Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Patient Care Issues and Contract Mental Health Program Mismanagement Atlanta VA Medical Center Decatur, Georgia

Report No. 12-02955-178

April 17, 2013

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations:
Telephone: 1-800-488-8244
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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection to assess the merit of allegations made by a complainant regarding Atlanta VA Medical Center mismanagement and lack of oversight of a mental health (MH) contract. We substantiated the original allegations of mismanagement in the administration of the contract, but also substantiated additional allegations that there was inadequate coordination, monitoring, and staffing for oversight of contracted MH patient care.

Our review also confirmed that facility managers did not provide adequate staff, training, resources, support, and guidance for effective oversight of the contracted MH program. MH Service Line managers and staff voiced numerous concerns including challenges in program oversight, inadequate clinical monitoring, staff burnout, and compromised patient safety. The lack of effective patient care management and program oversight by the facility contributed to problems with access to MH care and contributed to "patients falling through the cracks."

For this hotline complaint, we did not assess the quality of MH care provided by the Community Service Boards, which maintain accreditations from the Commission on Accreditation of Rehabilitation Facilities. Our focus was on what the facility did or did not do in regards to coordination and oversight of the contracted MH patient care.

We recommended that the Under Secretary for Health take note and rectify the deficiencies described in this report with respect to the provision of quality MH care and contract management, with the goal that veterans receive the highest quality medical care from either the VA or its partners.

We recommended that the Facility Director evaluate the care of patients discussed in this report with Regional Counsel for possible disclosure(s) to the appropriate surviving family member(s) of the patients.

The Under Secretary for Health and the Veterans Integrated Service Network and Facility Directors concurred with our recommendation(s) and provided an acceptable action plan. We will follow up on the planned actions until they are completed.

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

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections (OHI) conducted an inspection to assess the merit of allegations of mismanagement and lack of oversight of a mental health (MH) patient care contract at the Atlanta VA Medical Center (facility) in Decatur, Georgia.

Allegations

During May 2012, an anonymous complainant contacted the OIG Hotline Division and alleged that the facility's MH Service Line (MHSL):

- Did not provide appropriate oversight of the MH contract, for services provided by the DeKalb Community Service Board (CSB).[1]
- Received approval for $2 million for contracted MH care funding in fiscal year 2012; however, they submitted additional requests for up to $12 million. Further, a MHSL senior manager continued to send patients to the contractor when aware that the funds were not available for payment.
- In conjunction with the Health Administration Service (HAS),[2] processed and paid millions of dollars in CSB claims in which services were allegedly provided with little documentation to support the number and timeframe of treatments. CSB treatment plans, if available, were open ended with no expected outcomes or number of visits.
- Did not follow-up with the required Veterans Health Administration (VHA) authorization for residential patients that were extended beyond the 28-day residential program.

[1] DeKalb CSB is one of 26 CSBs providing outpatient MH care in Georgia. CSBs are public nonprofit organizations located throughout Georgia, some of which have multiple sites.
[2] Health Administration Service is the former Medical Administrative Service within the facility.

- Provided blanket authorizations for non-specified CSB services provided to patients. In one case, the facility authorized 12-20 treatments for a patient, but made payments for over 70 DeKalb CSB treatments. There were no consults for additional services, no prior approvals, and no inquiries by the MHSL or HAS regarding the additional services performed.
- Allowed contract pricing inconsistent with Medicare coding guidelines by paying for group therapy in 15-minute increments with no limits, which significantly exceeded Medicare reimbursement rates for excessively long sessions.[3]

In addressing these allegations, we conducted an inspection of the facility's contract MH program. During our inspection, staff brought the following additional allegations to our attention, and we evaluated these in this report:

- There were occurrences of adverse events, including the death of some CSB referred patients.
- Facility managers did not ensure:
  - Appropriate management of the MH contract or patient care activities, including quality assurance (QA) processes; staffing; oversight; monitoring and tracking; and invoice processing.
  - Effective communication and stewardship with CSBs, including clarification of policies, coordination of care, documentation of expectations and desired patient outcomes, and strategic planning.
  - Adequate process and lead-time for renewal of the MH contract which was due to expire January 31, 2013.
  - Seamless transition of the coordination of care for those patients whose CSB services will abruptly end with the contract's expiration.

Background

Facility

The 405-bed teaching facility provides a broad range of emergency, medical, surgical, geriatric, long-term care, and MH services. The facility also provides outpatient services at eight community based outpatient clinics located in Austell, Blairsville, East Point, Lawrenceville, Newnan, Oakwood, Rome, and Stockbridge, GA. The facility is part of Veterans Integrated Service Network (VISN) 7 and serves a veteran population of approximately 86,000 patients.

[3] Medicare reimbursement for Current Procedure Terminology (CPT) code 90853 refers to a group therapy session that is not defined by time. The allegation asserts that CSBs invoices used time-based increments (15 minutes) that, when totaled, significantly exceeded Medicare's reimbursement rate for a group therapy session.

In 2008, VISN 7 established a contract with Select Systems LLC (SELECT), an affiliate of the Georgia Association of Community Service Boards (CSB). The SELECT contract provides general outpatient MH services, crisis stabilization, and psychosocial rehabilitation/day treatment to patients referred by any of the eight VA Medical Centers in VISN 7. Twenty-six CSBs provide MH care as subcontractors under the contract with SELECT.

In addition to the SELECT contract, the facility contracts with a local private-sector MH hospital for patients requiring inpatient care when beds are not available at the facility's 40-bed inpatient MH unit or for the involuntarily admission of a patient, if required.

According to VISN Support Services Center, the total number of MH unique patient visits on the facility's General MH Clinic (GMHC) increased by 21.9, 11.5, and 6.3 percent in FY 2010, FY 2011, and FY 2012, respectively.

MH Electronic Wait List (EWL)

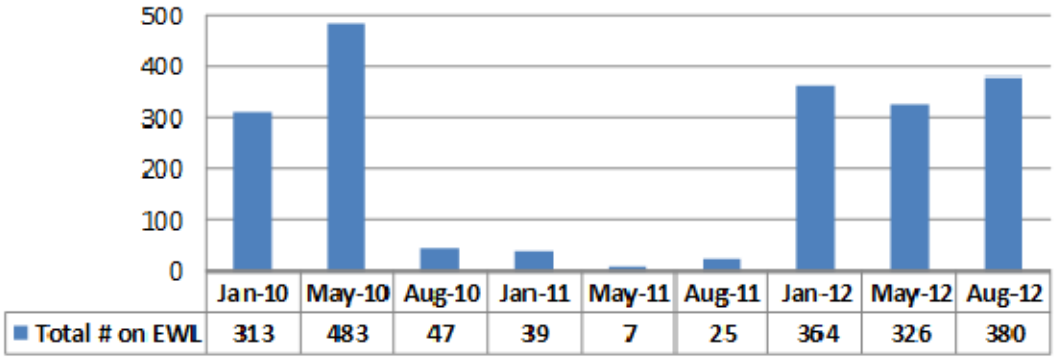
VHA requires that all new patients requesting, or referred for, MH services "…receive an initial evaluation within 24 hours, and a more comprehensive diagnostic and treatment planning evaluation within 14 days."[4] For measuring wait times, VHA defines a "new" patient as one not seen by a qualifying provider (licensed clinician) in a specific clinic within the previous 24 months. For example, an "established" primary care patient initially referred to the MH clinic is classified as a new patient to the MH clinic. The EWL is the official VHA wait list, and "… is used to list patients waiting to be scheduled, or waiting for a panel assignment. In general, the EWL is used to keep track of patients with whom the clinic does not have an established relationship (e.g., the patient has not been seen before in the clinic)."[5]

In 2011, OHI substantiated a hotline allegation that several MH clinics had significantly high numbers of patients on their EWLs over a period of months in FY 2010. The facility managers were aware of the high number of patients in need of MH services further adding to the EWL, but were slow in taking actions to address the condition. [6]

The facility increased the utilization of the SELECT contract, which reduced the patients on the EWL from January 2010 through May 2011; however, by August 2011, the EWL began to increase (see Chart 1).

[4] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.
[5] VHA Directive 2009-070, *VHA Outpatient Scheduling Processes and Procedures*, December 17, 2009.
[6] VA OIG Healthcare Inspection Report 10-02986-215, *Electronic Waiting List Management of Mental Health Clinics*, July 12, 2011.

Chart 1: Facility Outpatient Mental Health Wait List



As of July 2012, the facility reported 25 patients on the EWL for the GMHC and 372 patients on the EWL for CSB MH treatment (see Chart 2). Until the facility received confirmation that the patient attended their initial CSB appointment, they remained on the EWL. As of our site visit, the facility had no consistent process for notification or confirmation whether a referred patient attended an initial CSB appointment.

Chart 2: Electronic Wait List Growth at Atlanta VA Medical Center

EWL Site	Number of Patients on EWL in 2011	Number of Patients on EWL as of July 2012	Range of Days on EWL
CSB	36	372	1–261
GMHC	17	25	56–303
Total	*53*	*397*	

VA Central Office Consultative Review

In FY 2012, VA Central Office (VACO) conducted focused consultative reviews of all VHA MH programs and services. They visited the facility in May 2012 and made several recommendations to improve MH services. In their report, VACO reviewers noted the facility's estimate that the community provided 50 percent of all inpatient MH care and 25–33 percent of all outpatient care for the 15,000 MH outpatients enrolled at the facility.[7]

The VACO report also noted a high number of staff vacancies caused primarily by the lack of space and non-competitive salaries for psychiatrists. MHSL managers were aware of this and provided a vacancy report during the visit reflecting 66.25 vacant full time employee positions, with 28 of these positions being unfilled due to "awaiting space" or the anticipated FY 2013 domiciliary opening. The VACO report recommended

[7] VACO Consultative Site Visit Report, Atlanta VA Medical Center, May 15-16, 2012.

that the "…MHSL managers review their vacancies and work with the facility managers to develop an action plan to address the needed space to fill vacancies as quickly as possible."

Contract Liaison and Referrals

The facility's contract liaisons (CL) serve as coordinators for patients referred for MH treatment while in transition between the facility and CSBs. According to the functional statements, CL responsibilities include clinical oversight, treatment plan development in collaboration with the CSBs, site visits, problem resolution, and intermediary duties between the facility and the CSBs.

Initially, there was no separate consultation request or tracking system for CSB-referred patients. To coordinate these referrals, staff initiated the use of a specific CSB consultation request, established exclusion criteria, and identified a protocol for referrals.

At the time of our visit, the sequence of steps for a MH referral was:

1. A provider referred the patient to the facility's MH Assessment Team (MHAT).
2. A MHAT psychiatrist evaluated the patient, prescribed medications, and submitted a consult to either the facility's GMHC or a CSB for follow-up care based on clinical criteria that prioritized the most clinically urgent cases to remain at the facility's GMHC.
3. For CSB-referred patients, a MHSL Program Support Assistant (PSA) faxed copies of the medical record to the CSB.
4. The PSA administratively tracked the referral and updated the patient's electronic health record (EHR) to reflect consultation status.
5. Patient was placed on the CSB EWL until patient was seen at the CSB.

The facility reported referring 4,000–5,000 patients to CSBs for MH treatment since the initiation of the contract. The high volume of patients and limited staff resources made the referral and tracking of patients to the CSB programs a continuous challenge.

Scope and Methodology

We conducted two site visits, July 23–26 and September 24–25, 2012, during which we visited the facility, four of the most frequently utilized CSB outpatient programs, and one of the CSB substance abuse residential treatment programs. We conducted interviews with key personnel knowledgeable about the issues raised by the complainant. We reviewed EHRs and reports including patient advocate reports, incidents reports, root cause analyses (RCA), staffing and vacancy data, and quality management data. We also reviewed the SELECT contract, functional statements, relevant facility policies and procedures, as well as documentation and information provided by the CSBs.

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.

Inspection Results

Issue 1: Contract Program Administration and Management

As more patients were referred on the contract, the administrative and managerial difficulties increased. The contract was not specific on documentation requirements for patient coordination or invoicing. This was a complex contract that involved VISN 7 Contracting Officer, VISN 7 MH Administrative Officer, facility contracting officer technical representative (COTR), the CLs, SELECT contractor, and staff from the 16 CSBs used by the facility (as of June 2012). The lines of communication and responsibilities were not clear to handle the many issues that occurred frequently. Additionally, the facility's invoice approval and payment process involved the coordination of both clinical and administrative staff. While the COTRs and CLs are responsible for day-to-day coordination with each CSB, they did not have the authority to enforce contract provisions or resolve many of the billing issues.

Contract Administrative and Billing Issues

The contract statement of work outlined the contractor and facility's responsibilities for executing and administering the contract. The contract was missing elements of the statement of work that would provide guidance to the CSBs about VA documentation and notification requirements. The CLs spent most of their time reacting to emergent CSB questions and patient coordination problems, and were not able to do many of their other responsibilities such as tracking referrals, reviewing patient records, approving the authorizations, and certifying monthly invoices for each of the CSBs. The facility was required to certify that the CSB MH services were authorized and had been performed before invoice payment. The contract did not specify what documentation was required for reimbursement for MH services, so administrative coordination with each of the 26 CSBs was very time consuming. The facility struggled with how to smoothly process and pay the monthly invoices. The lack of clear lines of communication impeded the resolution of discrepancies.

As the number of patients referred to the CSBs continued to grow, the facility staff had increasing difficulty processing the claims and invoices. Furthermore, the facility did not promptly communicate the reasons for payment denial to the CSBs. This delayed resolution of the billing problems and prompted some CSBs to refuse acceptance of new patients.

Staff from a CSB wrote the following in an email to the facility:

> Thus, it is with disbelief that I send this email about the processes for payment. I have been calling and emailing for weeks to get monies released for payment. After weeks of persistence and follow up, I was finally informed that our invoices were being held because we billed the 853 [group therapy code] services at the […] rate instead of the correct rate […].

In some cases when the CSBs provided clinical progress notes along with invoices, the facility did not consistently scan and upload available CSB progress notes into the patient's EHR. The facility conducted a QA review in the third quarter of FY 2012 and found that only 35 percent of paid claims were properly documented. However, the four CSBs interviewed reported to us that the facility had significant communication gaps regarding changes in requirements or notification of missing documentation. Billing problems continued until recently when the facility added staff and made process improvements in response to CSB staff complaints regarding unpaid claims.

Authorization and Certification of Claims

According to the facility's functional statement, the CL is responsible for reviewing authorizations and treatment plans. The CL must ensure that there is an active authorization in place for the provision of CSB services by reviewing the consultations and treatment plans. Staff reported that many times they "rubber stamped" authorizations and extensions (for up to 24 months) because they could not keep up with the volume of work due to time constraints and lack of available resources.

Sufficient Funds

The facility did not know the number of patients receiving services on the SELECT contract, and therefore, could not adequately estimate the required funding. The facility's budget tracking sheet showed that $6.7 million was originally budgeted in FY12, but required an additional $3.2 million to fund the contract for the remainder of the FY.

We did not substantiate the allegation that MHSL senior managers continued to send patients to the CSBs when funds for payment were not available. We did find that the facility did not know the number of patients receiving MH care by the CSBs, which made budgeting difficult. However, we did not find evidence that the available funding had been an issue.

Contract Pricing

We did substantiate the allegation that contract pricing for services did not follow Medicare coding guidelines for the group therapy CPT code 90853, established at $35 per person per session; however, since this is a negotiated contract the Medicare rate is not a factor. Medicare sets an amount for a group therapy session with no time limit assigned.

The contract allowed CSB group therapy pricing on an individual basis for each 15-minute increment, with no maximum amount specified. We found some examples of the facility paying for CSB sessions billed in 12 increments (3 hours). The Contracting Officer determined that these payment terms had been agreed to in the price negotiation and could not be changed. A new contract could address this issue, but not in the current contract.

Issue 2: Contract MH Program Oversight and Referral

CSB Tracking Issues

We substantiated that the facility had not established an effective tracking and monitoring system for patients referred to CSBs. More importantly, program managers were unable to identify the enrolled CSB patients. In addition, the facility had not assigned sufficient oversight staff to appropriately monitor and track patient care.

The facility referred patients to the CSBs for several years before they started to track the patients referred. The facility estimated that they referred between 4,000 and 5,000 patients since 2010, but did not know the status of those patients. The facility managers were aware that a large number of patients were "falling through the cracks" and estimated that the MHAT team continued to refer up to 60 new patients each week to the CSBs.

One MHSL staff member reported the following:

> There is no case management or follow up. I do not have a list of how many people are being seen in the community. I do not know how to get that information unless we call 4000 or something vets and ask them. When I first started, I went out (on site visits). There is no time. We have referred out over 4000.

Administrative Staffing and Training

At the time of our review, the facility had assigned approximately 10 employees (some with collateral duties) to manage and provide oversight for over 4,000 patients referred to CSB programs. These included one COTR, two MH CLs, two Substance Abuse (SA) CLs, and six PSAs. Facility employees, including three who resigned and one who requested resignation, voiced strong concerns regarding a lack of support from facility managers in resolving problems brought to their attention. These employees also described challenges in program oversight, inadequate clinical monitoring, staff burnout, and compromised patient safety due to the unmanageable volume of patients assigned to the program.

An email on February 22, 2012, from the Director, Acute MH Services to the Chief MHSL summarized a meeting between the Chief of Staff, Chief of MHSL, COTR and MHSL Administrative Officer about inadequate staffing for clinical and administrative oversight as follows:

> The highlighted issues included the large number of patients that are involved (approximately 4,000 uniques, which is larger than other MH sections), no clinical staff dedicated to oversee clinical care provided by the contractors, clinical providers that have been pulled from other clinical areas to manage the contract, and how the service line is understaffed with regards to managing the contract. The group discussed that the service line is concerned that many patients have been lost to follow-up, that the MHSL does not have a handle on who those patients may be, and does not have sufficient staff to adequately determine this.

MH Contract Oversight

According to the CL functional statement, the CL independently conducts clinical site visits, develops treatment/recovery plans in collaboration with contract programs in support of the patient's individualized needs and recovery goals, and provides ongoing education for the contracted CSBs regarding clinical issues identified by the CSB and/or the facility.

Because of limited staff, they were unable to provide adequate clinical oversight, collaborative treatment planning with the CSB staff, or follow-up site visits. A July 29, 2011, MHSL Clinical Operations Committee meeting highlighted the importance of the facility monitoring CSB patients to ensure quality of care. The minutes included a discussion about the need for additional contract support, as follows.

> It was made clear that the current core group of three clinicians working on the CSB contracts is overwhelmed by the workload and will not be able to "hang on" for a year without additional contract support made available. To use contract providers efficiently would require more detailed monitoring of services for each veteran and the resources to monitor and review documentation if additional treatment is indicated.

In addition, VHA requires that all new COTRs have the training required to perform their duties no later than 6 months after their initial appointment.[8] The COTR assigned in February 2011 to the inpatient and outpatient MH program contracts had not yet received the required training more than a year later.

[8] *Office of Acquisition and Logistics Information Letter*, April 10, 2008, http://www.va.gov/oal/docs/library/ils/il08-02.pdf (accessed November 14, 2012).

We did not review the care provided by the CSBs. However, VA has responsibility to provide oversight and appropriate monitoring of access to contracted care to ensure that patients receive an equivalent level of care under a contract as they would receive at a VA facility. This is problematic due to lack of oversight of care and QA activities. Our review confirmed that there were ongoing concerns communicated to facility managers and documented through meeting minutes, e-mails, an RCA, and other reports

MH Contract Referrals

The process for scheduling initial CSB appointments was ambiguous and not tracked by the facility. Appointments were scheduled by the patient, the facility, or by the CSBs. Many times the facility did not know who was scheduled for CSB appointments or if patients were seen by the CSB providers. During the wait period for the initial CSB appointment, there was typically no clinical contact between the patient and the facility; therefore, the patient could "fall through the cracks."

We reviewed 85 EHRs from a list received from the facility of CSB referred patients. We found that 21 percent of our random sample of CSB referred patients were never provided care by the CSBs, with no follow-up provided by the facility. VHA requires that an initial MH appointment be scheduled within 14 days of a referral. The contract did not have a time requirement, but only stated that the expectation was patients would be seen as soon as possible. We found that patients waited an average of 19 days for their initial MHAT assessment (range from 1 to 80 days). Seventy-four percent of CSB referred patients had wait times greater than 14 days, with a wait time average of 92 days and a median of 56 days (range from 5 to 432 days).[9]

The following three cases illustrate the facility's lack of a clear process for CSB appointment scheduling, and the facility's insufficient processes for tracking referral status and monitoring interim intra-facility care coordination for patients referred to contracted care.

Patient 1 (2012): This case involves a middle-aged patient with a history of suicidal behavior. The patient's EHR chronology of documented events is as follows:

- Day 1 – Patient who was reportedly receiving MH treatment from a private psychiatrist called the Veterans Crisis Line with suicidal ideation (SI) due to chronic pain, depression, lack of sleep, and headaches. He was referred to MHAT for an evaluation.

- Day 10 – MHAT evaluated the patient with a complete MH intake by a psychiatrist. He reported ongoing SI, but denied intention to harm himself.

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

MHAT instructed the patient to contact the CSB to schedule an appointment in addition to continuing medications initiated by his private psychiatrist.

- Day 44 – VA facility staff made "an outreach [telephone] attempt" and documented in patient's EHR that they left a message for the patient on that day.
- Day 78 – A PSA documented that an initial CSB appointment was scheduled initially for day 93, but moved to 2 weeks later (day 107) per patient request.
- Day 107 – Patient was reportedly a "no show" for his initial CSB appointment.
- Day 206 – He attended an appointment with his primary care provider and reported feelings of depression. He also reported that he was seeing a private provider for MH issues.
- Day 223 – Patient found unresponsive in a hotel room by the police. The police were unsuccessful in reviving him and he died of an apparent drug overdose.

The facility subsequently developed a process to track CSB-referred patients in January 2012.

Patient 2 (2011): This case involves a middle-aged patient with a long history of MH issues, including suicidal behavior. A facility psychiatrist evaluated the patient and prescribed medications for treatment of depression. The patient expressed not having a plan to commit suicide. A follow-up appointment was scheduled for 4 weeks later. The psychiatrist also submitted a consultation to the CSB. A PSA informed the patient of the CSB referral process, including that CSB staff would review his medical record and contact him to schedule an appointment.

Approximately 3 weeks later, the patient was still waiting for an appointment with the CSB. We note that he was being seen in Health Care for Homeless Veterans groups and other treatment groups during this time. He expressed to the facility's Healthcare for Homeless Veterans staff that he felt hopeless, depressed, and suicidal. Healthcare for Homeless Veterans staff consulted with their psychiatrist who, unable to see the patient, directed staff to send him to the facility's Emergency Department. The patient was advised to go to the Emergency Department via public transportation, but never went. The next day the patient committed suicide..

In addition to issues involving a tracking process and coordination of care, this case raises questions regarding patient management on the day prior to the patient's death.

Patient 3 (2012): This case involves a patient with a psychiatric history to include depression with psychotic symptoms. The patient's EHR chronology of documented events is as follows:

- Day 1 – Patient referred to CSB for general MH care.
- Days 42 and 55 – Patient informed the VA facility staff that he was still waiting to be scheduled for an initial CSB MH appointment.
- Day 110 – While waiting for CSB appointment, patient was hospitalized for psychiatric symptomatology, to include depression, and SI.
- Day 157 – Patient again hospitalized for psychiatric issues, including depression, and SI. VA facility staff referred the patient to specialized CSB treatment as part of his discharge plan; however, they did not schedule an admission date at time of discharge.
- Day 173– CL documented patient not reachable by phone. Further documentation stated patient was incarcerated.

Residential SA Treatment

An allegation was made that services were authorized for residential patients beyond the 28-day residential program and that patients were referred by CSB providers to outpatient treatment without VA authorization. The usual length of stay for residential treatment is 28 days. We reviewed 23 EHRs of patients who received CSB residential treatment. Some patients remained at the residential facility longer than 28 days as alleged, which we found was due to the lack of housing for homeless patients. Upon admission to the residential program, patients are referred to the VA Homeless Program for housing services upon discharge. According to VA facility and CSB staff, there are often delays in placement due to a high demand for housing. Homeless patients who remain in the residential treatment program await discharge until adequate housing is secure. As alleged, there was no written authorization for clinically appropriate treatment extensions.

Issue 3: Contract Program QA Integration

The integration of an effective QA program between the facility and the CSBs is an essential requirement to ensure high quality of patient care as stated in the contract. The facility did not fulfill the following QA requirements.

- Establishing an effective monitoring and evaluating procedure
- Assessing and monitoring patient care through:
  - Reviewing medical record documentation
  - Evaluating performance measures
  - Inspecting facilities to ensure quality and patient safety in accordance with VHA and applicable external standards
  - Investigating adverse events and assessing adequacy of actions taken
  - Tracking and trending patient complaints and satisfaction
- Certifying and processing payment invoice promptly

We found the facility did not have a CSB-specific QA process in place to facilitate quality care and safety. In addition, CLs did not consistently provide follow up site visits, monitor patient progress, or review documentation of CSBs services provided. The four CSBs we visited were accredited by the Commission on Accreditation of Rehabilitation Facilities, and had active QA programs. While the CSBs maintained QA information, we were informed that the facility never requested it.

Conclusions

MHSL managers did not adequately oversee or monitor contracted patient care services to ensure safe and effective treatment. This lack of effective patient care management and program oversight by the facility contributed to problems with access to MH care and may have contributed to patients falling through the cracks. The facility's contract program lacked an integrated and effective QA program and did not have a CSB-specific QA process although a QA matrix was proposed for possible inclusion in the new contract. For example, VA facility program managers did not track and trend patient complaints, or conduct oversight visits to the CSB sites, as required by VA directives and the contract.

The facility failed to coordinate the necessary MH services for this at-risk population in that, as previously stated, 21 percent in our random sample of CSB-referred patients in need of MH care were not provided MH care by the CSBs or the facility. Fragmented and uncoordinated care may have contributed to delays in accessing MH treatment.

Our review also confirmed that facility managers did not provide adequate staff, training, resources, support, or guidance for effective oversight of the contracted MH program. MHSL managers and staff voiced numerous concerns including challenges in program oversight, inadequate clinical monitoring, staff burnout, and compromised patient safety. Furthermore, other administrative issues contributed to the delay because the facility managers did not pay invoices promptly. These delays affected the CSB's ability to accept new patients and plan their patient census.

On January 31, 2013, the contract with SELECT expired. Facility managers negotiated a short-term (8-month) contract to cover the need for community MH services until a longer-term contract is negotiated. Facility managers were recruiting additional MH staff and opening additional MH clinics to improve access to MH care at the facility. Facility managers acknowledged that they would continue to need CSB contractual arrangements. However, we believe the facility needs to communicate these plans to the CSBs in order to transition patient care effectively and to address future MH community resources.

Recommendations

Recommendation 1. We recommended that the Under Secretary for Health take note and rectify the deficiencies described in this report with respect to the provision of quality mental health care and contract management, with the goal that veterans receive the highest quality medical care from either the VA or its partners.

Recommendation 2. We recommended that the Facility Director evaluate the care of patients discussed in this report with Regional Counsel for possible disclosure(s) to the appropriate surviving family member(s) of the patients.

Comments

The Under Secretary for Health and the Veterans Integrated Service Network and Facility Directors concurred with our recommendations and provided acceptable action plans. (See Appendixes A and B, pages 15-20 for the Under Secretary's and 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

Appendix A

Under Secretary for Health Comments

Department of Veterans Affairs

Memorandum

Date: APR 05 2013

From: Under Secretary for Health (10)

Subj: Healthcare Inspection – Patient Care Issues and Contract Mental Health Program Mismanagement, Atlanta VA Medical Center, Decatur, Georgia (VAIQ 7344060)

To: Assistant Inspector General for Healthcare Inspections (54)

1. The Veterans Affairs (VA) Office of Inspector General Office of Healthcare Inspections conducted an inspection to assess the merit of allegations made by a complainant regarding Atlanta VA Medical Center mismanagement and lack of oversight of a mental health contract for services provided by the DeKalb Community Service Board.

2. I have reviewed the draft report and concur with the report's recommendations. Attached are corrective action plans.

3. Should you have additional questions, please contact Karen Rasmussen, M.D., Director, Management Review Service, at (202) 461-6643, or by e-mail at karen.rasmussen@va.gov.

Robert A. Petzel, M.D.

Attachment

Under Secretary for Health Comments to OIG's Report

The following Under Secretary for Health comments are submitted in response to the recommendations in the OIG's report:

OIG Recommendation

Recommendation 1. We recommended that the Under Secretary for Health take note and rectify the deficiencies described in this report with respect to the provision of quality mental health care and contract management, with the goal that veterans receive the highest quality medical care from either the VA or its partners.

Concur **Target Completion Date**: July 31, 2013

Response: The facility will develop an action plan and obtain approval by VHA leadership by the established timeline. The action plan will address the outlined issues and the facility will provide quarterly updates to the Director of Mental Health Operations on progress thereafter. The action plan will include the following:

1. Addressing specific contract concerns including contract administrative and billing issues, methods for authorization and certification of claims, budgetary review of sufficient funds to cover the contract, and contract pricing. This will also include reviewing and updating the contract, as needed, to address documentation and treatment requirements as outlined by VHA policy.

2. Addressing contract mental health program oversight and referral. This will include creation of a tracking and monitoring system for patients being served by contract services in the community. This tracker will include a listing of all patients currently served on the contract, addition of new referrals to contract care, date of initiation of treatment, date of conclusion of treatment, and date of referral back to VHA care, as appropriate. Wait times for initial appointments will be tracked for contract services. For Veterans waiting beyond the 14-day time frame, services will be initiated in another format until contract services are available. The action plan will include a review of staffing and training issues for oversight of the contract and a plan to mitigate any identified concerns. Further, contract oversight issues will be

addressed including receipt of Contracting Officer's Technical Representative training and monitoring of quality of mental health care at the contract site. Finally, extension of residential care beyond 28 days will have documentation of written authorization by the facility.

3. Addressing contract program quality assurance integration. The action plan will address the following requirements: establishing an effective monitoring and evaluating procedure, assessing and monitoring of patient care, and certifying and processing payment invoices promptly. Assessment and monitoring of patient care will include reviews of medical record documentation, performance measure evaluation, facility inspections to ensure quality and patient safety in accordance with VHA and applicable external standards, investigating adverse events and assessing adequacy of actions taken, and tracking and trending patient complaints and satisfaction.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: March 27, 2013

From: Director, VA Southeast Network, VISN 7 (10N7)

Subject: **Healthcare Inspection – Patient Care Issues and Contract Mental Health Program Mismanagement, Atlanta VA Medical Center, Decatur, Georgia**

To: **Assistant Inspector General for Healthcare Inspections (54)**

1. I have reviewed the draft report and support the facility's concurrence with Recommendation #2 and their corrective action plan as attached.

2. Thank you for the opportunity to review the report and for partnering with us to improve the quality and safety of care that we provide to Veterans at the Atlanta VA Medical Center.

Charles E. Sepich, FACHE

Charles E. Sepich, FACHE

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: 3/25/2013

From: Interim Director, Atlanta VA Medical Center (508/00)

Subject: **Healthcare Inspection – Patient Care Issues and Contract Mental Health Program Mismanagement, Atlanta VA Medical Center, Decatur, Georgia**

To: Director, VA Southeast Network 7 (10N7)

1. I have reviewed the draft report and concur with recommendation #2. The Facility's corrective action plan for this recommendation is attached.

2. Thank you for the opportunity to review the draft report. If you have any questions, please contact Vicki Heggen, Chief Quality Management at (404) 321-6111 (7653).

Sandy Leake, MSN, RN

Director's Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendation

Recommendation 2. We recommended that the Facility Director evaluate the care of patients discussed in this report with Regional Counsel for possible disclosure(s) to the appropriate surviving family member(s) of the patients.

Concur **Target Completion Date**: April 30, 2013

Facility's Response: Attempts to reach family members to provide clinical disclosure at the time of the events were unsuccessful. The Facility, in consultation with Regional Counsel and re-evaluation of these cases, will repeat our efforts in contacting family members in order to conduct institutional disclosure.

Appendix B

OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Acknowledgments	Anthony M. Leigh, CPA, CFE Terri Julian, Ph.D. Nelson Miranda, LCSW Melanie Oppat, MEd, LDN Michael Shepherd, MD, Physician Consultant Joanne Wasko, LCSW

Appendix C

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