



Department of Veterans Affairs Office of Inspector General

Healthcare Inspection

Alleged Clinical and Administrative Issues

VA Loma Linda Healthcare System Loma Linda, California

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection to determine the validity of allegations regarding concerns with Behavioral Medicine Service (BMS) staffing, workload management, patient evaluations, and supervision at the VA Loma Linda Healthcare System (the facility) in Loma Linda, CA.

An anonymous complainant alleged that:

- BMS is understaffed.
- Primary Care Mental Health Integration and Behavioral Healthcare Intake Program triage social workers are not evaluating patients adequately.
- Social workers are not required to keep their schedules full like other Behavioral Healthcare Outpatient Services and Treatment (BHOST) staff.
- Workload rules are not applied fairly to all staff.
- Patients “might wait a long time” before an intake or to see BHOST providers.
- Social workers lack clinical supervision and many are not licensed.
- The BMS Chief does not “ever meet with staff” or supervise mental health (MH) care delivery.

Based on the Veterans Integrated Service Network 22 workload expectations, we concluded that the facility needed more psychiatrists, psychologists, and social workers to meet the increased MH workload demands. We did not substantiate the allegations of inadequate patient evaluations or that the social workers’ schedules were not kept full. We were not able to determine if workload rules were “not applied fairly.” The 80/20 (80 percent clinical and 20 percent administrative) workload rule was implemented for psychiatrists, psychologists, and social workers.

We concluded that MH patients did not consistently receive timely initial and comprehensive evaluations. We determined that improvements are needed so that patients may be evaluated and treated within the timeframe required by Veterans Health Administration.

We determined that supervision for the social work staff was adequate and that unlicensed social work staff had appropriate clinical supervision. We concluded that the Chief, BMS, provided adequate supervision and oversight. However, the facility Director needs to establish a MH Executive Council.

We recommended that the Facility Director ensure that MH patients receive timely care, including specifically, initial evaluations within 24 hours and comprehensive evaluations within 14 days. A MH Executive Council is established as required by Veterans Health Administration. The VISN and Facility Director concurred with our recommendations and provided acceptable improvement plans.



DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

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

SUBJECT: Healthcare Inspection – Alleged Clinical and Administrative Issues, VA Loma Linda Healthcare System, Loma Linda, California

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an evaluation in response to an anonymous complaint alleging concerns with Behavioral Medicine Service (BMS) staffing, workload management, patient evaluations, and supervision at the VA Loma Linda Healthcare System (the facility) in Loma Linda, CA. The purpose of this inspection was to evaluate whether the allegations have merit.

Background

Veterans Health Administration (VHA) requires that all new patients referred to or requesting mental health (MH) services receive an initial evaluation within 24 hours with the goal of identifying patients with urgent care needs who may require hospitalization or immediate outpatient care. A more comprehensive diagnostic and treatment planning evaluation is required within 14 days, and waiting times for all services for established patients must be less than 30 days from the desired date of appointment. VHA also requires facilities to establish a MH Executive Council to propose strategies to improve care, to coordinate communication between services, and to review the MH impact of facility-wide policies.¹

The facility is a 264-bed tertiary care system that provides comprehensive healthcare through inpatient and outpatient services in medicine, surgery, and behavioral medicine. Outpatient care is provided at both the facility and its five community-based outpatient clinics in Corona, Palm Desert, Sun City, Upland, and Victorville, CA. The facility is part of Veterans Integrated Service Network (VISN) 22.

The facility's BMS offers a wide range of wellness and recovery options for patients suffering from emotional stress, chemical dependency, or psychiatric illnesses. An

¹ VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.

integrated network of inpatient and outpatient behavioral health care teams consisting of psychiatrists, psychologists, social workers, and other clinical and administrative support staff promote optimum continuity of care. They ensure that patients receive needed treatment at the right time and in the most appropriate setting.

The Primary Care Mental Health Integration (PCMHI) program, which works in conjunction with the Primary Care Patient Aligned Care Teams (PACT), is one of the ways in which BMS is addressing MH needs. This collaborative approach involves psychiatrists, psychologists, registered nurse care managers, and social workers providing time-limited, evidenced-based interventions directed at the management of depression, anxiety, and substance abuse in the primary care setting.

At the next level of MH care, BMS utilizes the Behavioral Healthcare Intake Program (BHIP) to simplify the transition and expedite access to outpatient behavioral healthcare services. BHIP's function is to complete a brief evaluation of new MH patients within 24 hours of initial contact, and if indicated, schedule a BHIP intake appointment for the comprehensive evaluation. BHIP also provides on-call services to the Emergency Department and primary care providers for urgent or emergency psychiatric situations that occur during regular business hours. An interdisciplinary team of psychiatrists, psychologists, social workers, and nurse practitioners provides the BHIP services, which include an initial triage evaluation followed by a comprehensive evaluation with a functional assessment in the following areas:

- Psychological
- Physical
- Substance use/abuse
- Developmental
- Family
- Educational
- Social/cultural
- Environmental
- Recreational
- Vocational

Based on this assessment, the evaluating clinician develops an individualized initial treatment plan, and when indicated, consults with the team psychiatrist for a medication evaluation. Members of the team are available to each other for consultation and treatment planning as needed. Patients may have several BHIP visits before they are

referred to Behavioral Healthcare Outpatient Services and Treatment (BHOST) or other appropriate referrals for ongoing services as needed.²

The facility's BHOST is the foundation of the BMS's outpatient treatment services. Psychiatrists, psychologists, social workers, and other clinical and administrative support staff offer a spectrum of ambulatory MH care, including psychiatric medication management, individual/group psychotherapy, crisis intervention, and dual diagnosis treatment. The duration of therapy as well as length and frequency of patient visits are individualized according to patient needs. Once stabilized, BHOST clinicians refer patients back to their primary care providers in PCMHI.

An anonymous complainant alleged that:

- BMS is understaffed.
- PCMHI and BHIP triage social workers are not evaluating patients adequately.
- Social workers are not required to keep their schedules full like other BHOST staff.
- Workload rules are not applied fairly to all staff.
- Patients "might wait a long time" before an intake or to see BHOST providers.
- Social workers lack clinical supervision and many are not licensed.
- The BMS Chief does not "ever meet with staff" or supervise MH care delivery at the facility.

Scope and Methodology

We conducted a site visit on March 13, 2012, and interviewed facility BMS staff from psychiatry, psychology, and social work service. We reviewed facility documents including local policies and standard operating procedures, BMS staffing and workload reports for 2011, and other relevant documents. We also reviewed the VISN's workload expectations for MH disciplines, VHA MH policies, and patient's electronic health records (EHR).

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

² VA Loma Linda Healthcare System, *Behavioral Healthcare Intake Program*, May 2001.

Inspection Results

The complainant made a total of seven allegations in the following four categories:

Issue 1: Staffing

We substantiated the allegation that BMS is understaffed based on the VISN 22 MH workload and productivity data. We noted that the VISN and facility leaders have already taken actions to meet staffing deficiencies.

In the absence of a national staffing standard for MH, the VISN 22 Clinical Services Council approved an Executive Decision Request (EDR)³ memorandum in May 2010. The EDR memorandum provides VISN-wide workload expectations for psychiatrists, psychologists, social workers, and nurse practitioners based on unique⁴ patients (uniques) seen and patient encounters⁵ (encounters) during a one-year period.

We reviewed the VISN's workload and productivity report (adjusted according to their clinical full-time employee equivalents [FTE]) for the facility during January through December 2011. The recommended volume (or panel size) of assigned patients is 80–100 percent of the VISN established guideline for each discipline. Based on this report, on average, psychiatrists, psychologists, and social workers' workloads were above the recommended panel sizes.

In January 2012, the facility received approval to hire 34 FTEs for MH, 27 of which are clinical staff positions. Two of the three approved psychiatrist positions had already been filled and during the time of our site visit, interviews were in progress for the remaining position. Eight new positions for social workers and five new positions for psychologists were also approved and interviews were in progress.

Issue 2: Workload Management

Social Workers' Patient Evaluation and Referrals to BHOST

We did not substantiate the allegation that PCMHI and BHIP triage social workers are not evaluating patients adequately.

We reviewed the EHR of 48 new MH patients who presented for care from January through December 2011. We found that the social workers consistently documented their triage and intake assessments on approved electronic templates. Forty-seven patients

³ VISN 22 Network Executive Board, *VISN 22 Workload Expectations for Mental Health Disciplines*, May 25, 2010.

⁴ Each patient with an identified and unduplicated social security number who uses healthcare services provided or funded by the VA.

⁵ Professional contact between a patient and a provider vested with the responsibility for diagnosing, evaluating, and treating the patient's condition per VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures*, June 9, 2010.

received initial evaluations appropriately; one patient refused further assessment and care. Of these 47 patients, 43 received intake assessments (comprehensive evaluations) at the MH clinic and 4 did not require further care. Thirty patients were subsequently referred to ongoing outpatient MH care and 13 patients were referred back to their primary care providers in PCMHI.

Social Workers' Appointment Schedules

We did not substantiate the allegation that social workers are not required to keep their schedules full like other BHOST staff. We found that social workers perform a variety of assignments and tasks including patient triage, individual short-term therapy, and group sessions.

We reviewed the VISN social workers' productivity data which included the number of appointments scheduled and work accomplished by each social worker for their assigned patients; the data showed workload exceeded VISN expectations. The social work service executive also monitors workload and productivity on a regular basis to ensure social workers' clinical time with patients is effective.

Unfair Application of Workload Rules

We could neither substantiate nor refute the allegation of unfair workload rules. The complainant specifically alleged that the "rules are not applied fairly to all VA staff."

We reviewed facility encounter data⁶ for psychiatrists, psychologists, and social workers from January through December 2011. For each clinician, the following factors were considered: total number of visits or encounters, expected number of visits or encounters, and assigned clinical FTE. As reported by the VISN, psychiatrists, psychologists, and social workers either met or exceeded their recommended workload expectations.

At the time of our site visit, psychiatrists and psychologists were expected to spend 80 percent of their time performing clinical duties and 20 percent of their time carrying out administrative duties. Because the same standards were not assigned to social workers, the perception could be that "workload rules" were not applied fairly to all staff. Facility leadership confirmed that the "80/20" rule was implemented for social workers in May 2012.

Issue 3: Patient Evaluations

We substantiated the allegation that patients "might wait a long time" for an intake assessment (comprehensive 14-day evaluation). In our review of the 48 new MH patients' EHRs mentioned previously, we assessed timeliness of the comprehensive 14-day and initial 24-hour evaluations.

⁶ Provided by VISN 22 MH Program Coordinator.

For the initial evaluation, one patient refused care before the evaluation could be completed. For the 47 remaining patients, waiting times for the initial evaluation ranged from 0 to 25.9 days. We found that 21 patients (45 percent) did not receive an initial evaluation within the required 24 hours, and for this subset the median waiting time was 6.1 days.

In evaluating the timeliness of comprehensive evaluations for the 47 patients, 2 did not appear for their scheduled appointment, and 2 had no documented evidence in the EHR that they were seen. Of the 43 patients who had a comprehensive evaluation, 14 (33 percent) were not evaluated within 14 days. Waiting times for the comprehensive evaluations ranged from 0 to 55 days. For the subset who did not have a comprehensive evaluation within 14 days, the median wait was 20.5 days.

Issue 4: Supervision and Oversight

Social Workers' Clinical Supervision and Licensure

We did not substantiate the allegation that social workers lacked clinical supervision; however, we substantiated that six social workers did not have licensure.

VHA Directive 2009-066,⁷ defines a social worker as an individual who has a Master's degree in social work from a school of social work that is accredited by the Council on Social Work Education. Social workers hired after August 14, 1991, who have not yet attained state licenses, must practice under the clinical supervision of a qualified social worker until they can meet the minimum prerequisites needed to qualify for taking a state licensure examination.

We reviewed the licensure documentation for all 63 social workers on staff. Of the 63, 55 were licensed, 2 had their licensure requirements grandfathered or waived,⁸ and the remaining 6 unlicensed social workers were in the process of meeting the prerequisites needed to take the state licensing examination. For each of the six unlicensed social workers, the facility provided evidence of co-signed notes by their clinical supervisors, and we determined that these individuals received appropriate clinical supervision by a qualified, licensed social worker.

Additionally, we examined processes for general supervision of all social work staff. The social work service executive completes performance evaluations three times per year: during the mid-year review report, during the annual appraisal, and in preparation for the annual budget meeting for the following fiscal year. Social work meetings are held quarterly to communicate current topics or areas of concern, and additional management

⁷ VHA Directive 2009-066, *Social Work Professional Standards Accreditation and Reimbursement from Third-Party Payers*, December 7, 2009.

⁸ VHA Directive 2009-066.

and oversight responsibilities are accomplished through emails and individual meetings as needed.

BMS Chief Supervision and MH Program Oversight

We did not substantiate that the Chief, BMS, did not provide supervision of MH care delivery. However, we substantiated the allegation that the Chief, BMS, did not “ever meet with staff.”

We noted that the Chief, BMS, delegates supervisory authority to and maintains communication with BMS supervisors. Weekly meetings are held with the supervising psychologist, the social work service executive, and the BMS program manager to discuss operational and personnel issues at this service-level leadership meeting. The Chief, BMS, appears to be aware of the capabilities of the psychiatrists and completes performance evaluations and ongoing professional practice evaluations of staff psychiatrists.

Each discipline reportedly conducts separate staff meetings with established agenda items. However, we found inconsistent documentation of staff meeting minutes, and only psychiatry service recorded meeting minutes for 10 of their staff meetings held between January 2011 and February 2012. We noted that the psychiatry staff meetings were chaired by the psychiatry training director and that the Chief, BMS, attended 5 of the 10 meetings.

The Chief, BMS, reportedly has an open door policy to meet with other BMS staff on an as-needed basis. However, the facility had not established a more formal process such as a MH Executive Council or any formally established committee geared towards improving care and coordinating communication between all MH disciplines, as required by VHA.⁹

Conclusions

Based on the VISN 22 workload expectations, we concluded that the facility needed more psychiatrists, psychologists, and social workers to meet the increased MH workload demands. We noted that the VISN and facility leaders have already taken actions to address staffing deficiencies.

We did not substantiate the allegation of inadequate patient evaluations by social workers. We also determined that social workers’ schedules were kept full with various assignments and tasks including patient triage, individual short-term therapy, and group sessions.

⁹ VHA Handbook 1160.01.

Despite our review of various processes, we were not able to determine if workload rules are “not applied fairly”. The 80/20 workload rule was implemented for psychiatrists and psychologists, and social workers.

We concluded that MH patients did not consistently receive timely initial and comprehensive evaluations. Although our conclusions are limited because of the small number of cases reviewed, improvements are needed so that patients may be evaluated and treated within the timeframe required by VHA.

We concluded that supervision for the social work staff was adequate and that unlicensed social work staff had appropriate clinical supervision.

We also concluded that the Chief, BMS, provided adequate supervision and oversight. We determined that the facility Director needs to establish a MH Executive Council as required by VHA.

Recommendations

Recommendation 1. We recommended that the Facility Director ensure that MH patients receive timely care, including initial evaluations within 24 hours and comprehensive evaluations within 14 days.

Recommendation 2. We recommended that the Facility Director establish a MH Executive Council as required by VHA.

Comments

The VISN Director concurred with our findings and recommendations. The VISN and Facility Directors provided acceptable improvement plans. (See Appendixes A and B, pages 9–12, for the full text of the Directors’ comments.) We will follow up on the planned actions until they are completed.



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

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: November 5, 2012

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

Subject: **Healthcare Inspection – Clinical and Administrative Issues, VA Loma Linda Healthcare System, Loma Linda, CA**

To: Director, Los Angeles Office of Healthcare Inspections (54LA)

Thru: Director, Management Review Service (VHA 10AR MRS)

1. I concur with the findings and recommendations in the Healthcare Inspection—Clinical and Administrative Issues report of the VA Loma Linda Healthcare System, Loma Linda, CA.
2. If you have any questions regarding our response, please contact Robert M. Smith, M.D., Acting Chief Medical Officer, VA Desert Pacific Healthcare Network, at (562) 826-5963.

(original signed by:)

Stan Johnson, MHA, FACHE

Director, VA Desert Pacific Healthcare Network (10N22)

Facility Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: 11/02/2012

From: Director, VA Loma Linda Healthcare System (605/00)

Subject: Healthcare Inspection – Alleged Clinical and Administrative Issues, VA Loma Linda Healthcare System, Loma Linda, CA

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

1. Please see the Loma Linda VA Healthcare System response to Draft Report of the Healthcare Inspection of the Loma Linda VA Healthcare System.
2. If you have any questions or need additional information, please contact Cindy Angulo at 909-583-6171



Shane M. Elliott, MBA, Acting Medical Center Director
Director, VA Loma Linda Healthcare System (605/00)

Director's Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General's report:

OIG Recommendations

Recommendation 1. We recommended that the Facility Director ensure that MH patients receive timely care, including initial evaluations within 24 hours and comprehensive evaluations within 14 days.

Concur Target Completion Date: 11-13-2012

Facility's Response:

Timely Care

When a patient screens positive on the Depression and/or PTSD screen, or is expressing Mental Health concerns or behaviors, the provider will do a warm hand-off to the MH staff located within Primary Care or Behavioral Medicine on-call team. This new process will be implemented by 11-13-2012.

The FY12 External Peer Review Program numbers for comprehensive 14 day MH evaluations show VA LLHCS ended consistently above the 96% compliance target, VA LLHCS ended FY12 at 97%. We believe that the selected sample was a poor representation of what is actually occurring for comprehensive MH evaluations within 14 days. The VA LLHCS monitors compliance with this metric on an ongoing basis.

Status: In Process

Recommendation 2. We recommended that the Facility Director establish a MH Executive Council as required by VHA.

Concur **Target Completion Date:** 11-13-12

Facility's Response:

Mental Health Executive Council

Concur - While we do not agree with the complaint that the Chief did not “ever meet with staff,” we do agree with the fact that “there is not a formal MH committee meeting with participants from all MH disciplines.” The Charter for the Mental Health Executive Council has been drafted and will be approved at MEC on November 13, 2012. The first meeting is scheduled to take place November 27, 2012.

Status: In Process

OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720
Acknowledgments	Douglas Henao, RD, Co-Team Leader Simonette Reyes, RN, Co-Team Leader Alan Mallinger, MD Mary Toy, RN

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