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Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Allegation of Underutilization of Mental Health Clinics, and Concern for Delays in Patient Care, at the Hinesville VA Clinic in Georgia

Healthcare Inspection | **24-00704-21** | **December 17, 2024**

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to determine the validity of an allegation that select therapists do not maintain optimal utilization of individual mental health clinics at the Hinesville VA Clinic (Clinic) in Georgia, part of the Ralph H. Johnson VA Health Care System (facility) in Charleston, South Carolina.[1] In November 2023, the OIG received the allegation, which included patient case examples and an explanation that barriers related to the Clinic's Choose My Therapy (CMT) program and overall clinic processes resulted in patients not receiving care, timely care, or follow-up care.[2]

The OIG substantiated that the therapists' clinic utilization rates were not optimal. Clinic utilization in the Veterans Health Administration (VHA) represents the "[p]ercentage of actual clinic slots [appointments] used by patients."[3] Essentially, if available appointments are not utilized, patient access is limited. VHA requires clinic practice management that ensures resources, such as therapists, are used effectively to maximize patient access.[4] Clinical and administrative staff are required to review key metrics, such as clinic utilization, for continuous

[1] "About the Ralph H. Johnson VA Health Care System," VA Charleston Health Care, accessed December 5, 2023, https://www.va.gov/charleston-health-care/about-us/; The therapists provide individual psychotherapies, such as evidence-based psychotherapy. Evidence-based psychotherapies are consistently found to be effective treatment of symptoms for conditions such as depression, anxiety, and posttraumatic stress disorder; VHA Directive 1160.05, *Evidence-based Psychotherapies and Psychosocial Interventions for Mental and Behavioral Health Conditions,* June 2, 2021.

[2] "Choose My Therapy Workshop," Ralph H. Johnson VA Health Care System intranet site, accessed December 8, 2023, https://www.va.gov/files/2023-04/Choose%20My%20Therapy%20Workshop%20Packet_Hinesville.pdf. (This website is not publicly accessible). The CMT program is a two-session workshop designed to engage patients in mental health treatment through education of therapy options, such as individual psychotherapy, then matching patients to a therapy of the patients' choosing. The workshop is "not a long-term or standalone treatment but an entry into therapy."

[3] VHA Office of Integrated Veteran Care, "VHA Office of Integrated Veteran Care Clinic Profile Management Business Rules," updated May 24, 2023. The guidebook is located on a website not publicly accessible, is continually updated, and embedded into VHA Directive 1231(3), *Outpatient Clinic Practice Management*, October 18, 2019, amended July 19, 2022. This directive was rescinded and replaced by VHA Directive 1231(4), *Outpatient Clinic Practice Management*, October 18, 2019, amended February 7, 2024. Unless otherwise noted, the 2024 directive contains the same or similar language regarding principles and requirements for management of clinics. For the purposes of this report, the OIG refers to actual clinic utilization as clinic utilization, unless otherwise noted.

[4] VHA Directive 1231(3); VHA Directive 1231(4). VHA's Clinic Practice Management program "provides the framework for standardizing outpatient clinical practices across the VA healthcare system" to ensure "timely, high-quality outpatient care."

assessment of clinic performance, at minimum monthly.[5] VHA recommends facility leaders set a local target for clinic utilization and notes some facilities use a range from 80 to 120 percent.[6]

The OIG analyzed clinic utilization data of Clinic therapists who provided individual psychotherapy from January through December 2023, and found that the therapists generally had clinic utilization rates below VHA's lowest recommended target of 80 percent and that the section chief has overall responsibility to review key metrics, such as clinic utilization. Most of the therapists had median utilization rates below 70 percent, ranging from 32–68 percent. During interviews, the Clinic mental health section chief (section chief) acknowledged being aware of the low utilization rates since 2022 and indicated that complex scheduling processes resulted in utilization data that did not reflect the true workload of therapists. The section chief reported having made some changes to improve utilization but cited competing priorities as barriers to taking further action.

The OIG also found that patients experienced delayed access to mental health care. Timely access to mental health care is a priority for VHA as delayed initiation of mental health treatment, particularly for those with complex needs, may put patients at risk for negative outcomes.[7] VHA specifies that evidence-based psychotherapy appointments should be scheduled "on a weekly recurring basis."[8] The OIG analyzed data of 285 unique patients who received a diagnostic evaluation and found that patients experienced a median wait time of at least three weeks to the first, second, and third individual psychotherapy sessions. Essentially, following diagnostic evaluation, it took over nine weeks for patients to receive three individual psychotherapy sessions. Further analysis of the data showed a progressive loss of patients engaged in treatment. Specifically, 169 of the 285 patients (approximately 59 percent) did not continue to a third individual psychotherapy session and the OIG concluded that patient attrition may have been due to the delays of at least three weeks at each step.[9] The OIG identified that clinic practice management deficiencies, such as consult management and patient scheduling, contributed to delays in patients' access to mental health care at the Clinic.

Additionally, the OIG learned that Clinic mental health staff utilized a prohibited spreadsheet waitlist. VHA prohibits the "[u]se of [spreadsheets], paper lists, shared drives, calendars, logbooks, or other locations where patient information is recorded for tracking appointment

[5] VHA Directive 1231(3); VHA Directive 1231(4).

[6] VHA Office of Integrated Veteran Care, "VHA Office of Integrated Veteran Care Clinic Profile Management Business Rules." For the purposes of this report, the OIG considers clinic utilization as low for any clinic utilization rate below 80 percent.

[7] Sharon M Nelson et al., "Access to Timely Mental Health Care Treatment Initiation Among Veterans Health Administration Patients With and Without Serious Mental Illness," *Psychological Services* 19, no. 3 (June 3, 2021): 488-493, https://doi.org/10.1037/ser0000534.

[8] VHA Directive 1160.01.

[9] The OIG did not determine the specific factors causing patient attrition and acknowledges causes as multifactorial.

requests, including 'interest lists.'"[10] The OIG learned through interviews that therapists, during weekly therapist meetings, reviewed a spreadsheet with names of patients awaiting therapy. According to the section chief, the therapists used the spreadsheet to track patients because the patients did not have clinical consults in the electronic health records. The spreadsheet was discontinued in April 2023 when Clinic mental health staff implemented the use of clinical consults, which allowed staff to track patients. The OIG obtained a deleted spreadsheet and found that it reflected the described process to track patients' requests, as early as 2021, for therapy. Although the section chief said the practice of maintaining a spreadsheet was discontinued, the OIG questioned whether patients listed on the spreadsheet eventually received needed care.

The OIG made six recommendations addressed to the Facility Director related to ensuring optimal mental health clinic utilization, accurate use of current procedural terminology codes, consult management and patient scheduling processes, review of the patients who experienced a median wait time of at least three weeks between individual therapy sessions and who were listed on the discontinued waitlist, and evaluation of CMT programs operating in other facility locations.

VA Comments

The Veterans Integrated Service Network and Facility Directors concurred with recommendations 2, 3, 5, and 6 and concurred in principle with recommendations 1 and 4. Acceptable action plans were provided (see appendixes B and C). Based on information provided, the OIG considers recommendations 1, 4, and 6 closed. For the remaining open recommendations, the OIG will follow up on the planned actions until they are completed.

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

[10] Deputy Under Secretary for Health for Operations and Management, "Electronic Wait List Reminder for All Clinics," memorandum to Network Directors, October 20, 2017.

Contents

Abbreviations

CMT	Choose My Therapy
CPT	current procedural terminology
EBP	evidence-based 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 determine the validity of an allegation that five therapists do not maintain optimal utilization of individual mental health clinics at the Hinesville VA Clinic (Clinic) in Georgia, part of the Ralph H. Johnson VA Health Care System (facility) in Charleston, South Carolina.[1] Additionally, the OIG identified delays in mental health care at the Clinic.

Background

The facility is part of Veterans Integrated Service Network (VISN) 7. In addition to the Clinic, the facility operates clinics in North Charleston, Beaufort, Goose Creek, and Myrtle Beach, South Carolina; and Brunswick and Savannah, Georgia.[2]

The Clinic provides outpatient services in primary care and mental health. Mental health services include evaluation and treatment of depression, anxiety, post-traumatic stress disorder, personality disorders, addictive behaviors, and relationship problems. Mental health treatment is provided through medication management and individual or group therapy.[3] Therapists provide treatment such as evidence-based psychotherapies (EBPs) that have been consistently found to be effective in the treatment of symptoms for conditions such as depression, anxiety, and post-traumatic stress disorder.[4]

Choose My Therapy

Veterans Health Administration (VHA) policy specifies that therapists and patients should participate in a shared decision-making model to identify which evidence-based treatment options meet patients' treatment goals.[5] Choose My Therapy (CMT) is a program designed to

[1] "About the Ralph H. Johnson VA Health Care System," VA Charleston Health Care, accessed December 5, 2023, https://www.va.gov/charleston-health-care/about-us/; The five therapists include four clinical psychologists and one clinical social worker; all are healthcare providers from the Clinic's General Mental Health (GMH) clinic. For the purposes of this report, the OIG uses the term *therapists* in lieu of *providers* unless otherwise noted.

[2] "About the Ralph H. Johnson VA Health Care System," VA Charleston Health Care, accessed December 5, 2023, https://www.va.gov/charleston-health-care/about-us/.

[3] "Hinesville VA Clinic," VA Charleston Health Care, accessed December 18, 2023, https://www.va.gov/charleston-health-care/locations/hinesville-va-clinic/.

[4] *Mayo Clinic*, "psychotherapy," accessed April 8, 2024, https://www.mayoclinic.org/tests-procedures/psychotherapy/about/pac-20384616. Psychotherapy is a treatment option for mental health issues that involves talking with a mental health provider (therapist) to gain insight to specific symptoms and learn coping skills to respond to challenging situations; VHA Directive 1160.05, *Evidence-based Psychotherapies and Psychosocial Interventions for Mental and Behavioral Health Conditions*, June 2 2021; The section chief of mental health reported that therapists are permitted to telework to provide treatment virtually.

[5] VHA Directive 1160.05.

engage patients in mental health treatment through education of therapy options, such as EBPs, then matching patients to a therapy of the patients' choosing.[6]

Allegation and Related Concerns

In early November 2023, the OIG received an allegation and patient case examples of mental health clinic underutilization due to the CMT program creating a barrier to receiving treatment, and overall clinic processes resulting in patients not getting care, timely care, or follow-up.[7] After reviewing the allegation and patient cases, the OIG noted inefficient use of the mental health clinics resulting in delayed patient care related to the CMT program.

In early December 2023, the OIG opened a healthcare inspection to evaluate the mental health clinic access allegation and OIG-identified concerns related to consult management and scheduling practices as factors related to delayed patient care.

Scope and Methodology

The OIG initiated the inspection on December 11, 2023, and conducted virtual interviews from January 18 through March 14, 2024. To clarify the allegations, the OIG virtually interviewed the complainant. The OIG also interviewed Clinic mental health clinical and administrative staff, as well as leaders from the Clinic and facility. Additionally, the OIG corresponded with the VISN 7 chief mental health officer.

The OIG reviewed relevant VHA and facility policies pertaining to clinical practice management and clinic utilization; scheduling and consult management; the CMT program; and mental health care access. Additionally, the OIG reviewed the electronic health records of 14 patients, provided by the complainant as case examples.

The OIG also reviewed clinic utilization data of seven Clinic therapists (the therapists) who provide EBP, including the five therapists described in the allegations, from January through December 2023.[8] To determine mental health clinic utilization rates, the OIG reviewed therapist-

[6] "Choose My Therapy Workshop," Ralph H. Johnson VA Health Care System intranet site, accessed December 8, 2023, https://www.va.gov/files/2023-04/Choose%20My%20Therapy%20Workshop%20Packet_Hinesville.pdf. (This website is not publicly accessible). CMT is a two-session workshop designed to streamline the therapy referral process and provide patients with education on therapy options, encouragement, and motivation. The workshop "is not a long-term or standalone treatment but an entry into therapy."

[7] The complaint included three patient case examples. During the inspection, the complainant provided the OIG team with 11 additional examples, for a total of 14 patient case examples.

[8] The seven therapists include the five therapists and, for comparison, two additional therapists who provide EBP at the Clinic. Of note, the OIG did not include clinic utilization data for one therapist who reported providing EBP as of October 2023.

specific utilization data from VHA's Clinic Utilization Statistical Summary Reports.[9] Using individual mental health care clinics, the OIG examined actual clinic utilization (clinic utilization) rates for each therapist.[10]

To determine the days elapsed between initial diagnostic evaluations and the start of individual psychotherapy, such as EBP, the OIG obtained a list of the facility's EBP therapists, including the therapists, and analyzed patients' diagnostic and psychotherapy appointments (sessions) data compiled from VA's Corporate Data Warehouse. The OIG identified patients who had initial diagnostic evaluations that were medically justified, from October 1, 2022, through September 30, 2023. After identifying the patients, the OIG compiled the dates of each patient's first three individual psychotherapy sessions [i.e., sessions coded as individual psychotherapy using current procedural terminology (CPT) codes] through April 11, 2024.[11] Patients may have received diagnostic evaluations or subsequent psychotherapy sessions by the same or multiple providers. The number of days between the initial diagnostic evaluation and subsequent first, second, and third CPT-coded psychotherapy sessions was then calculated to determine the corresponding elapsed time intervals for each patient.[12] The OIG also noted when patients did not continue

[9] "Clinic Utilization Dashboard," Power BI VSSC Access Team, accessed February 15, 2024, https://app.powerbigov.us/groups/me/apps/057a6693-7190-4fd4-9491-f8a038913689/reports/70332590-e0b9-445d-a014-81bbc410b497/ReportSectionfe1e32a2efea11b87c4e?ctid=e95f1b23-abaf-45ee-821d-b7ab251ab3bf. (This website is not publicly accessible.); "VHA Support Service Center," VHA Office of Quality and Patient Safety, accessed March 14, 2024, https://vaww.qps.med.va.gov/divisions/api/vssc/vsscDefault.aspx. (This website is not publicly accessible.) The Clinic Utilization Statistical Summary report is a tool used to track past and future appointment slots as a method to monitor clinic capacity on an ongoing basis. This report is from the VHA Support Service Center (VSSC) report hub, which provides analytical information that impacts care.

[10] VHA's individual mental health care clinic code is stop code 502. A stop code defines the clinical group responsible for the care. VHA Managerial Cost Accounting Office, "VistA Stop Codes Instructional Guide," revised May 2024; Acting Deputy Under Secretary for Health for Operations and Management, "Updated Stop Codes Used for 20 Day Wait Time Access Standard," memorandum to Veterans Integrated Service Network Directors (10N1-23) and et al., August 8, 2019. The guidebook is located on a website not publicly accessible, is continually updated, and embedded into VHA Directive 1231(3), *Outpatient Clinic Practice Management*, October 18, 2019, amended July 19, 2022. This directive was rescinded and replaced by VHA Directive 1231(4), *Outpatient Clinic Practice Management*, October 18, 2019, amended February 7, 2024. Unless otherwise noted, the 2024 directive contains the same or similar language regarding principles and requirements for management of clinics; VHA Office of Integrated Veteran Care, "VHA Office of Integrated Veteran Care Clinic Profile Management Business Rules," updated May 24, 2023. For the purposes of this report, the OIG refers to actual clinic utilization as clinic utilization, unless otherwise noted.

[11] CPT codes used for the data were 90791 and 90792 for initial diagnostic evaluations and 90832, 90833, 90834, 90836, 90837, and 90838 for individual psychotherapy sessions. "CPT Overview and Code Approval," American Medical Association, accessed March 28, 2024, https://www.ama-assn.org/practice-management/cpt/cpt-overview-and-code-approval. CPT code is a widely accepted uniform language used to report evaluation and management services. Each code uses common standards, so users have a common understanding of the services provided.

[12] The OIG acknowledges that treatment planning may take more than one session and, therefore, selected to review data for the second and third psychotherapy sessions; however, for the purposes of this report, the OIG defines the start of psychotherapy treatment as the second psychotherapy-coded session following diagnostic evaluation.

psychotherapy after the first or second psychotherapy sessions. Additionally, the OIG recovered and reviewed a Clinic spreadsheet of patients requesting EBP.

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, as amended, 5 U.S.C. §§ 401–424. 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.

Inspection Results

1. Underutilization of Mental Health Clinics

The OIG substantiated that the therapists' clinic utilization rates were not optimal. The OIG found that the therapists generally had clinic utilization rates below VHA's lowest recommended target of 80 percent and that the section chief had overall responsibility to review key metrics, such as clinic utilization. Specifically, six of the seven therapists had median utilization rates below 70 percent, ranging from 32–68 percent (see figure 1).

According to VHA, clinic utilization data is a metric that can provide insight to supply and demand for services, and analysis of this data can "identify potential barriers and, more importantly, trend improvements."[13] Clinic utilization represents the "[p]ercentage of actual clinic slots [appointments] used by patients," accounting for cancellations and measures if the

[13] VHA Office of Integrated Veteran Care, "VHA Office of Integrated Veteran Care Clinic Profile Management Business Rules." For this report, the OIG reviewed clinics that represent individual mental health care provided by each Clinic therapist. VHA's initiative to review clinic utilization began in July 2017 and additional initiatives to improve access that focused on measures other than clinic utilization began in June 2018.

clinic has kept up with the demand of patient appointments.[14] Essentially, if available appointments are not utilized, patient access is limited.

For clinic utilization data to reflect "true clinic access," clinic profiles must be accurate.[15] A clinic profile sets capacity for the clinic, defining scheduling parameters for the therapist's available appointments. To represent true clinic capacity, the therapist's clinic profile should have the number of slots equal to the exact number of hours per week designated to patient care, accounting for all appointments available. Management of clinic profiles is essential to ensure consistent utilization of resources, such as appointments, to improve patient access.[16]

VHA requires clinic practice management that ensures resources, such as therapists, are used effectively to maximize patient access.[17] Clinical leads have "overall responsibility for clinical functions."[18] Clinical and administrative staff are required to review key metrics, such as clinic utilization, for continuous assessment of clinic performance, at minimum monthly.[19] VHA recommends facility leaders set a local target for clinic utilization and notes some facilities use a range from 80 to 120 percent.[20] "Utilization that is too high or too low signals the need for additional review and modification."[21] Figure 1 shows the median of the average monthly clinic utilization rates of the therapists.

[14] VHA Office of Integrated Veteran Care, "VHA Office of Integrated Veteran Care Clinic Profile Management Business Rules." For the purposes of this report, the OIG uses the term slots to refer to appointments in reference to clinic utilization.

[15] VHA Office of Integrated Veteran Care, "VHA Office of Integrated Veteran Care Clinic Profile Management Business Rules."

[16] VHA Office of Integrated Veteran Care, "VHA Office of Integrated Veteran Care Clinic Profile Management Business Rules." Although each clinic profile has no more than one therapist, therapists may have several clinic profiles to represent each modality of care they provide, such as in-person or virtual care clinics.

[17] VHA Directive 1231(3); VHA Directive 1231(4). VHA's Clinic Practice Management program "provides the framework for standardizing outpatient clinical practices across the VA healthcare system" to ensure "timely, high-quality outpatient care."

[18] VHA Directive 1231(3); VHA Directive 1231(4).

[19] VHA Directive 1231(3); VHA Directive 1231(4).

[20] VHA Office of Integrated Veteran Care, "VHA Office of Integrated Veteran Care Clinic Profile Management Business Rules." For the purposes of this report, the OIG considers clinic utilization as low for any clinic utilization rate below 80 percent.

[21] VHA Office of Integrated Veteran Care, "VHA Office of Integrated Veteran Care Clinic Profile Management Business Rules."

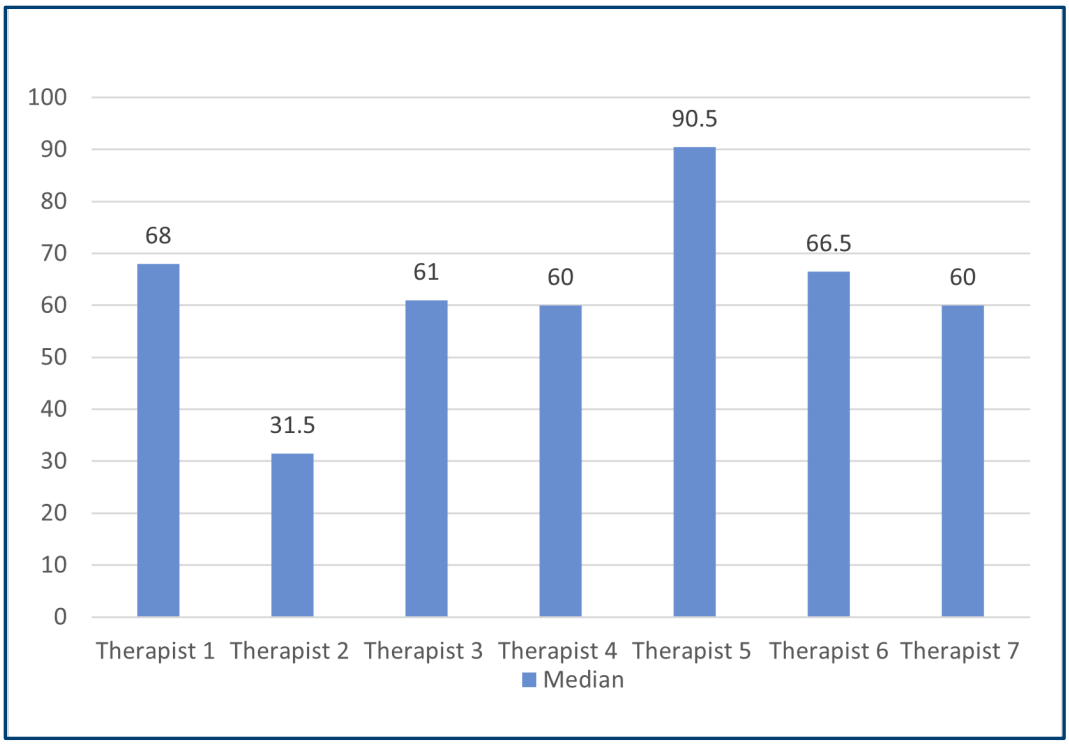

Figure 1. *Median of the average monthly actual clinic utilization rate by therapist from January 2023 through December 2023.*
Source: OIG analysis of VHA Support Service Center Access Team data of actual clinic utilization, by therapist, at the Clinic for individual patient care. Specifically, the median value for the months from January through December 2023. A median represents the point in the middle where there is the same number of instances above and below.[22]
Note: The above clinic utilization rates represent all of the therapists' clinic profiles except group therapies.

One therapist met the target of 80 to 120 percent utilization each month except in the last three months of the year. Of the remaining therapists,

- three never met the target,
- two met the target for one month, and
- one met the target for three months (see figure 2).

[22] *Merriam-Webster.com Dictionary,* "median," accessed April 29, 2024, https://www.merriam-webster.com/dictionary/median.

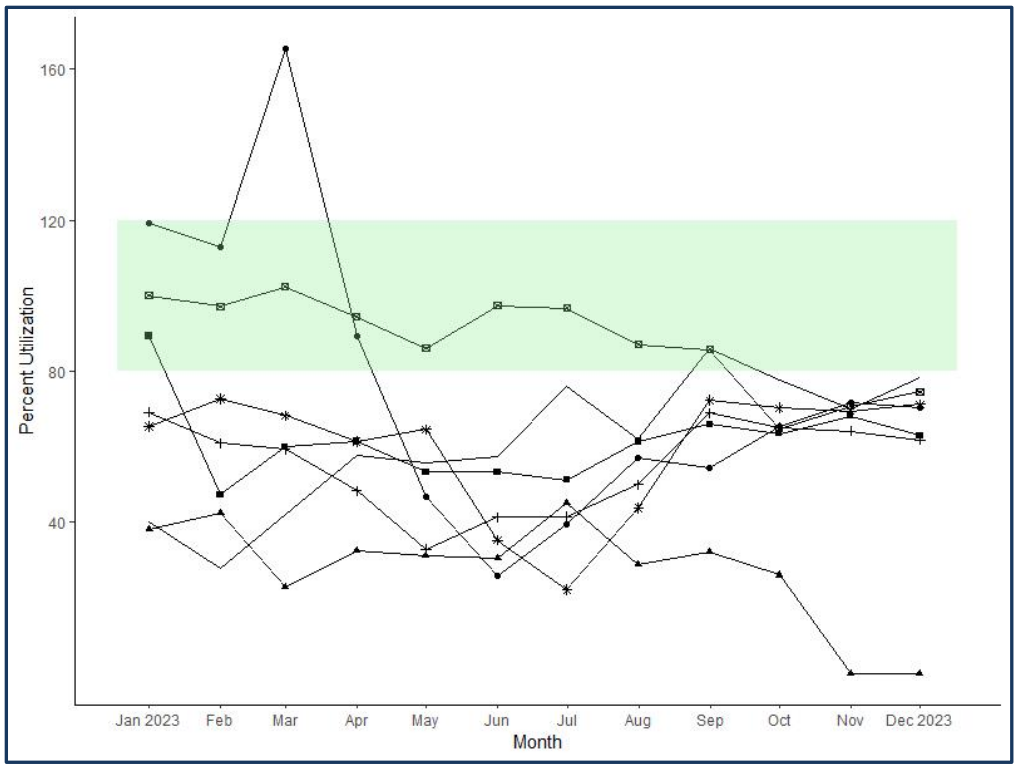

Figure 2. *Monthly clinic utilization percentage by therapist from January through December 2023.*
Source: OIG analysis of VHA Support Service Center Access Team data of actual clinic utilization, by therapist, at the Clinic for individual patient care from January 2023 through December 2023.
Note: Zero values in November and December 2023 indicate therapy was not provided and the OIG did not consider these months in the analysis of clinic utilization data. Additionally, clinic utilization rates represent all of the therapists' clinic profiles except group therapies.

The OIG found that mental health leaders made efforts to address low utilization through clinic profile modifications.

- In an April 2023 email, facility mental health leaders asked mental health section chiefs to review utilization, focusing on scheduled utilization less than 85 percent, to identify clinics in need of modification and issues with patient access.[23]

[23] Facility mental health leaders included the former chief of mental health and the assistant chief of mental health. At the time of this communication and according to facility correspondence, the former chief of mental health held the role officially and left the facility on June 29, 2024. The division chief of inpatient and acute mental health services took on additional duties to assist with assistant chief of mental health duties then officially began the role in August 2023. The former chief of mental health added that if there are issues with patients getting timely access to care then "utilization should be upwards to 90 [percent]."

- In May 2023, the Clinic mental health section chief (the section chief) confirmed completion of clinic modifications, such as the deletion of unused therapists' clinics and clinic slots (appointments) to more accurately reflect true capacity, to the former chief of mental health.

However, clinic utilization rates did not improve, and by late August 2023, the section chief's former acting supervisor sent an email to the section chief in which the former chief of mental health stated, "access for therapy appointments in [the Clinic] is worsening" and "what I can tell right now is that in the next week, there are 45 open slots." The former chief of mental health told the OIG that as a result, subsequent EBP intake appointments were scheduled "based on the [patient's] needs and the [patient's] desires," and the former chief of mental health would not require in-person appointments as the section chief had requested.

When asked about the low clinic utilization rates, the section chief told the OIG that it had been a "legitimate" concern going back to 2022, relating to EBP clinics. According to the section chief, each therapist had five clinics (one for each treatment modality), rather than the usual three clinics for face-to-face, virtual, and telephone appointments as described by the VISN chief mental health officer. The section chief told the OIG this arrangement resulted in complex scheduling processes and utilization data that did not reflect the true workload of therapists or an accurate account of patient appointments as they occurred.[24] To streamline the process and resolve the scheduling errors, the section chief reported closing (eliminating) some of the EBP clinics in fall 2023. When asked why clinics were not closed until fall 2023, the section chief noted having limited time to devote to this "time intensive process" due to competing priorities.[25]

The deputy director of quality management told the OIG a local target was not set in efforts to minimize layers of policies and leaders adhere to national guidance instead. The OIG found that most of the therapists were unaware of, uncertain about, or did not understand the facility's clinic utilization target. For example, one therapist believed to have met optimal clinic utilization "because I'm booking up like every single slot that I have." However, the therapist's clinic utilization was only within the range of 80 to 120 percent for 3 of the 12 months.

[24] If a therapist has additional clinic slots, in excess to what can be provided, clinic utilization rates will look lower than it is. For example, a therapist's clinic capacity is to see 30 patients per week. If the clinics are set up with 30 slots (appointments) and the therapist sees 25 patients, the clinic utilization rate is approximately 83 percent. However, if a therapist's clinics have 40 slots, 10 more than the therapist can provide, the clinic utilization rate is lower at roughly 63 percent.

[25] Of note, the section chief told the OIG, in an email communication two months following initial interviews, "I don't concede that utilization was low prior [in 2022]." The section chief added, utilization was not measurable and is only a method to determine how hard therapists are working.

The OIG found that VISN and facility leaders do not require monitoring or reporting of clinic utilization by policy but expect the use of the data to address patient access issues.[26] The facility chief of staff explained that although facility review of clinic utilization began in spring 2023, service chiefs were expected to monitor the data to ensure required clinic practice management. The former chief of mental health reported that although section chiefs were provided training on and encouraged to review clinic utilization, "[t]his is an informal process" and reviews were not "on a set schedule."

The OIG concluded that the clinic utilization rates of therapists at the Clinic were consistently low. Although the facility does not require regular monitoring of clinic utilization, the OIG would have expected the section chief to review actual clinic utilization as a part of ongoing clinic practice management to assess clinic functions and make changes, as necessary, to maximize patient access.

2. Delayed Access to Mental Health Care

The OIG reviewed the patient case examples and found that patients experienced delayed access to mental health care. One of the patients exhibited suicidal behavior, a serious negative outcome; however, the OIG determined that the serious negative outcome was unrelated to delayed access to mental health care.[27]

Timely access to mental health care is a priority for VHA as delayed initiation of mental health treatment, particularly for those with complex needs, may put patients at risk for negative outcomes.[28] VHA recognizes "mental health care [as] an essential component of overall health

[26] The VISN and facility leaders that communicated and were interviewed by the OIG represent the VISN chief mental health officer and the facility Chiefs of Staff and mental health. The VISN chief mental health officer added that "the VISN does not routinely monitor [u]tilization data."

[27] For this report, the OIG defined serious negative outcome as mental health hospitalization or suicidal behavior documented in a Suicidal Behavior and Overdose Report or a Comprehensive Suicide Risk Evaluation during an interval up to one calendar year from initial engagement in a mental health clinic: VHA Directive 1160.07, *Suicide Prevention Program*, May 24, 2021. The Suicidal Behavior and Overdose Report or a Comprehensive Suicide Risk Evaluation are VHA-standardized reporting templates in patient electronic health records used to "facilitate national surveillance efforts" and to alert staff such as the suicide prevention team to review patients following a suicidal intent-related event. The patient's suicidal behavior was in the form of preparation for a suicide attempt that was interrupted by a family member.

[28] Sharon M Nelson et al., "Access to Timely Mental Health Care Treatment Initiation Among Veterans Health Administration Patients With and Without Serious Mental Illness," *Psychological Services* 19, no. 3 (June 3, 2021): 488-493, https://doi.org/10.1037/ser0000534.

care" and organizes mental health services "across a continuum of care" that "must promote timely and effective treatment."[29]

If patients' mental health treatment requires a series of appointments on a recurring basis, as is the case with EBP, VHA defines timely access based on the first appointment date. VHA outlines that subsequent EBP appointments should be scheduled "on a weekly recurring basis" and in accordance with the appropriate clinical timing based upon the intervention.[30]

During interviews, Clinic therapists reported using two groups of CPT codes when providing EBP: one for initial diagnostic evaluations and the other, psychotherapy-specific CPT codes, for EBP sessions. However, one therapist told the OIG of having used a psychotherapy-specific CPT code for diagnostic evaluations as well as EBP sessions. Therefore, the OIG excluded this therapist in the following data analysis as the therapist's patients would be unidentifiable through the data.[31]

The OIG analyzed data of 285 unique patients who received a diagnostic evaluation and found that patients experienced a median wait time of at least three weeks for subsequent CPT-coded psychotherapy sessions. The OIG found the following:

- A median time of 25 days from diagnostic evaluation to the first CPT-coded psychotherapy session, which therapists told the OIG was generally used for treatment planning prior to beginning actual psychotherapy.[32] Wait times ranged from 3 to 473 days, with 25 percent of patients waiting longer than 53 days.
- A median time of 23 days from the treatment planning session described above to the second CPT-coded psychotherapy session. Wait times ranged from 1 to 418 days with 25 percent of patients waiting longer than 52 days.

[29] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics,* September 11, 2008*,* amended November 16, 2015, rescinded and replaced by VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*, April 27, 2023. The VHA Directive has expanded content related to continuum of care not previously outlined in the handbook.

[30] VHA Handbook 1160.01; VHA Directive 1160.01. The VHA Directive has expanded content related to frequency of appointments not previously outlined in the handbook.

[31] VHA Directive 1907.01(1), *VHA Health Information Management and Health Records,* April 5, 2021, amended December 11, 2023. Therapists are responsible for completing encounter information such as CPT codes associated with service(s) provided to maintain an accurate record of patient care. Of note, the excluded therapist saw a total of 107 unique patients from October 1, 2022, through April 11, 2024, using individual psychotherapy CPT codes.

[32] During interviews, therapists explained the typical order of the treatment implementation process at the Clinic was to complete a diagnostic evaluation and then a treatment planning session (using a psychotherapy CPT code), followed by psychotherapy.

- A median time of 21 days from the second to the third CPT-coded psychotherapy session. Wait times ranged from 3 to 230 days with 25 percent of patients waiting longer than 42 days.

The median wait time from the diagnostic evaluation to the second CPT-coded psychotherapy session, when patients would generally start receiving psychotherapy, was 60 days. Additionally, the median wait time between the second and third CPT-coded psychotherapy sessions was three weeks, which is longer than VHA's weekly expectation for subsequent EBP sessions.

Patient Attrition Concerns

The OIG found a progressive loss of patients engaged in treatment. Overall, 169 of 285 patients (approximately 59 percent) did not continue to a third CPT-coded psychotherapy session.[33] See figure 3 for further details.

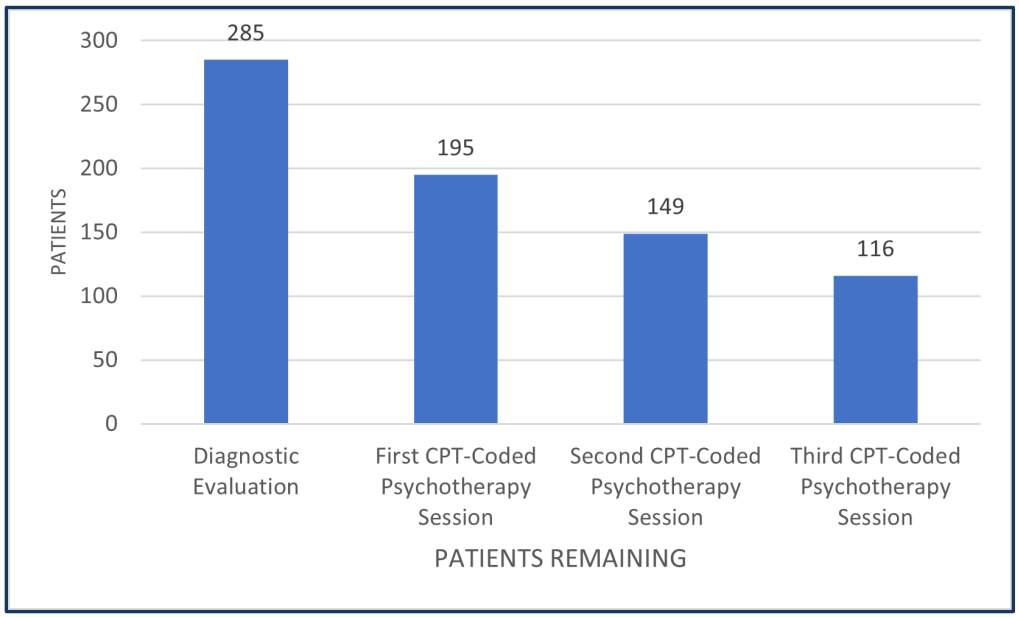

Figure 3. *Patients remaining after diagnostic evaluation.*
Source: OIG analysis of the number of patients at the diagnostic and treatment planning and subsequent psychotherapy-coded sessions as provided by Clinic therapists from October 1, 2022, through April 11, 2024.

Patients, after diagnostic evaluation, could go on to treatments other than individual psychotherapy, such as group psychotherapy. Thus, the OIG reviewed both individual and group

[33] The OIG did not determine the specific factors causing patient attrition and acknowledges causes as multifactorial.

psychotherapy sessions during this time frame and found 24 more patients, for a total of 219.[34] For this group of patients, the median wait time from the diagnostic evaluation to the second CPT-coded psychotherapy session, when patients would generally start receiving psychotherapy, was 42 days. See Appendix A for additional information.[35]

The OIG concluded that patients experienced delays in mental health care. Specifically, a median wait time of at least three weeks for each step between diagnostic evaluation and the third CPT-coded psychotherapy sessions, which is a deviation from VHA's expectation of weekly intervals for EBP and may have been a factor in the high rate of patient attrition. Additionally, the OIG found one therapist misused a psychotherapy-specific CPT code for diagnostic evaluations, which prevents accurate records of patient care and may inhibit clinical leaders' ability to improve access to care through review of patient data.

Contributing Factors to Delays in Patient Access to Mental Health Care

The OIG identified that deficiencies in clinic practice management, such as consult management and patient scheduling, contributed to delays in patients' access to mental health care at the Clinic. The OIG reviewed patient case examples and found that Clinic staff did not utilize clinical consults for CMT (a two-session workshop designed to streamline referrals to therapy, such as EBP), which precluded minimum scheduling efforts as required.[36]

VHA ensures timely and clinically appropriate care to patients by managing and standardizing consult and scheduling processes.[37] There are different types of consults, including an administrative consult and a clinical consult.[38] VHA policy states that if a patient requires additional treatment, such as EBP, a clinical consult must be entered.[39] Through clinical consults, patients are scheduled for appointments; VHA requires minimum scheduling efforts to ensure that patient appointments are managed safely and timely.[40] Minimum scheduling efforts require at least four contact attempts when scheduling or rescheduling a patient's mental health

[34] Through document review, the OIG learned that Clinic mental health providers variously code Choose My Therapy as group therapy, a psychoeducational session, or a stress management class.

[35] Underlined terms are hyperlinks to another section of the report. To return to the point of origin, press and hold the "alt" and "left arrow" keys together.

[36] "Choose My Therapy Workshop," Ralph H. Johnson VA Health Care System.

[37] VHA Directive 1232(5), *Consult Processes and Procedures,* August 24, 2016, amended December 5, 2022. A consult is a "request for clinical services on behalf of a patient" made in the patient's electronic health record.

[38] VHA Directive 1232(5). Administrative consults should not be used to schedule clinical care.

[39] VHA Office of Integrated Veteran Care, "VHA Consult Use for Established Patients in Mental Health Standard Operating Procedure," last updated December 16, 2022.

[40] VHA Directive 1230, *Outpatient Scheduling Management,* June 1, 2022.

appointment, such as if a patient cancels or no-shows, or the provider's clinic appointments are canceled.[41]

According to the former facility chief of mental health service and the section chief, the CMT program started in November 2019, following the VISN's 2018 call for volunteers to participate in a national project on shared decision-making. The CMT program is two educational sessions for patients, occurring weekly on a set day and time, designed to "efficiently match veterans with the therapy of their choosing" and per the section chief, functioned as an entry point to therapy.[42] The section chief also explained CMT was not a stand-alone or long-term treatment, and no scheduled appointments were created for the two CMT sessions.

The former chief of mental health reported that the CMT administrative consult process was developed to generate appointment links, allowing patients to attend CMT educational sessions virtually during the COVID pandemic. [43] The section chief directed Clinic clinicians to use administrative consults from March 2022 until April 2023, to send patients to the CMT program after assessing their need for therapy:

- The former chief of mental health explained that if patients attended a session, staff marked consults as completed; if patients did not attend a session, staff marked consults as canceled.
- The section chief described via email that following completion of the CMT program (both sessions and a written assignment), staff made one phone call to patients to determine their choice of therapy.[44]

Per documentation from the section chief, if a patient did not complete any one of the CMT program elements, such as the written assignment, or missed the phone call, the patient was "returned to the referring provider."[45] The section chief confirmed that minimum scheduling efforts were not followed for patients in CMT.

[41] VHA Office of Integrated Veteran Care, "Minimum Scheduling Effort for Outpatient Appointments Standard Operating Procedure (SOP)," last updated July 28, 2022.

[42] "Choose My Therapy Workshop," Ralph H. Johnson VA Health Care System.

[43] VHA Office of Integrated Veteran Care, "Consult Business Rules and Uses of the Consult Package Standard Operating Procedure," last updated June 1, 2023. Administrative consults should not be used as scheduling orders or to request patient appointments as administrative consults are not included in patient access data related to consult timeliness, which is monitored by VHA. VHA Directive 1232(5).

[44] The patient writing assignment for CMT consisted of a one-page worksheet with three questions related to patients' therapy goals. "Choose My Therapy Workshop," Ralph H. Johnson VA Health Care System.

[45] The OIG found that regardless of the amount of time between or the reason for not completing CMT elements, such as the written assignment, patients either were returned to the referring provider or did not receive follow-up.

The OIG reviewed patient examples provided by the complainant. The OIG reviewed the electronic health records and found two patients experienced approximately four and six-month delays of therapy intake and one patient did not receive follow-up.

- One patient had a CMT consult placed in early spring 2023 but did not attend the first CMT session one week later. Another CMT consult was placed over three months later in midsummer 2023;however, the CMT session was canceled due to staffing and the patient did not attend the make-up CMT session two weeks later. After CMT opportunities failed, the referring provider placed a consult late summer 2023, for the patient to receive a psychotherapy evaluation, which occurred the following month.
- A second patient had a CMT consult placed in midspring 2023. The patient attended CMT session one two days later and session two two weeks later. Because the patient did not complete the CMT written assignment, the patient was referred back to the provider who had placed the CMT consult. The patient presented to the Clinic early summer 2023 as a walk-in with the completed CMT written assignment. The provider placed a consult for psychotherapy five days later. Ultimately, the patient completed two diagnostic evaluation appointments two weeks apart in late summer 2023.
- A third patient had a CMT consult placed in early summer 2023. The patient did not attend the scheduled CMT session two weeks later, resulting in a canceled consult. As of spring 2024, the OIG did not find documentation from Clinic staff in the electronic health record to indicate follow-up with the patient's interest in therapy occurred, after the patient did not attend the first session of CMT.

Of note, email communications showed a Clinic staff member expressed concerns about the CMT process to the section chief in June 2023, which the section chief acknowledged, and considered discontinuing CMT. The former chief of mental health told the OIG of becoming first aware of concerns regarding CMT in September 2023 and started a review of CMT processes with the section chief. The former chief of mental health determined that CMT was not working as intended, and the decision to halt the program until effective ways to operate could be established, such as scheduled consults and patient follow-up.[46]

The OIG concluded that clinic practice management deficiencies, such as the use of administrative consults and the lack of minimum scheduling efforts through CMT, contributed to delayed initiation of EBP and created a barrier to optimizing patient access and experience,

[46] The OIG learned from email communications from the section chief to Clinic staff that the last date for patients to start the CMT program was September 21, 2023.

which did not prioritize mental health care as required by VHA. Utilization of clinical consults and minimum scheduling efforts would have likely improved patient engagement.

3. Additional Concern: Follow-Up Care of Patients on a Prohibited Wait List

The OIG learned that in April 2023, Clinic mental health staff implemented the use of clinical consults through the CMT program, which allowed staff to track patients awaiting EBP.[47] However, the OIG found that prior to the use of the clinical consult, therapists tracked patients waiting to start EBP therapy utilizing a prohibited spreadsheet.

VHA prohibits the "[u]se of [spreadsheets], paper lists, shared drives, calendars, log books, or other locations where patient information is recorded for tracking appointment requests, including 'interest lists'."[48]

According to therapists and the section chief, therapists met weekly to discuss and assign a therapist to patients who had completed CMT and requested EBP. During these weekly therapist meetings, therapists reviewed a spreadsheet with names of patients awaiting therapy and determined which therapist had availability to work with each of the patients.[49] The section chief told the OIG that the therapists developed the process of using the spreadsheet to track patients because the patients did not have clinical consults in the electronic health records.

The section chief told the OIG that, as of April 2023, the spreadsheet was no longer used, and patients' care requests were tracked through clinical consults.[50] Therapists also reported that the spreadsheet was no longer used once the process changed to placing consults for the patients. The OIG obtained a deleted spreadsheet and found that it reflected the described process to track patients' requests for EBPs and noted patients dating back to 2021.

The OIG concluded that when patients completed CMT, the section chief did not require therapists to place clinical consults for EBP until April 2023 and allowed the use of a prohibited wait list. Although the spreadsheet was reported as no longer in use as of April 2023, the OIG

[47] VHA Directive 1232(5). A clinical consult is a document in a patient's electronic health record, "used as two-way communication on behalf of a patient consisting of a physician or provider (sender) request seeking opinion, advice, or expertise regarding evaluation or management of a specific problem answered by a physician or other health care provider (receiver)."

[48] Deputy Under Secretary for Health for Operations and Management, "Electronic Wait List Reminder for All Clinics," memorandum to Network Directors, October 20, 2017.

[49] Therapists told the OIG of using the electronic spreadsheet, stored in a shared location on an electronic messaging platform, for work collaboration. The section chief reported never having accessed the spreadsheet, despite having knowledge of it.

[50] The therapists informed the OIG that the spreadsheet was deleted; however, the majority of therapists could not recall when. The OIG noted that most patient names were removed from the spreadsheet on September 8, 2023.

questions whether patients on the spreadsheet received care as requested while the previous process was in place.

Conclusion

The OIG substantiated that the therapists' clinic utilization rates were not optimal. While VHA's lowest recommended target is 80 percent, most of the therapists had low median clinic utilization rates ranging from 32–68 percent. The section chief had been aware of the low utilization rates but cited competing priorities as barriers to taking timely and effective interventions.

The OIG analyzed data of 285 patients who received a diagnostic evaluation and found that the patients experienced delayed access to mental health care. Specifically, a median wait time of at least three weeks between subsequent CPT-coded psychotherapy sessions, which exceeded VHA's expectation of weekly treatment intervals. Moreover, only 116 of the 285 patients remained by the third CPT-coded psychotherapy session, reflecting an approximate 59 percent patient attrition rate. Deficiencies in clinic practice management, such as consult management and patient scheduling, contributed to the delays.

Additionally, Clinic mental health staff utilized a prohibited electronic spreadsheet waitlist to track patients awaiting EBP therapy. Although the spreadsheet was discontinued in April 2023, the OIG questioned whether patients on the spreadsheet eventually received care.

Recommendations 1–6

1. The Ralph H. Johnson VA Health Care System Director ensures optimal mental health clinic utilization at the Hinesville VA Clinic.
2. The Ralph H. Johnson VA Health Care System Director ensures that mental health Hinesville VA Clinic staff are using accurate current procedural terminology codes to document services provided to patients in the electronic medical record.
3. The Ralph H. Johnson VA Health Care System Director confirms evaluation of administrative processes to include consult management and patient scheduling within the mental health service at the Hinesville VA Clinic and takes action as necessary to optimize patient access and experience.
4. The Ralph H. Johnson VA Health Care System Director completes a review of the patients identified by the Office of Inspector General to have experienced a median wait time of at least three weeks between individual therapy sessions and takes action to resolve any patient care concerns identified during the review.
5. The Ralph H. Johnson VA Health Care System Director considers evaluating the Choose My Therapy program at other system sites for clinic practice management deficiencies and takes action as appropriate.

6. The Ralph H. Johnson VA Health Care System Director ensures that all patients listed in the electronic spreadsheet have received mental health follow-up care.

Appendix A: Median Wait Times and Patient Attrition for Patients Receiving Individual or Group Psychotherapy

The OIG analyzed data of 285 unique patients who received a diagnostic evaluation and found that patients experienced a median wait time of approximately two-and-a-half to three weeks for subsequent CPT-coded individual or group psychotherapy sessions.

- A median time of 18 days from diagnostic evaluation to the first CPT-coded psychotherapy session, which therapists told the OIG was generally used for treatment planning prior to beginning actual psychotherapy.[51] Wait times ranged from 1 to 473 days, with 25 percent of patients waiting longer than 42 days.
- A median time of 21 days from the first to the second CPT-coded psychotherapy session. Wait times ranged from 1 to 378 days with 25 percent of patients waiting longer than 41 days.
- A median time of 21 days from the second to the third CPT-coded psychotherapy session. Wait times ranged from 1 to 230 days with 25 percent of patients waiting longer than 42 days.

The OIG also found a progressive loss of patients engaged in treatment. Overall, 162 of 285 patients (57 percent) did not continue to the third CPT-coded psychotherapy session.[52] See figure A.1. for further details.

[51] During interviews, therapists explained the typical order of the treatment implementation process at the Clinic as completion of a diagnostic evaluation, a treatment planning session (using a psychotherapy CPT code), followed by psychotherapy.

[52] The OIG did not determine the specific factors causing patient attrition and acknowledges causes as multifactorial.

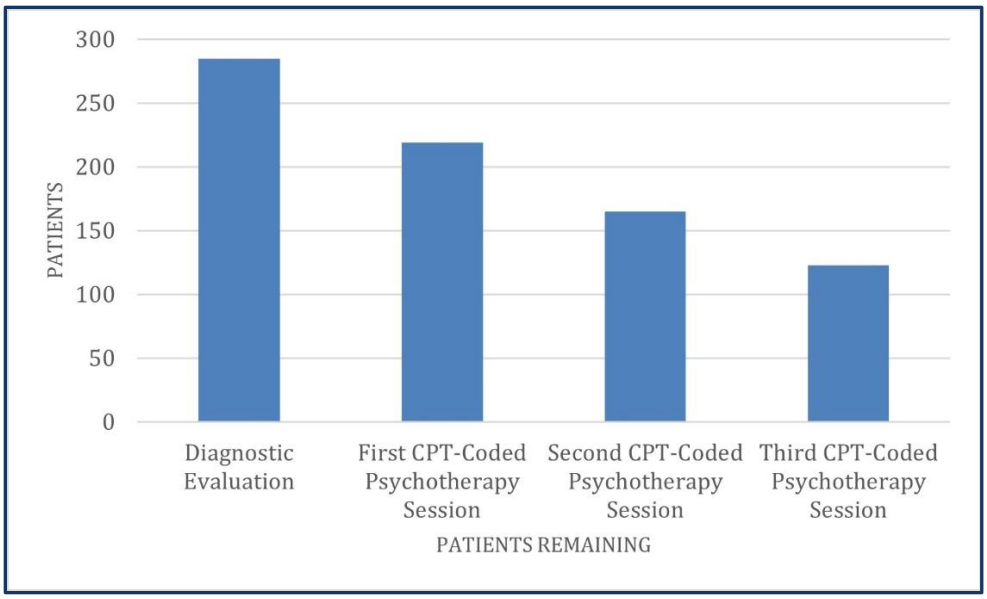

Figure A.1. *Patients remaining after diagnostic evaluation.*
Source: OIG analysis of the number of patients at the diagnostic and treatment planning and subsequent individual or group psychotherapy-coded sessions as provided by therapists from October 1, 2022, through April 11, 2024.

Appendix B: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: November 5, 2024

From: Director, Department of Veterans Affairs (VA) Southeast Network (10N7)

Subj: Office of Inspector General (OIG) Draft Report: Allegation of Underutilization of Mental Health Clinics, and Concern for Delays in Patient Care, at the Hinesville VA Clinic in Georgia

To: Office of the Under Secretary for Health (10)
Director, Office of Healthcare Inspections (54MHP1)
Executive Director, Office of Integrity and Compliance (10OIC)

1. I have completed a full review of the OIG Draft Report, Allegation of Underutilization of Mental Health Clinics, and Concern for Delays in Patient Care, at the Hinesville VA Clinic in Georgia. The Ralph H. Johnson VA Health Care System makes patient care and safety a priority and we appreciate the Office of the Inspector General's partnership in our continuous improvement efforts for our Veterans.

2. I have reviewed and concur with the recommendations 2, 3, 5, and 6. I support the concur in principle with recommendations 1 and 4 based on VHA guidance and evidence provided in the VHA comments section.

3. I appreciate the opportunity for this review as part of a continuing process to improve the care of our Veterans.

4. If you have any questions or require further information, please contact the VISN 7 Quality Management Officer.

(*Original signed by:*)

David M. Walker, MD, MBA, FACHE
Network Director

[OIG comment: The OIG received the above memorandum from VHA on November 8, 2024.]

Appendix C: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: October 29, 2024

From: Director, Ralph H. Johnson Department of Veterans Affairs (VA) Health Care System (534/00)

Subj: Office of Inspector General (OIG) Draft Report: Allegation of Underutilization of Mental Health Clinics, and Concern for Delays in Patient Care, at the Hinesville VA Clinic in Georgia

To: Director, VA Southeast Network (10N7)

1. Thank you for the opportunity to review and comment on the draft report regarding Allegation of Underutilization of Mental Health Clinics, and Concern for Delays in Patient Care, at the Hinesville VA Clinic in Georgia. The Ralph H. Johnson VA Health Care System makes patient care and safety a priority and we appreciate the Office of the Inspector General's partnership in our continuous improvement efforts for our Veterans.

2. I have reviewed and concur with the recommendations 2, 3, 5, and 6 and provided action plans in the attachment. I concur in principle with recommendations 1 and 4 based on Veterans Health Administration (VHA) guidance and evidence provided in the VHA comments section.

3. Comments regarding the contents of this memorandum may be directed to the Director of Quality and Patient Safety.

(*Original signed by*:)

Scott R. Isaacks, FACHE
Director, Ralph H. Johnson VA Health Care System

[OIG comment: The OIG received the above memorandum from VHA on October 31, 2024.]

Facility Director Response

Recommendation 1

The Ralph H. Johnson VA Health Care System Director ensures optimal mental health clinic utilization at the Hinesville VA Clinic.

_X _Concur In Principle

____Concur

____Nonconcur

Target date for completion: October 2, 2024

Director Comments

We concur in principle with the recommendation and have completed a review of the evidence. Based upon that review, it was determined that all VA requirements were met and that utilization was appropriate. Clinic utilization is broadly defined as 80-120% which does not take all Mental Health requirements into consideration. We have ensured optimal mental health clinic utilization at the Hinesville VA Clinic. The Clinic Utilization Statistical Summary (CUSS) in one of many tools that may be used to monitor clinic utilization. Additional measures which may be more appropriate include Veteran access, satisfaction, bookable hours, and workload. The Hinesville clinic well exceeds the national average in all of these areas. To enhance scheduling availability for Veterans and to address limitations of the VA scheduling system, providers commonly have multiple clinics available to see patients. Face to Face clinics, VA Video Connect (VVC) video conferencing clinics and Open Access clinics are all necessary for providing flexibility in meeting the unique needs of this highly vulnerable population, as well as for appropriate data capture. The Office of Integrated Veteran Care's (IVC's) clinic profile management business rules (updated on May 24, 2023) on clinic profiles states that although 100% clinic utilization may appear to be ideal, there are significant issues associated with this number which includes the lack of capacity for walk-in appointments, which would stretch resources beyond the limits of the clinic. The "Integrated Access Initiatives" section on IVC's operations SharePoint states there are several different initiatives focused on improving efficiency and productivity which optimizes Veterans access to care. More specifically, the Bookable Hours and Appointment Length Standards initiative, along with the Improving Capacity, Efficiency, and Productivity (ICEP) initiative, are national initiatives focused on optimizing provider productivity and Veterans access to care. While clinic utilization is one measure referenced in VA's clinic practice management guidelines, there are several other key performance indicators which better assess the efficiency of VA providers. Clinic utilization or the CUSS Report are noted as poor indicators of workload or productivity in MH clinic due to complexity of services demanding maximum clinic flexibility. While efforts have been made to eliminate the need to maintain multiple clinical modalities in a provider's schedule (which can overrepresent availability), such

actions could limit Veteran choice and optimal scheduling flexibility for MH efficiency. Until VHA establishes a single schedule, resource-based scheduling system, utilization metrics will fail to reflect actual MH workload efficiency. Despite these known issues with using utilization as a measurement, in FY24, October 1, 2023 to August 16, 2024, Hinesville MH (69.9) and Charleston MH utilization metric (77.5%) still exceed both VISN 7 (50.5%) and National averages (35.1%). Of note, utilization rates do not account for significant workload attained by additional patient care in which an appointment was not made such as a walk-in, which averages 15% of all monthly workload at Charleston.

Other methods of monitoring optimization of clinical practice more appropriately in MH are: access, productivity, encounters, quality of care, and Veteran satisfaction. Data, available at the CBOC level, finds that the Hinesville CBOC consistently meets the Mission Act standard for new patient access (FY24, October 1, 2023 to August 16,2023) Hinesville 15.1 days vs National 20.6 days). From a Bookable Hours standpoint, Hinesville (100%) exceeds Charleston (71.2%), VISN7 (61.1%) and National (53.5%) averages for % at or above 80% Bookable. In terms of Veteran satisfaction in Hinesville, Press Ganey FY24Q4 data confirm Veterans in the Hinesville Outpatient Behavioral Health Clinics score higher than their national peers on items relevant to this review including access overall (91.67); ease of getting an appointment (91.67); and convenience of appointments (91.67).

As Veterans often receive their care throughout a hospital system, it is pertinent to also look at Charleston MH has a whole to determine leadership oversight of clinic optimization. In terms of access and productivity, the facility has consistently met Mission Act Standards for new patient access (for FY24, October 1, 2023 to August 16, 2023 Charleston is 16.1 days which is lower than the National average of 20.6 days) and their group utilization has recovered from COVID decreases. The facility is ranked in the top 10 of VHA in Mental Health wait times. In addition, Charleston's mental health productivity for 2023 was 2091 wRVUs versus 1751 wRVUs for National. This also was sustained into FY24 with Charleston at 2517 wRVUs and 1917 wRVUs for National.

In 2023, mental health therapists in Charleston average encounters per adjusted clinical Full-Time Employee per pay period trend was 52.0 which was higher than the National average of 47.3. This trend has been sustained for FY24, October 1, 2023, to August 16, 2024, with Charleston at 56.9 and National 47.8. Specifically, when comparing data to determine clinic optimization and appropriate mental health follow-up care, one comparison is the average encounters per period with the average unique patients seen. Charleston averages 57 encounters per pay period with an average of 42 uniques (74%). This is considerably higher than the national average of 48 encounters per pay period with an average of 35 unique patients (73%).

Strategic Analytics for Improvement and Learning (SAIL) metrics during the quarters under review demonstrate Charleston is not an outlier in general reach of psychotherapy and continuity of psychotherapy appointments over an interval that is consistent with evidenced-based protocols

for Veterans with depression, Post Traumatic Stress Disorder (PTSD) and severe mental illness. Finally, MH SAIL Veteran Satisfaction Survey data for the time period of the OIG review provides evidence Veterans are extremely satisfied with their care as the FY23Q4 standard was 0.83 and FY 24 Q1 was 0.77 which are both significantly above the national average.

In summary, there is no indication of underutilization of resources that has resulted in patient impact and Charleston is currently exceeding VA benchmarks for access, productivity and bookable hours which are more appropriate mechanisms in which to assess clinic management performance.

OIG Comment

The OIG considers this recommendation closed.

Recommendation 2

The Ralph H. Johnson VA Health Care System Director ensures that mental health Hinesville VA Clinic staff are using accurate current procedural terminology codes to document services provided to patients in the electronic medical record.

_X _Concur

____Nonconcur

Target date for completion: March 2025

Director Comments

The Director reviewed the evidence referencing one clinician not using proper codes. We believe this is an isolated administrative error, which is not reflective of the proper coding of the more than 279 Mental Health providers in Charleston Mental Health Service and this did not affect the care of patients. To ensure full understanding and compliance with coding guidelines for all staff, education will be provided to include not only Hinesville providers, but all Mental Health providers regarding the use of proper codes. Further, Health Information Management Service (HIMS) will perform a monthly a coding audit of all Hinesville providers to assure accuracy of new patient and subsequent visits. The results of this audit will be reported through the Integrity and Compliance Committee monthly and at the Quality Executive Council quarterly.

Recommendation 3

The Ralph H. Johnson VA Health Care System Director confirms evaluation of administrative processes to include consult management and patient scheduling within the mental health service at the Hinesville VA Clinic and takes action as necessary to optimize patient access and experience.

_X _Concur

____Nonconcur

Target date for completion: March 2025

Director Comments

The Director reviewed the consult management and patient scheduling processes within mental health service at the Hinesville VA Clinic. While Choose My Therapy was not a required program, as part of Charleston's focus on high reliability and innovation, this project was initiated as an evidence-based program to enhance patient-centered care and maximize patient access and experience. It was determined there were areas for improvement in the administrative and scheduling processes for this novel clinic. In March 2023, mental health services initiated the use of clinical consults for scheduling following the initial intake examination. This is consistent with the Standard Operating Procedure associated with VHA Directive 1232 on VHA Consults for Established Patients in Mental Health (last updated December 16, 2022). The guidelines provided in the Consult Timeliness Standard Operating Procedure (last updated July 8, 2024) will be followed to include monitoring of action taken and scheduling of an appointment within 20 days or at the patients preferred date.

To ensure compliance, the Group Practice Manager will perform a monthly monitor of all Hinesville between clinic and within team consults for compliance. The denominator will be the total number of consults audited. The numerator will consist of the number of consults meeting the scheduling criteria. The results of this audit will be reported through the Integrity and Compliance Committee monthly and at the Quality Executive Council quarterly.

Recommendation 4

The Ralph H. Johnson VA Health Care System Director completes a review of the patients identified by the Office of Inspector General to have experienced a median wait time of at least three weeks between individual therapy sessions and takes action to resolve any patient care concerns identified during the review.

__X _Concur In Principle

____Concur

____Nonconcur

Target date for completion: October 2, 2024

Director Comments

We agree in principle with completing a review of compliance with applicable requirements and ensuring that appropriate patient care was provided for all patients that were considered in this report. Based upon that analysis, it was determined that VA requirements were met and that appropriate patient care was provided. Directive 1160.01 uses the statement regarding weekly therapy as an example of potential scheduling for mental health follow up visits. The actual statement is "All subsequent appointments must be scheduled in accordance with the appropriate

clinical timing for the specific intervention/treatment plan (e.g., on a weekly recurring basis for 10-15 weeks for evidence-based psychotherapy)." Also, VHA Directive 1160.05 (Evidence Based Psychotherapy EBP) delivery only requires conformance with scheduling to the delivery requirements of EBPs in format, length, frequency, and timing of treatments. There is no evidence to support a set standard within VHA for the time between EBP therapy.

The allegation of pervasive issues with delayed follow-up mental health care in the Charleston VA Mental Health Service was reviewed and was not substantiated.

The OIG references review of 285 unique patients who received a diagnostic evaluation and identified delays. The OIG provided the facility with a list of 161 patients. Each patient was reviewed by the mental health section chief. Seventy-nine of the 161 patients completed three visits. Of the remaining 82 patients, 29 patients had a second visit with appropriate referrals or follow up care. Fifty-three patients declined further treatment or needed specialized care and those referrals were completed. In terms of the attrition noted by the OIG, Hinesville does not appear to be an outlier based on published evidence from the literature in Veteran populations. Several studies found Veterans who engage in therapy have high drop-out rates, ranging from 36-68% with a mean of 42%.[1]

Finally, MH SAIL Veteran Satisfaction Survey data for the time period of the OIG review provides evidence Veterans are extremely satisfied with their care as the FY23Q4 standard was 0.83 and FY 24 Q1 was 0.77 which are both significantly above the national average. More specifically to Hinesville, Press Ganey FY24Q4 data confirm Veterans in the Hinesville Outpatient Behavioral Health Clinics score higher than their national peers on items relevant to this review including access overall (91.67%); ease of getting an appointment (91.67%); and convenience of appointments (91.67%).

OIG Comment

The OIG considers this recommendation closed.

[1] Fischer MS, Bhatia V, Baddeley JL, Al-Jabari R, & Libet J (2018). Couple therapy with veterans: Early improvements and predictors of early dropout. *Family Process*. 10.1111/famp.12308

Goetter EM, Bui E, Ojserkis RA, Zakarian RJ, Brendel RW, & Simon NM (2015). A Systematic Review of Dropout From Psychotherapy for Posttraumatic Stress Disorder Among Iraq and Afghanistan Combat Veterans. *Journal of Traumatic Stress*. 10.1002/jts.22038

Steenkamp MM, & Litz BT (2013). Psychotherapy for military-related posttraumatic stress disorder: Review of the evidence. In *Clinical Psychology Review*. 10.1016/j.cpr.2012.10.002

Garcia HA, Kelley LP, Rentz TO, & Lee S (2011). Pretreatment Predictors of Dropout From Cognitive Behavioral Therapy for PTSD in Iraq and Afghanistan War Veterans. *Psychological Services*. 10.1037/a0022705

Recommendation 5

The Ralph H. Johnson VA Health Care System Director considers evaluating the Choose My Therapy program at other system sites for clinic practice management deficiencies and takes action as appropriate.

_X _Concur

____Nonconcur

Target date for completion: August 2024

Director Comments

The Director has reviewed the evidence and has taken appropriate action. Though not a required program, this was an evidence-based, innovative approach to enhanced shared decision making that the facility piloted as a high reliability organization. This program was created to help Veterans participate in shared decision-making regarding therapy and treatment options. VHA Directive 1160.01, recommends mental health services set a goal of organizing programs across a continuum of care and provide a team-based, interprofessional, patient-centered, recovery-oriented structure. This directive notes that treatment should take place at the least intensive level of care that is appropriate to meet Veterans' needs, taking into consideration the severity and complexity of illness, what matters most to them in their lives, and the Veteran's expressed preferences for treatment. With this clinic, during intake visits, patients were assessed to understand the problems/issues that they are dealing with and offered a variety of care. Care could include psychotherapy but could also typically include medication and other community-based options. Patients typically are interested in trying a variety of options. Sometimes the patient wishes to explore other options before starting psychotherapy.

While we believe this was a worthwhile innovative approach to provide excellent care to Veterans, the program has been discontinued with shared decision making now occurring individually at the patient's initial appointment.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 6

The Ralph H. Johnson VA Health Care System Director ensures that all patients listed in the electronic spreadsheet have received mental health follow-up care.

_X _Concur

____Nonconcur

Target date for completion: August 2024

Director Comments

The Director has completed the review of all 660 patients on the electronic spreadsheet used by the Hinesville Mental Health staff as a means of communication for assuring that each Veteran received the therapy/therapist that met his/her unique needs. All staff were reeducated to utilize the approved methods of communication and consults. The review found that 652 patients received mental health follow up in an established mental health clinic. Of the remaining 8 names on the list, 5 were determined to be therapist names that were being assigned to a specific patient. Two names did not have a unique identifier (social security number or date of birth), but the identity of these Veterans was determined and both had mental health follow up. There was one name on the spreadsheet that could not be identified, but mental health providers in the Hinesville clinic confirmed that it was an employee, and a pseudonym was used to protect the employee's identity. The Veteran employee received the care that was needed.

OIG Comment

The OIG considers this recommendation closed.

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	Clarissa Reynolds, NHA, MBA, Director Limin Clegg, PhD Michelle Ernzen, MSN, RN Jonathan Ginsberg, JD Alan Mallinger, MD Tanya Oberle, LCSW, MSW Ashley Summers, MJ, RN Jarvis Yu, PhD
Other Contributors	Amanda Brown, MSN, RN Alicia Castillo-Flores, MBA, MPH Christopher D. Hoffman, LCSW, MBA Barbara Mallory-Sampat, JD, MSN Daphney Morris, MSN, RN Natalie Sadow, MBA Robert Yang, MD

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