterans Integrated Service Network (VISN) 22 Chief Mental Health Officer will conduct a review of the treatment protocols for video recorded therapy and management of patient access to recordings, in accordance with VHA Handbook 1160.01 (1), VHA Directive 1078 and VHA Directive 1605.01 and other applicable VHA and VA Greater Los Angeles Healthcare System policies. Upon completion of the review, the VISN Director will ensure corrective actions are implemented until completed.

Appendix C: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: October 13, 2022

From: Director, Greater Los Angeles Healthcare System (691)

Subj: Healthcare Inspection— Inadequate Supervision of a Mental Health Provider and Improper Records Management for a Female Patient at the VA Greater Los Angeles Health Care System in California

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

1. I have reviewed and concur with the OIG's report, Inadequate Supervision of a Mental Health Provider and Improper Records Management for a Female Patient at the VA Greater Los Angeles HCS in California. VA remains committed to honoring our Nation's Veterans by ensuring a safe environment to deliver exceptional health care.
2. I note the delivery of healthcare via telehealth during the COVID 19 pandemic produced rapid changes in our Protected Health Information (PHI) processes. These rapid changes and various new platforms for delivery of care highlighted our lack of established procedures for PHI in new electronic media. Nonetheless it remains incumbent on VA Greater Los Angeles Health Care System to protect Veterans' health information in every clinical environment. VA Greater Los Angeles Health Care System continues to be committed to ensuring Veteran health care data remain in protected VHA systems.
3. I would like to thank the Office of Inspector General for their thorough review of this case and recommendations on process improvements. VA Greater Los Angeles Health Care System appreciates the opportunity to partner with the OIG on our high reliability journey. We remain steadfast in our commitment to zero harm.
4. If you have any additional questions or need further information, please contact the – Chief Quality Management.

(*Original signed by*:)

Steven E. Braverman MD
Medical Center Director

Facility Director Response

Recommendation 3

The Greater Los Angeles Healthcare System Director reviews the facility leader and staff responses, including those of the supervisor and patient advocate, to ensure the patient's concerns were adequately addressed, and takes action as indicated.

Concur.

Target date for completion: January 1, 2023

Director Comments

VA GLA Healthcare System Chief Veteran Experience Officer will conduct an assessment of staff responses to this patient's concerns and makes recommendations for improvement. Ongoing monthly audits will be conducted to ensure compliance to VHA Directive 1003.04. The Veteran Experience Officer oversees the department supporting the facility's goal of ensuring positive interactions between patients and employees, that are intentional and appropriate.

VA GLA Healthcare System Chief Veteran Experience Officer will conduct random audits of the Patient Advocacy Tracking System Report (PATS-R) monitoring monthly compliance until 90% or greater success is reached for a minimum of 3 consecutive months. VA GLA Healthcare System Monitoring data will be reported monthly to the Quality Executive Council (QEC).

Recommendation 5

The Greater Los Angeles Healthcare System Director ensures records control schedules, including one for video recordings, are completed for the Mental Health Department as required by Veterans Health Administration policy.

Concur.

Target date for completion: March 1, 2023

Director Comments

Based on VA GLA Healthcare System internal review, changes were required to the process in which consent forms for video and audio recordings were stored Sept 21, 2022. At VA GLA Healthcare System, the psychotherapy sessions are video/audio taped for training purposes. Initially, VA GLA Healthcare System Chief of Mental Health Education and her team trained VA GLA psychotherapy residents and fellows on this process which is in accordance with Standard Operating Procedure (SOP) #116-ADM [administrative]-12 dated

July 2021 "Guidelines for Video Recording of Psychotherapy Sessions" and includes specific instructions for residents for document control of electronic health records and video recordings. Additionally, a chief resident was tasked with tracking all residents' psychotherapy cases, including the completion of required consent forms. The Director of Psychotherapy and the Outpatient Chief Resident will meet quarterly to review this tracking and follow-up on any outstanding documentation requirements.

On July 1, 2022, the documentation of consent for video and audio recording was reviewed during mandatory orientation for all residents providing outpatient care at the VA GLA VA Healthcare System. As of July 2022, 100% VA GLA Healthcare System psychiatry residents performing psychotherapy were trained. Additionally, on Sept 21, 2022, all psychotherapy supervisors re-reviewed the SOP #116-ADM [administrative]-12 dated July 2021 for obtaining and documenting consent for audio and video recording of psychotherapy sessions and will review with residents at the start of each psychotherapy case. VA GLA VA Healthcare System re-education will be provided after the SOP #116-ADM [administrative]-12 (per recommendation 6 below) has been updated.

The Chief resident will ensure tracking of all residents' psychotherapy cases, including the completion of required consent forms for video and audio recording. No video or audio recordings will occur before a signed consent is on file. VA GLA Healthcare System will conduct an immediate review of Veterans currently receiving psychotherapy for consent compliance. There are less than five ISTDP patient per year and less than twenty psychotherapy patients per year. Monthly reviews of new psychotherapy patient consent will be completed.

The VA GLA Healthcare System Director of Psychotherapy will report monitoring data monthly to the Quality Executive Council (QEC) to achieve 100% compliance for three consecutive months.

Recommendation 6

The Greater Los Angeles Healthcare System Director reviews processes related to the utilization of video recordings, in consultation with appropriate staff, to ensure compliance with Veterans Health Administration requirements.

Concur.

Target date for completion: January 1, 2023

Director Comments

Based on the review by Mental Health, Privacy Officers and records management experts, modification will be made to VA GLA SOP Audio and Video Recordings #116-ADM [administrative]-12 dated July 2021. The VA GLA Healthcare System Chief of Staff will update

SOP #116-ADM [administrative]-12 and the Chief of Mental Health will provide training to VA GLA Mental Health providers by December 1, 2022.

Communication and training of the updated SOP will be monitored monthly until compliance in training 90% or greater success is reached. Monitoring training data will be reported monthly to the Quality Executive Council (QEC).

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Lori Lohar, Director Karen Berthiaume, RPh, BS Erin Butler, LCSW Jonathan Ginsberg, JD Vanessa Masullo, MD Tanya Oberle, MSW, LCSW
Other Contributors	Elizabeth Bullock Alan Mallinger, MD Sarah Mainzer, JD, BSN Ryan McGovern Natalie Sadow, MBA

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, Desert Pacific Healthcare Network (10N22)
Director, Greater Los Angeles Healthcare System (691)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Accountability
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate:
Dianne Feinstein, Alex Padilla
U.S. House of Representatives:
Pete Aguilar, Nanette Barragán, Julia Brownley, Ken Calvert, Salud Carbajal, Tony Cárdenas, Judy Chu, Luis Correa, Mike Garcia, Robert Garcia, Jimmy Gomez, Sydney Kamlager, Young Kim, Ted Lieu, Kevin McCarthy, Grace Napolitano, Jay Obernolte, Jimmy Panetta, Katie Porter, Linda T. Sanchez, Adam Schiff, Brad Sherman, Michelle Steel, Mark Takano, Norma Torres, Maxine Waters

OIG reports are available at www.va.gov/oig.