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

Office of Healthcare Inspections

## VETERANS HEALTH ADMINISTRATION

# Staff Mitigated the Impact of Appointment Cancellations in a Mental Health Clinic at the VA Northern Indiana Healthcare System in Fort Wayne

**Healthcare Inspection** | **24-01535-55** | **February 13, 2025**

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# Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess clinic cancellation practices, including the timing of cancellations, at a VA Northern Indiana Healthcare System (system) mental health clinic in Fort Wayne, Indiana.

In early 2024, the OIG received a congressional request as well as allegations from a complainant that mental health staff at the Fort Wayne VA Clinic Mental Health Annex (Fort Wayne clinic) were canceling appointments the same day as the scheduled appointments and then rescheduling patients' appointments with providers who no longer worked at the system.

A preliminary review of data submitted by the complainant confirmed concerns about clinic cancellation practices but did not support the allegation that patients were scheduled with providers who no longer worked at the system. As such, the OIG opened this healthcare inspection in March 2024 to evaluate outpatient mental health clinic cancellation processes at the Fort Wayne clinic. The OIG identified an additional concern regarding the system's review of short-notice clinic cancellations, which failed to include social work mental health provider data.[1]

The OIG found that after the sudden resignation of a social work mental health provider (the provider), mental health leaders and a social work supervisor addressed the needs of the provider's patients using a standard clinical disposition process.[2] The clinical disposition process involved clinical staff review of each patient's electronic health record (EHR), a discussion of treatment options with the patient, and documentation of the patient's clinical disposition in the EHR.[3] Mental health leaders and a social work supervisor completed the clinical disposition process before advanced medical support assistants canceled a patient's previously scheduled appointment(s) with the provider.

During interviews, mental health leaders and a social work supervisor told the OIG that, during the clinical disposition process, patients were presented with multiple treatment options to minimize the negative impact to care resulting from the provider's abrupt resignation. The social

[1] Clinical social workers provide individual therapy, group therapy, and family therapy to address emotional, behavioral, and mental health needs.

[2] In early 2024, the provider sent a notification of resignation via email to a social work supervisor and left the position the same day.

[3] While not delineated in policy, the system's clinical disposition process is a standard practice among system mental health providers.

work supervisor reported that the majority of patients contacted preferred to be scheduled with a newly hired provider, and "very few" wanted treatment through care in the community.[4]

In an effort to understand the potential impact of the clinic cancellations on affected patients, the OIG reviewed the EHRs of 108 patients who had scheduled appointments canceled after the provider's resignation. The review confirmed that mental health leaders and a social work supervisor involved patients in decisions regarding their follow-up care by presenting patients with multiple treatment options. Although this clinical disposition and cancellation process did, to varying degrees, extend the appointment wait time of all 108 patients, the OIG saw examples of patients who chose to wait for their preferred option rather than accept interim mental health care.[5]

Throughout the review of the 108 EHRs, the OIG assessed for adverse outcomes.[6] There were no concerns identified. The OIG also reviewed joint patient safety reporting data from the date of the provider's resignation through spring 2024, and did not identify any joint patient safety reports related to the cancellations.[7]

System policy defines procedures for providers to request a clinic cancellation based on the time of the provider request. A clinic cancellation is considered urgent when requested between 48 hours and 45 days before a patient's scheduled appointment.[8] The OIG found that the chief of mental health and the chief of social work did not notify the Chief of Staff (COS), or the COS's delegate, to seek approval for urgent cancellations of the provider's clinic as required by the system clinic cancellation policy.[9]

The OIG found that, after the provider's sudden resignation, system administrative medical support assistants canceled 219 appointments (83 patients) between 48 hours and 45 days prior to

[4] Care in the community allows systems to "purchase care in the community for eligible Veterans, after VA options to render care have been considered." Office of Integrated Veteran Care, *Office of Integrated Veteran Care (IVC) Community Care Field Guidebook*, accessed August 19, 2024, https://dvagov.sharepoint.com/sites/VHAOCC/CNM/CI/OCCFGB/SitePages/FGB.aspx?xsdata. (This site is not publicly accessible).

[5] In interviews, advance medical support assistants told the OIG of reminding patients, when canceling and rescheduling appointments, to call the veteran crisis line or the outpatient mental health clinic or go to the emergency department for support if they had an emergency or mental health crisis. The Veterans Crisis Line, previously known as the National Suicide Prevention Lifeline, connects veterans, service members, and their families to a trained crisis responder via telephone, online chat, or text messaging. Veterans Crisis Line, "Frequently Asked Questions," accessed October 7, 2024, https://www.veteranscrisisline.net/about/what-is-988/.

[6] For the purposes of this inspection, the OIG defines an adverse outcome as self-harm behavior or hospital admission related to psychiatric deterioration.

[7] The Joint Patient Safety Reporting system is VHA's patient safety event reporting system.

[8] System Policy 11-71-21, *Clinic Cancellation Policy,* January 21, 2021. A clinic cancellation that could not be anticipated (typically less than 48 hours' notice) does not require COS or COS delegate approval.

[9] System Policy 11-71-21.

each patient's scheduled appointment, doing so without the required COS or COS delegate notification and approval.

The chief of mental health and the chief of social work reported awareness of the system clinic cancellation policy. The chief of mental health explained that clinic cancellations less than 45 days prior to an appointment date "could have [a] more substantial impact on [a patient's] care . . . and [are] reviewed by the COS,' however "[I am] not sure I would have known to apply a [provider] resignation to our [system] clinic [cancellation policy]."[10] During an interview with the OIG, the COS confirmed being unaware of the provider's resignation.

The OIG reviewed appointment cancellation timing and substantiated that, due to mental health leaders' decision to complete the clinical disposition process prior to appointment cancellations, some appointment cancellations did occur on the same day as patients' scheduled appointments. Of the cancellations, 69 (64 percent) occurred on the same day or one day prior to the appointment scheduled with the provider who resigned. The remaining patients had cancellations between 2 and 31 days prior to the appointment scheduled with the provider. The OIG is concerned that canceling appointments on short notice may be disruptive to patient care. Ultimately, due to mental health and social work leaders' communication failures, the COS was unaware of and could not approve the clinic cancellations. COS involvement was necessary to assess the need for, and potential allocation of, resources, and allow for evaluation of the potential patient impact.

During the inspection, the OIG identified an additional concern regarding system staff's failure to include social work mental health provider data in the system-initiated review. The COS reported initiating a review following a complaint regarding Fort Wayne mental health clinic cancellations with short notice. When notified of the omission by the OIG during an interview, the COS acknowledged the exclusion. However, when a completed final clinic cancellation review was submitted, the OIG found that the review still did not include social work mental health providers. Therefore, neither the provider's resignation, nor the provider's clinic, were included in the review. The OIG is unclear on the system rationale for omitting the mental health social work clinics in the system's final review.

The OIG made two recommendations to the System Director related to the lack of COS notification of urgent clinic cancellations as required by policy, and the failure to include social work mental health provider data in the system review and evaluation of short-notice clinic cancellations within mental health clinics.

[10] System Policy 11-71-21.

## VA Comments and OIG Response

The Veterans Integrated Service Network and Facility Directors concurred with the findings and recommendations and provided acceptable action plans (see appendixes A and B). 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

# Contents

# Abbreviations

| | |
|---|---|
| AMSA | advanced medical support assistant |
| COS | Chief of Staff |
| EHR | electronic health record |
| JPSR | joint patient safety reporting |
| 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 clinic cancellation practices at a VA Northern Indiana Healthcare System (system) mental health clinic in Fort Wayne. During the course of the inspection, the OIG identified an additional concern regarding the system's review of short-notice clinic cancellations.

## Background

The system is part of Veterans Integrated Service Network (VISN) 10, VA Healthcare System Serving Ohio, Indiana, and Michigan, and consists of the Fort Wayne and Marion VA Medical Centers, and six community-based outpatient clinics, which include the Fort Wayne VA Clinic Mental Health Annex (Fort Wayne clinic).[1] In fiscal year 2023, the Fort Wayne clinic offered primary care and mental health services to over 5,000 unique patients and completed over 33,000 outpatient visits.[2]

## Allegations and Additional Concern

In early 2024, the OIG received a congressional request as well as allegations from a complainant that alleged outpatient mental health staff at the Fort Wayne clinic were canceling appointments the same day as appointments were scheduled and that patients with canceled appointments were scheduled with providers who no longer worked at the system. A preliminary review of data submitted by the complainant raised concerns about the practice of same day cancellations but did not support the allegation that the appointments were scheduled with providers who no longer worked at the system. As such, the OIG opened this healthcare inspection in March 2024 to evaluate Fort Wayne clinic outpatient mental health cancellation processes. During the course of the inspection, the OIG identified an additional concern related to the system's review of clinic cancellations with short notice.

# Scope and Methodology

The OIG initiated this inspection on March 20, 2024, and conducted an on-site visit May 21– 23, 2024. The OIG interviewed the complainant, interim System Director, Chief of Staff (COS), mental health leaders, chief of social work, social work supervisor, and

[1] The VA Northern Indiana Healthcare System community-based outpatient clinics are located in Fort Wayne (Mental Health Annex), Mishawaka, Muncie, and Peru, Indiana; and Defiance, Ohio.

[2] The fiscal year for the federal government is a 12-month period from October 1 through September 30 of any given year and is designated by the calendar year in which it ends. 49 C.F.R. § 1511.3 (2023). For example, fiscal year 2023 began October 1, 2022, and ended September 30, 2023.

administrative staff, as well as Fort Wayne clinic mental health providers and the VISN mental health chief medical officer.

The OIG reviewed relevant Veterans Health Administration (VHA) directives and system policies related to clinic cancellations and outpatient clinic practice management. The OIG also reviewed the electronic health records (EHRs) of 108 patients who had scheduled appointments canceled after a social work mental health provider's (the provider) sudden resignation, as well as joint patient safety reporting (JPSR) documents from early 2024 through spring 2024.[3]

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

The OIG conducted this healthcare inspection to assess clinic cancellation practices and the timing of cancellations at the Fort Wayne clinic. The OIG found that mental health leaders and a social work supervisor took steps to transition patients to alternative appointments or treatment after the provider's sudden resignation.[4] However, the chief of mental health and the chief of social work failed to notify the COS of mental health clinic cancellations as required by policy.[5]

[3] The Joint Patient Safety Reporting system is VHA's "patient safety event reporting system and database." VHA National Center for Patient Safety, *Guidebook for JPSR Business Rules and Guidance*, November 2021.

[4] "Clinical social workers provide individual therapy, group therapy, and family therapy to address emotional, behavioral and mental health needs." VHA, *What VA Social Workers Do* publication, accessed October 10, 2024, www.socialwork.va.gov/docs/WhatVASocialWorkersDo_R.PDF. In early 2024, the provider sent a notification of resignation via email to a social work supervisor and left the position the same day.

[5] System Policy 11-71-21, *Clinic Cancellation Policy,* January 21, 2021.

To evaluate the outcome of affected patients' clinical dispositions, and any potential adverse outcomes associated with clinic cancellations, the OIG reviewed the EHRs of 108 patients who had scheduled appointments canceled after the provider's resignation. JPSR data related to the clinic cancellations were also reviewed, and the OIG did not identify any concerns. During the inspection, the OIG identified an additional concern regarding a system review of clinic cancellations with short notice.

## Staff Mitigated the Impact of Sudden Resignation

During the review of clinic cancellation processes, the OIG found that mental health leaders and a social work supervisor addressed the needs of the provider's patients by using a standard clinical disposition process.[6]

During interviews, the chief of mental health, chief of social work, a mental health leader, and a Fort Wayne clinic provider described the steps taken to transition patients to alternate appointments or treatment when a provider anticipates leaving a current position; this process is called a clinical disposition.

A clinical disposition includes

- a review of the patient's EHR,
- discussion of treatment options with the patient, and
- documentation in the EHR of patient's clinical disposition.

A lead advance medical support assistant (AMSA) told the OIG that following completion of a patient's clinical disposition, a mental health leader notifies an AMSA to cancel appointments and schedule an alternative appointment as warranted.

In interviews with the OIG, the chief of mental health and chief of social work explained that advance notice of a provider's resignation allows for clinical disposition and coordination of a patient's treatment transition to a new provider with the goal to minimize disruption of care. Another mental health leader told the OIG that this was "the first time that I've been in a leadership position when someone left unexpectedly, where the clinician was [not] able to initiate a plan for [patients'] follow up care." Additionally, the chief of social work explained that a provider resigning abruptly ". . . was a situation that [had not] happened before, at least with me."

During an interview, the chief of mental health recalled that after the provider's resignation, a mental health leader and social work supervisor "[worked] diligently" to review the EHRs of the

[6] While not delineated in policy, the system's clinical disposition process is a standard practice among system mental health providers.

provider's patients and contact patients and added, "I would say the bulk [of patient contacts] were done within . . . four weeks."

Mental health leaders and a social work supervisor told the OIG that patients were presented with multiple treatment options to minimize the negative impact to care resulting from the provider's abrupt resignation. Options included

- waiting approximately six weeks to establish care with a newly hired mental health provider;[7]
- scheduling with an existing Fort Wayne mental health clinic provider, including Primary Care Mental Health Integration services, which provides mental health care services in collaboration with primary care providers;[8]
- receiving treatment through care in the community;[9]
- utilizing alternative services including Whole Health, peer support, or music therapy; and [10]
- discharging from care if treatment goals had been met.

The social work supervisor also reported that the majority of patients contacted preferred to be scheduled with the newly hired provider, and "very few" wanted treatment through care in the community. Following clinical disposition, a mental health leader or the social work supervisor notified AMSA staff to cancel patients' previously scheduled appointment(s) with the provider.

During interviews with the OIG, a mental health leader and social work supervisor explained that calls to patients were made, ". . . as quickly as we could in advance [of the patients' next appointment]" and acknowledged the process of patient contact and clinical disposition was prolonged due to other workload and supervisory responsibilities. The chief of mental health told

[7] A mental health leader and social work supervisor told the OIG that a new provider had been hired and was scheduled to start treating patients in mid-February 2024.

[8] VHA Office of Mental Health, "Primary Care-Mental Health Integration (PC-MHI) Functional Tool," September 7, 2012, accessed July 23, 2024, https://www.mentalhealth.va.gov/coe/cih-visn2/Documents/Clinical/Operations_Policies_Procedures/PC-MHI_Functional_Tool_v10_090712.pdf.

[9] Care in the community allows systems to "purchase care in the community for eligible Veterans, after VA options to render care have been considered." *VHA Office of Integrated Veteran Care (IVC) Community Care Field Guidebook*, accessed August 19, 2024, https://dvagov.sharepoint.com/sites/VHAOCC/CNM/CI/OCCFGB/SitePages/FGB.aspx?xsdata (This website is not publicly accessible).

[10] Whole Health is an approach to care that supports patient health and well-being by developing a personalized health plan based on a patient's individual values, needs, and goals. VHA Office of Patient Centered Care and Cultural Transformation, "What is Whole Health?", accessed July 23, 2024, https://www.va.gov/WHOLEHEALTH/docs/LWH-Introduction_508.pdf. Peer support specialists are employees who are veterans and provide peer support services to help patients with similar experiences utilizing one-on-one or group meetings. Veterans Health Library, "Peer Support Services in VA," accessed November 4, 2024, https://www.veteranshealthlibrary.va.gov/142,41684_VAs.

the OIG of being unaware that the patient contacts for clinical disposition took approximately 10 weeks to complete, and stated, "I would say that we appreciate that it maybe [did not] go as quickly as people wanted." Further, the chief of mental health told the OIG, "it seemed like the process [clinical disposition] was going well . . . I did [not] have any concerns at the time," and "I did feel like social work was monitoring [the clinical disposition process] appropriately." The chief of social work told the OIG that the social work supervisor did not report any concerns about the progress of patient contacts for clinical disposition and stated, "I was under the assumption that things were moving along . . . without any information to contradict that."

The OIG found that mental health leaders and a social work supervisor did use a standard clinical disposition process to address the needs of the provider's patients and help transition patients to alternate appointments or treatment. Further, the clinical disposition process was completed before the cancellation of patients' appointments.

## Impact of The Provider's Sudden Resignation

In an effort to understand the potential impact of the clinic cancellations on affected patients, the OIG reviewed the EHRs of 108 patients who had scheduled appointments canceled after the provider's resignation. The OIG assessed the outcome of clinical disposition, adverse patient outcomes, and JPSR data for any reports related to the clinic cancellations.[11]

The OIG found that the clinical disposition process began the day of the provider's resignation in early January 2024 and continued through March 2024. Sixty-six patients (61 percent) had a contact and clinical disposition completed within 30 days of the provider's resignation and all patients contacts and clinical dispositions were completed within 10 weeks.

The OIG found that mental health leaders and a social work supervisor presented 107 patients with multiple treatment options to minimize negative impact to care resulting from the provider's abrupt resignation.[12] The OIG also found that through the clinical disposition process, mental health leaders and a social work supervisor involved patients in decisions regarding follow-up care, and that appointments were canceled only after a patient agreed to mental health follow-up or to discharge from care if treatment goals had been met.

Although this clinical disposition and cancellation process did, to varying degrees, extend the waiting time of all patients, the OIG saw examples where patients chose to wait for their

[11] For the purposes of this inspection, the OIG defines an adverse outcome as self-harm behavior or hospital admission related to psychiatric deterioration.

[12] Upon review of the EHRs of 108 patients who had appointments canceled after the provider's departure, the OIG found that mental health leaders and a social work supervisor did not present 1 patient with multiple treatment options as this patient called to reschedule the appointment with the provider. When told the provider had left, the patient requested an appointment with the new provider. The new provider saw the patient approximately five weeks after the cancellation of the patient's appointment.

preferred option rather than accept interim mental health care. With respect to the various dispositions, the OIG found that 72 patients had appointments scheduled with the newly hired provider; 16 patients were seen by an existing Fort Wayne mental health clinic provider; and 7 patients chose care in the community. Some patients received care from primary care mental health integration or an alternative support service, or declined future services.[13]

In an interview, the lead AMSA told the OIG of, when canceling appointments, reminding patients to call the Veterans Crisis Line or the outpatient mental health clinic or go to an emergency department for support if they had an emergency or mental health crisis.[14] Throughout the review of the 108 EHRs, the OIG also assessed for adverse outcomes. There were no concerns identified. The OIG also reviewed JPSR data from the date of the provider's resignation through spring 2024 and did not identify any JPSR events related to the cancellations. Additionally, the COS reported that the system completed a review of JPSRs from October 2021 through May 2024, which yielded "no instances of concerns or complaints regarding the cancellation of outpatient mental health appointments following [the] provider's resignation or departure from the [mental health] service." Further, the VISN mental health chief officer, chief of mental health, chief of social work, and a mental health leader denied awareness of any adverse events or patient safety concerns related to the clinic cancellations.

The OIG concluded that there were many patients who had canceled appointments due to the provider's sudden resignation, however, mental health leaders and a social work supervisor took steps to address these cancellations via the clinical disposition process. Additionally, the OIG identified no adverse outcomes as a result of the provider's resignation and resulting appointment cancellations.

## Resignation Led to Urgent Clinic Cancellations

The OIG found that the chief of mental health and the chief of social work did not notify the COS, or the COS's delegate, and seek approval for urgent clinic cancellations of the provider's clinic as required.[15]

[13] The OIG found that some patients preferred two dispositions—receiving care from primary care mental health integration services until their appointment with the newly hired provider.

[14] The Veterans Crisis Line, previously known as the National Suicide Prevention Lifeline, connects veterans, service members, and their families to a trained crisis responder via telephone, online chat, or text messaging. Veterans Crisis Line, "Frequently Asked Questions," accessed October 2, 2024, https://www.veteranscrisisline.net/about/what-is-988/.

[15] System Policy 11-71-21.

VHA policy states "cancellation of patient care activities must be avoided whenever possible."[16] As defined in system policy, a clinic cancellation occurs when an appointment is canceled by clinic staff and not a patient.[17] An urgent clinic cancellation occurs when a clinic is canceled after a request is made between 48 hours and 45 days before a patient's scheduled appointment.[18] The request goes "through the [provider's] immediate supervisor and the [provider's service chief] to the COS or [COS] delegate" for approval.[19] The OIG found that 219 appointments (83 patients) were canceled after the provider's resignation, and between 48 hours and 45 days before the patients' scheduled appointments, and therefore required COS or COS delegate notification and approval for urgent clinic cancellations. In the case of this inspection, given the provider's sudden departure, the OIG would have expected the provider's supervisor, the supervisory social worker, to initiate the urgent clinic cancellation request. The chief of mental health and the chief of social work reported awareness of the system policy.[20] The chief of mental health explained that clinic cancellations ". . . less than 45 days [prior to an appointment date] have an additional level of supervision . . . because [these cancellations] could have [a] more substantial impact on [a patient's] care . . . and [are] reviewed by the COS." However, the chief of mental health explained "[I am] not sure I would have known to apply a [provider] resignation to our [system] clinic [cancellation policy]."[21] During an interview, the chief of social work told the OIG they did not inform the COS of the provider's resignation and subsequent clinic cancellations. During an interview with the OIG, the COS confirmed being unaware of the provider's resignation.

The OIG reviewed appointment cancellation timing and substantiated that, due to mental health leaders' decision to complete the clinical disposition process prior to appointment cancellations, some cancellations did occur on the same day as a patient's scheduled appointment. Of the cancellations, 69 (64 percent) occurred on the same day or one day prior to the appointment scheduled with the provider. The remaining patients had cancellations between 2 and 31 days prior to the appointment scheduled with the provider. The OIG is concerned that canceling appointments on short notice may be disruptive to patient care.

The OIG concluded that after the provider's sudden resignation, the chief of mental health and the chief of social work did not notify the COS or COS delegate and seek approval for urgent clinic cancellations of the provider's clinic. Ultimately, the failure to notify the COS of the

[16] VHA Directive 1231(3), *Outpatient Clinic Practice Management*, October 18, 2019, amended July 19, 2022, rescinded and replaced by VHA Directive 1231(4), *Outpatient Clinic Practice Management*, October 18, 2019, amended February 7, 2024.

[17] System Policy 11-71-21.

[18] System Policy 11-71-21. A clinic cancellation that could not be anticipated (referred to as an emergency clinic cancellation), and is typically less than 48 hours' notice, does not require COS or COS delegate approval.

[19] System Policy 11-71-21.

[20] System Policy 11-71-21.

[21] System Policy 11-71-21.

provider's clinic cancellations did not allow for COS approval of the clinic cancellations, or for the assessment of the need for, and potential allocation of resources; nor did it allow for COS evaluation of potential patient impact.

## Additional Concern Regarding System Review of Short-Notice Clinic Cancellations

During the inspection, the OIG identified an additional concern regarding the system's failure to include social work providers assigned to mental health clinics in a system-initiated review of Fort Wayne mental health clinic cancellations with short notice. Once the exclusion was identified, the OIG notified the COS of the omission during an interview. However, despite the OIG's notification regarding the omission, the system's final review still did not include the social work providers, including the provider who had resigned.

During an interview with the OIG, the COS reported having initiated a review following a complaint regarding Fort Wayne mental health clinic cancellations with short notice. Only four mental health providers were identified and assessed during the review; none of the identified providers had worked at the system since 2022. In addition, no clinical concerns were noted. The COS told the OIG that the review did not include mental health social work clinics. During the same interview, the OIG informed the COS that the provider who resigned was a social work mental health provider; the COS acknowledged the exclusion and told the OIG, ". . . thank you . . . I'd like to include that clinic in our review."

The System Director completed a final clinic cancellation review. The OIG evaluated the system's final review and found that it indicated that "before a Mental Health provider leaves their position, there is a process in place to ensure continued care" for patients. Further, the review concluded that, "[the system] took proactive measures to conduct a review into Mental Health Social Work services in order to assess the clinic cancellation process" and did not indicate any corrective actions to be taken. However, the OIG found that the completed system review did not include social work mental health providers and, therefore, did not identify the provider's resignation nor was the provider's clinic included in the review.

The OIG found that despite providing the COS with information regarding the provider's clinic cancellations, and COS acknowledgment of the system's omission of mental health social work clinics in the system's initial review, the COS failed to include these clinics in the system's final review. The OIG is unclear on the system's rationale for omitting the mental health social work clinics in the system's final review.

# Conclusion

The OIG found that after the provider's sudden resignation, mental health leaders and a social work supervisor took steps to minimize the impact of clinic cancellations by offering patients

alternative treatment options to facilitate continuity of care. However, the OIG also found that the chief of mental health and the chief of social work did not notify the COS or COS's delegate and seek approval for urgent clinic cancellations of the provider's clinic, per system policy. Although some of the cancellations occurred on the same day as the previously scheduled appointments, this was due, in part, to mental health leaders' decision to complete the clinical disposition process prior to appointment cancellations. Ultimately, the failure to notify the COS of the provider's clinic cancellations did not allow for COS approval of the clinic cancellations and COS evaluation of potential patient impact.

The OIG identified an additional concern regarding the system's failure to include social work providers assigned to mental health clinics during a system-initiated review of Fort Wayne mental health clinic cancellations with short notice. Despite being notified of the omission by the OIG during an interview, the system's final review still did not include the social work providers, including the provider who had resigned.

## Recommendations 1–2

1. The VA Northern Indiana Healthcare System Director evaluates the system clinic cancellation policy and Chief of Staff notification of urgent clinic cancellations and takes action as appropriate.
2. The VA Northern Indiana Healthcare System Director reviews short-notice clinical cancellations for social work mental health clinics, including the provider's clinic, to evaluate patient impact and take actions as appropriate.

# Appendix A: VISN Director Memorandum

## Department of Veterans Affairs Memorandum

Date: January 7, 2025

From: Veterans Integrated Service Network (VISN) 10 Network Director, VA Healthcare System Serving Ohio, Indiana, and Michigan

Subj: Office of Inspector General (OIG) Draft Report: Healthcare Inspection—Staff Mitigated the Impact of Appointment Cancellations in a Mental Health Clinic at the VA Northern Indiana Healthcare System in Fort Wayne

To: Assistant Inspector General for Healthcare Inspections (54)
Executive Director, Office of Integrity and Compliance (10OIC)

1. Thank you for the opportunity to review and comment on the VA OIG Draft Report: Staff Mitigated the Impact of Appointment Cancellations in a Mental Health Clinic at the VA Northern Indiana Healthcare System in Fort Wayne.
2. I concur with the responses and action plans submitted by the Northern Indiana Healthcare System Medical Center Director.
3. If you have any questions or require further information, please contact the VISN 10 Deputy Quality Management Officer.

(*Original signed by*:)

Laura E. Ruzick, FACHE
Network Director

[OIG comment: The OIG received the above memorandum from VHA on January 7, 2025.]

# Appendix B: System Director Memorandum

## Department of Veterans Affairs Memorandum

Date: January 7, 2025

From: Director, VA Northern Indiana Healthcare System (610)

Subj: Office of Inspector General (OIG) Draft Report: Healthcare Inspection—Staff Mitigated the Impact of Appointment Cancellations in a Mental Health Clinic at the VA Northern Indiana Healthcare System in Fort Wayne

To: Veterans Integrated Service Network (VISN) 10 Network Director, VA Healthcare System Serving Ohio, Indiana, and Michigan (10N10)

1. Thank you for the opportunity to review and comment on the draft report regarding appointment cancellations in a mental health clinic at the VA Northern Indiana Healthcare System in Fort Wayne.
2. I concur with the draft report and OIG's recommendations.
3. The VA Northern Indiana Healthcare System is dedicated to delivering the highest quality of care to the Veterans we serve. We are eager to integrate these valuable recommendations to enhance our development into a highly reliable organization.
4. Comments regarding the contents of this memorandum may be directed to the VA Northern Indiana Healthcare System Chief of Quality Management.

(*Original signed by*:)

Jon Beidelschies, JD, FACHE
Medical Center Director

[OIG comment: The OIG received the above memorandum from VHA on January 7, 2025.]

# System Director Response

## Recommendation 1

The VA Northern Indiana Healthcare System Director evaluates the system clinic cancellation policy and service chief notification to the Chief of Staff of urgent clinic cancellations, and takes action as appropriate.

__X__Concur

____Nonconcur

Target date for completion: April 2025

### Director Comments

The facility reviewed and revised the Clinic Cancellation Standard Operating Procedure (SOP) in accordance with VHA Directive 1231(4), *Outpatient Clinic Practice Management*. This SOP was formally signed and put into effect on September 17, 2024. In December 2024, the facility conducted training regarding the SOP. The facility will oversee compliance with the SOP and will provide reports to the "Soonest and Best Care Committee" and through the established governance framework.

## Recommendation 2

The VA Northern Indiana Healthcare System Director reviews short-notice clinical cancellations for social work mental health clinics, including the provider's clinic, to evaluate patient impact and takes actions as appropriate.

__X__Concur

____Nonconcur

Target date for completion: July 2024 - Closed

### Director Comments

A review of the short-notice clinical cancellations within social work mental health clinics, including the provider's clinic referenced in the report, was completed at the direction of the Chief of Staff and coordinated through the Quality Management service line. Supervisory mental health clinicians, unaffiliated with the allegations, completed the chart reviews to evaluate the impact on patients and determine any necessary actions. The record review began in May 2024 and concluded in July 2024. The findings indicated that there was no patient harm or adverse outcomes related to the cancellations, and no corrective actions were deemed necessary.

## OIG Comments

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

# OIG Contact and Staff Acknowledgments

| | |
|---|---|
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