



**Department of Veterans Affairs  
Office of Inspector General**

**Office of Healthcare Inspections**

**Report No. 14-04897-221**

**Healthcare Inspection  
Quality of Mental Health Care  
Concerns  
VA Long Beach Healthcare System  
Long Beach, California**

**March 30, 2016**

**Washington, DC 20420**

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## Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection in response to complaints about the quality of care for patients with mental health conditions at the VA Long Beach Healthcare System (system), Long Beach, CA.

We did not substantiate that female patients with military sexual trauma were denied mental health counseling and did not receive individual counseling because of the lack of trained therapists.

We did not substantiate that the system denied medical care to female patients with 100 percent military sexual trauma-related mental health conditions, that these patients waited months for medical treatments, or that the Non-VA Care Coordination referral process was inefficient.

We did not substantiate that a male patient committed suicide in 2014 because he was denied mental health treatment. However, we identified quality of care concerns related to chronic pain management for one patient. The primary care provider did not refer the patient to specialists for second level review.

We recommended that the System Director ensure that primary care providers follow established guidelines for referral of patients with chronic pain as required by VA policy.

### Comments

The Veterans Integrated Service Network and System Directors concurred with our recommendation and provided an acceptable action plan. (See Appendixes A and B, pages 12–14 for 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

## Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection to assess the merit of allegations made by an anonymous complainant regarding the quality of care provided to patients with mental health (MH) conditions at the VA Long Beach Healthcare System (system), Long Beach, CA.

## Background

The system is a tertiary medical center that provides primary and secondary medical, surgical, neurological, psychiatric, and rehabilitative care. Patients are served at the parent facility and at community based outpatient clinics in Anaheim, Santa Ana, Whittier, Laguna Hills, and The Villages at Cabrillo. The system has 237 hospital beds and 99 community living center beds. It is part of Veterans Integrated System Network (VISN) 22.

The MH program provides evaluation and assistance for issues such as depression, mood and anxiety disorders, military sexual trauma (MST), elder abuse, and post-traumatic stress disorder (PTSD). Interdisciplinary personnel providing MH services include psychiatrists, clinical psychologists, social workers, registered nurses, pharmacists, MH technicians, and rehabilitation specialists.

MST is the term used by VA to refer to experiences of sexual assault or repeated, threatening sexual harassment that a veteran experienced during his or her military service.<sup>1</sup> MST in itself is not a diagnosis, rather, an experience that is associated with some patterns of symptoms. It is also considered a predictor of psychological distress and is associated with several MH diagnoses such as PTSD.<sup>2</sup>

### Women's MH Center

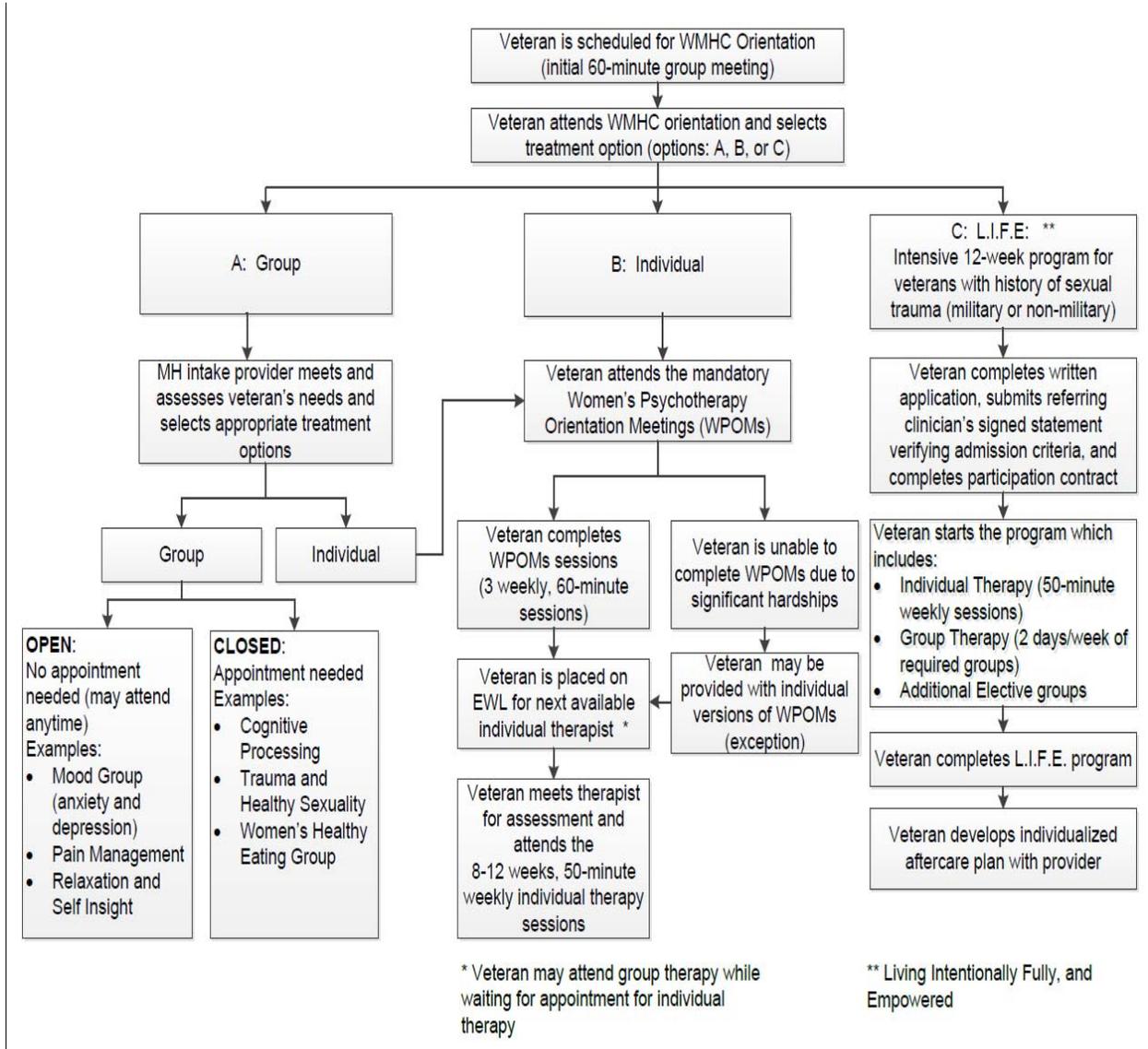
The system's Women's MH Center (WMHC) provides female patients with resources to resolve emotional distress, promote flexible thinking and integration, and maintain healthier relationships. It also provides treatment for sexual trauma, PTSD, anxiety, depression, difficulty in relationships, self-esteem, shame, anger, and grief. Female patients who need MH services are referred to the WMHC, which offers individual and group psychotherapies and support groups. Referred patients attend WMHC orientation, and the patient, in consultation with the provider, selects the best treatment option(s). Figure 1 on the next page displays the referral process and the three treatment options offered.

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<sup>1</sup> MST-MH Fact Sheet October 1, 2014. [http://www.mentalhealth.va.gov/docs/mst\\_general\\_factsheet.pdf](http://www.mentalhealth.va.gov/docs/mst_general_factsheet.pdf). Last accessed April 15, 2015.

<sup>2</sup> OIG report, *Inpatient and Residential Programs For Female Veterans with Mental Health Conditions Related to Military Sexual Trauma*, (Report No. 12-03399-54, December 5, 2012).

**Figure 1. WMHC Referral Process**



Source: VHA, VA OIG

### Non-VA Care Coordination Referral Process

Eligible patients are provided with Non-VA Care Coordination (NVCC) when VA services are not feasibly available. A preapproval for treatment in the community is required for non-VA medical care unless the medical event is an emergency.

The following is the process by which the system approves NVCC:

1. A provider places a consultation (consult) requesting care in the community. Typically this occurs when the service is not available at the system.
2. Administrative staff enter the names of new patients who cannot be scheduled within 90 days on the electronic wait list.

3. Administrative staff enter the names of established patients on the Veterans Choice Program<sup>3</sup> electronic wait list. This is required by VHA when a patient is given an appointment beyond the 30-day target.

### **VA Stepped Care for Chronic Pain Management**

VA defines stepped care as a strategy to provide a comprehensive range of treatments to patients with acute pain to long-term management of chronic pain diseases and disorders that may persist for more than 90 days or the patient's lifetime.<sup>4</sup>

- **Step One - Primary Care.** Requires the development of a competent primary care provider (PCP) workforce (including behavioral health) to manage common pain conditions. This entails the availability of system supports, family and patient education programs, collaboration with mental health-primary care teams, and post-deployment programs.
- **Step Two - Secondary Consultation.** Requires timely access to specialty consultation in pain medicine, physical medicine and rehabilitation, polytrauma programs and teams, inpatient pain medicine consultation, and collaboration of pain medicine and palliative care teams.
- **Step Three - Tertiary, Interdisciplinary Care.** Requires advanced pain medicine diagnostics and pain rehabilitation programs accredited by the Commission on Accreditation of Rehabilitation Facilities.

### **Allegations**

The OIG received a recording of a telephone message from an anonymous complainant regarding MH care provided at the VA Long Beach Healthcare System. Specifically, the complainant alleged that:

- (1) Female patients with MST were denied MH counseling and received group, not individual, counseling due to a lack of trained therapists.
- (2) Female patients with 100 percent MST-related MH conditions were denied medical care. Specifically:
  - a. These patients waited months for VA medical treatment.

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<sup>3</sup> The Veterans Choice Program provides non-VA health care for eligible veterans when the local VA medical center cannot provide the services due to lack of providers, longer than 30-day wait times for services, or when veterans live greater than 40 miles from the nearest VA medical center.

<sup>4</sup> VHA Directive 2009-053, *Pain Management*, October 28, 2009. This Directive expired October 31, 2014, and has not yet been updated.

- b. These patients experienced inefficient referrals through the NVCC program. Authorizations were not sent to outside providers, and therefore, patients could not schedule appointments with non-VA providers.

(3) A male patient committed suicide because he could not get MH treatment.

## Scope and Methodology

We conducted our work from October 2014 through February 2015. This included a site visit November 4–5, 2014. We interviewed system psychiatrists, psychologists, and licensed marriage and family therapists (LMFTs). In addition, we interviewed system managers, clinical care providers, and staff knowledgeable about MH and NVCC operations.

We reviewed relevant Veterans Health Administration (VHA) and system policies and procedures, patient advocate reports, committee meeting minutes, training records, staffing and workload data, and other applicable documents. Additionally, we reviewed the following:

- The electronic health records (EHRs) of female patients who had individual psychotherapy referrals during fiscal year (FY) 2014.
- The EHRs of female patients with 100 percent MST-related MH conditions seen in the WMHC who had psychotherapy and medical consults during FYs 2013 and 2014. We reviewed all 131 consults ordered for the 23 female patients identified. (See Figure 4.)
- The EHRs of 11 female patients with 100 percent MST-related MH conditions seen in the WMHC who had NVCC referrals in FY 2014. We focused our review on NVCC referral authorization and disposition processes.
- The EHRs of four patients identified by the system as having committed suicide during the 3<sup>rd</sup> or 4<sup>th</sup> quarter of FY 2014 and reports completed by the system's Suicide Prevention Coordinator. The complainant did not provide information, beyond the relative timeframe (approximately 1 month before the complainant contacted the OIG in September 2014) regarding the male patient who allegedly committed suicide.

We **substantiated** allegations when the facts and findings supported that the alleged events or actions took place. We **did not substantiate** allegations when the facts showed the allegations were unfounded. We **could not substantiate** allegations when there was no conclusive evidence to either sustain or refute the allegation.

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: Access to MH Counseling

We did not substantiate the allegation that female patients with MST were denied MH counseling and received group, not individual, counseling due to a lack of MST-trained therapists. We reviewed workload data and did not find evidence that the system denied female patients individual counseling. We also verified that all staff providing psychotherapy had completed required MST training.<sup>5</sup>

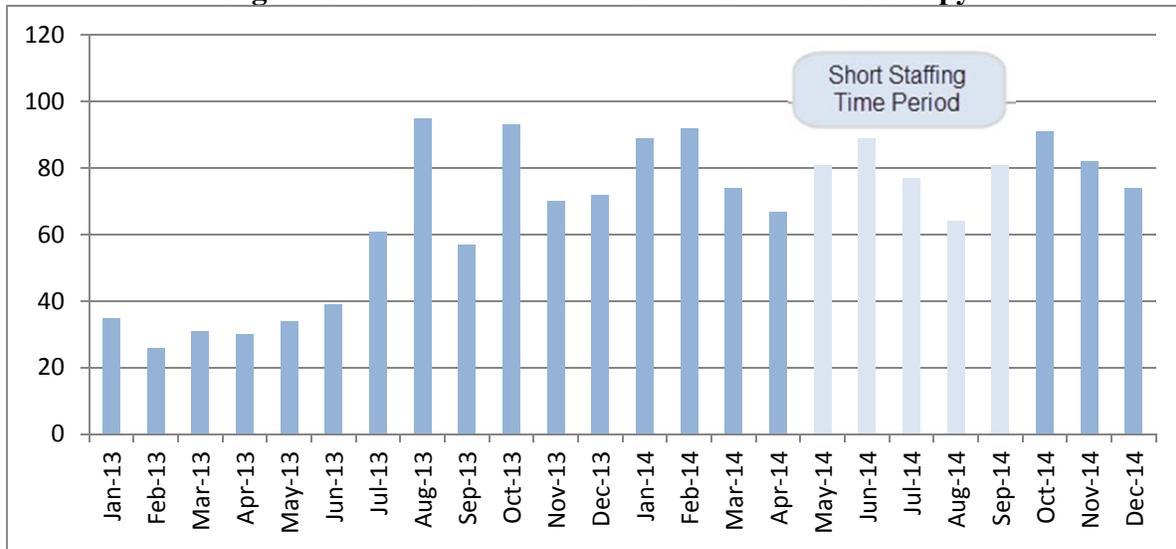
The system acknowledged that from May through September 2014, the WMHC had reduced staffing due to scheduled leave and the departure of a social worker. The WMHC's 0.5 full-time employee equivalent (FTE) social worker position was vacant, and the two 0.5 FTE LMFTs were on maternity leave. The WMHC's two psychologists and a part-time psychology trainee were unable to keep up with new referrals for individual therapy, which led to delays for patients seeking individual therapy. However, staff told us that none of the patients seeking individual therapy during this timeframe waited more than 90 days, and patients did not experience delays or extended waits for group therapy.

We reviewed monthly WMHC workload from January 1, 2013, through December 31, 2014. This timeframe precedes, coincides with, and follows the 2014 time period during which fewer WMHC clinical staff were available to provide therapy. Generally, the number of individuals seen each month for individual psychotherapy increased since mid-2013. Additional staff available to provide psychotherapy had been added to the clinic in 2013. Although the number of unique patients receiving individual therapy decreased during August and September 2014, reflecting the provider who had left the clinic and other providers on leave, overall the number of unique patients seen each month for individual psychotherapy during May to September 2014 was comparable to preceding and subsequent months. Figure 2 on the next page depicts the number of women patients seen by month who received individual therapy in the WMHC between January 1, 2013 and December 31, 2014.

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<sup>5</sup> VHA Directive 2012-004, *Mandatory Training of VHA Mental Health and Primary Care Providers on Provision of Care to Veterans Who Experienced Military Sexual Trauma*, January 23, 2012.

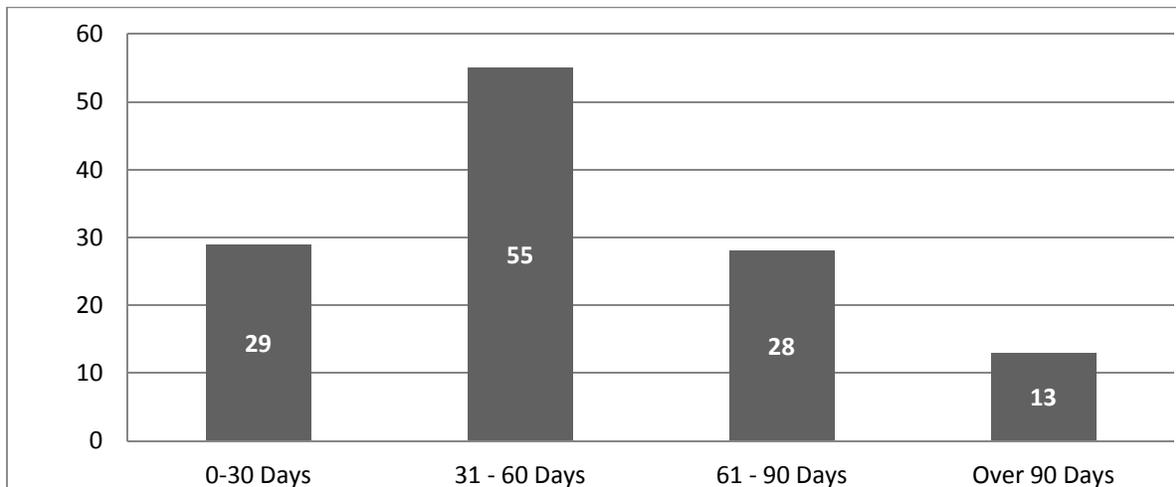
**Figure 2. Female Patients Seen for Individual Therapy**



Source: VHA, VA OIG

We reviewed the EHRs of 125 female patients who had individual psychotherapy referrals during FY 2014. The majority of women patients (67 percent) received individual therapy within 60 days, and 90 percent received individual therapy within 90 days of the referral. Figure 3 below shows the wait times for individual psychotherapy from the referral date.

**Figure 3. Individual Psychotherapy Wait Times FY 2014**



Source: VHA, VA OIG

In response to the staffing constraints experienced by the WMHC during 2014, the system subsequently increased the number of WMHC staff. In mid-November, around the time of our site visit, the WMHC gained an additional 1.0 FTE psychologist, and the previously 0.5 FTE social work position was converted to full-time.

As of February 1, 2015, the WMHC had three 1.0 FTE psychologists, one 1.0 FTE social worker, two 0.5 FTE LMFTs, and two 0.5 FTE psychology trainees to conduct psychotherapy.

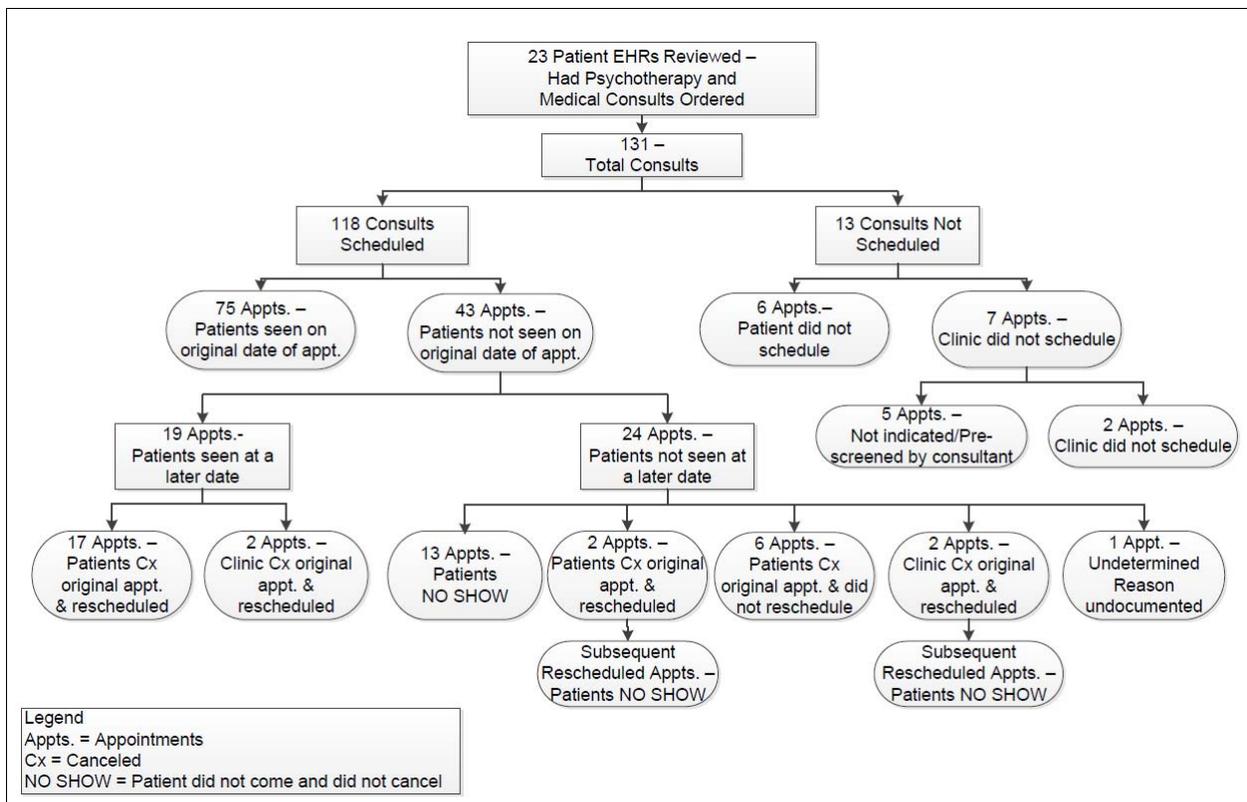
**Issue 2: Access to Medical Care and Non-VA Care**

*Denial of Medical Care*

We did not substantiate the allegation that women patients with 100 percent MST-related MH conditions were denied medical care. We reviewed the EHRs of 23 patients who were seen in the WMHC and had psychotherapy and medical consults during FYs 2013 and 2014. We reviewed 131 medical consults ordered for these patients.

Of the 131 consults ordered, 118 were scheduled. The system completed 75 consults on the scheduled dates, rescheduled and completed 19 at later dates, and canceled 24. The reasons for canceling included that patients either did not show for or canceled the original appointments and did not reschedule or patients/clinic canceled the original appointments, they were rescheduled, and patients did not show for the rescheduled appointments. For the 13 unscheduled consults, in 6 cases, patients did not respond to staff scheduling attempts, 5 consults were no longer needed, and 2 consults had no documentation related to the reasons for not scheduling. Figure 4 below shows the disposition of the medical consults.

**Figure 4. Medical Consults Disposition**

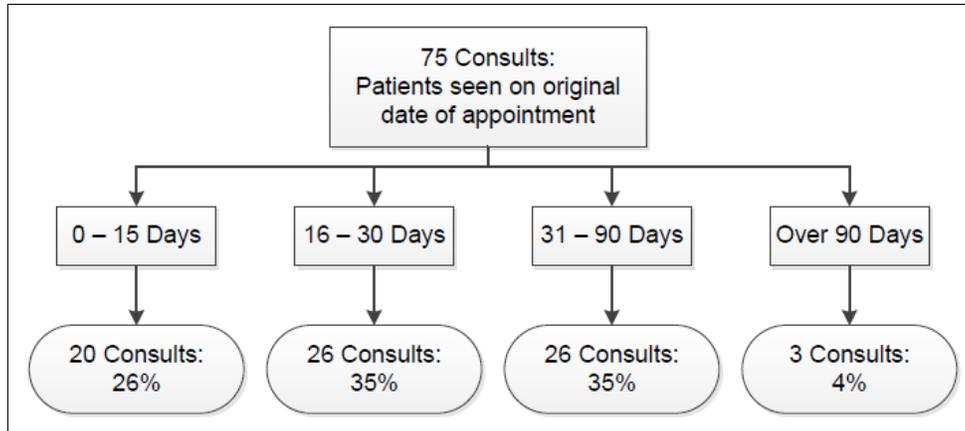


Source: VHA, VA OIG

*Excessive Waits for VA Medical Treatments*

We did not substantiate the allegation that women patients with 100 percent MST-related MH conditions had to wait months for VA medical treatment. For the 75 consults that were performed on the original appointment date, consultants completed 46 within 30 days, and 29 had waits greater than 30 days. We measured the consult wait times as the time in days from consult creation to when the provider saw the patient. Overall, 96 percent of patients were seen within 90 days. Figure 5 below shows the wait times for the 75 completed consults.

**Figure 5. Medical Consult Wait Times**



Source: VHA, VA OIG

*Inefficient NVCC Program Referral*

We did not substantiate the allegation that the NVCC program referral process was inefficient. Of the 11 unique patients who had 13 NVCC consults for FY 2014, at the time of our onsite visit in November 2014, 8 consults had been completed (the patients were seen by NVCC consultants) and 5 consults had TriWest<sup>6</sup> care referrals but the patients had not yet been seen. For the eight completed consults, the number of days from consult to appointment date ranged from 3 to 55 days. As of February 2015, one patient was seen by a TriWest contract provider; a second patient failed to show for the scheduled appointment twice, and the consult was returned to the system. The system contacted the patient who was later referred to another NVCC consultant. For the remaining three TriWest consults, referrals were made; however, the TriWest portal showed “no network available.” According to system staff, this means that TriWest did not have a provider within their network who could accommodate these patients based on proximity to their homes. TriWest returned the consults back to the system, and staff documented multiple unsuccessful attempts to contact each patient. The system subsequently canceled the consults.

<sup>6</sup> TriWest is a non-VA contractor who coordinates veterans’ care from health care providers in the community when VA facilities are not able to provide the needed care or specialty.

Staff identified barriers to finding NVCC contract providers willing to accept system patients. Barriers included difficulties finding contract providers willing to accept VA payment rates, concerns the system would send payments late to contract providers, and concerns that the system would not pay contract providers for services rendered.

We found that authorizations were sent to community providers for patients referred to NVCC care, and the consults were either completed, scheduled, or canceled.

Our review did not support the allegations that women patients were denied medical care, that they waited months for VA medical treatment, and that the NVCC authorization and referral processes were inefficient.

### **Issue 3: Suicide Resulting from Inability To Receive MH Treatment**

We did not substantiate the allegation that an unidentified male patient committed suicide because he was unable to get MH treatment. We reviewed the EHRs of four patients who the system reported committed suicide during the 3<sup>rd</sup> or 4<sup>th</sup> quarter of FY 2014. Below are brief synopses of the cases.

**Patient 1** – This patient had been admitted at the system multiple times over a period of 8 years. In 2014, he was admitted with a chief complaint of “unable to control thoughts.” He was discharged 6 days later. Shortly after discharge, a MH nurse, Operation Enduring Freedom/Operation Iraqi Freedom patient advocate program support assistant, and primary care clinic nurse called the patient but were unable to reach him. The program support assistant also contacted the patient’s family to see whether they had an updated phone number for the patient. The patient missed his scheduled follow-up appointment 1 week later. A MH outpatient case management staff member called three times and left messages for the patient to call and reschedule the appointment. The patient committed suicide 2 weeks after discharge.

**Patient 2** – This patient had been receiving outpatient care at the system for more than 12 years. Diagnoses included anxiety, depression, PTSD, and alcohol misuse. The patient had participated in group therapy and been treated by a system psychiatrist for 3 months in early 2014. The EHR showed a telephone encounter inviting him to attend cognitive processing therapy for insomnia group and a follow-up phone conversation with a psychologist less than 2 weeks before he committed suicide in late spring.

**Patient 3** – This patient had a long history of chronic pain with associated insomnia and depressed mood. His diagnoses included severe chronic neck and lower back pain, chronic bilateral shoulder arthralgias (joint pain), and bilateral hip and knee pain mainly due to degenerative joint disease. He was on long-term high-dose opioid treatment. The patient’s pain was also managed with non-medication treatments. The patient had signed an opiate treatment agreement in 2010 and been prescribed different antidepressant medications. In 2011, he declined referral to MH. The patient was last seen at the system in the primary care clinic in December 2013. The PCP’s note indicated negative screens for depression, PTSD, and alcohol misuse. The patient was continued on his usual pain medication dosage. The VA stepped care for chronic pain management requires specialty consultation for second level review of patients with

long-term pain conditions.<sup>7</sup> The EHR showed that the PCP did not refer the patient to specialists for second level review.

In early September, the Chief of Pharmacy notified the Suicide Prevention Coordinator that the patient's mailed-out medications were sent back to the pharmacy and marked "deceased." System staff learned the patient had committed suicide at home.

**Patient 4** – This patient had multiple diagnoses including generalized anxiety disorder, phantom limb pain related to an amputation,<sup>8</sup> and history of prostate cancer. He had been receiving inpatient and outpatient care at the system since mid-1990s. The patient was admitted to the system in 2014 with worsening phantom limb pain, malaise,<sup>9</sup> pain with urination, and loose stools. On admission, he denied feeling hopeless or having thoughts of harming himself. He was treated for a urinary tract infection thought to be secondary to partial urinary obstruction. While in the hospital, he was restarted on pain medication, which he had run out of prior to admission. Three days after discharge, the patient's primary care Patient Aligned Care Team made three unsuccessful attempts to call the patient for a post hospitalization follow-up. The patient committed suicide 4 days after being discharged from the system.

Our review of these cases did not substantiate the allegation that a male patient committed suicide because of an inability to receive MH treatment. However, during our review, we identified quality of care concerns related to chronic pain management for patient 3. The VA stepped care for chronic pain management requires specialty consultation for second level review. We found no evidence that the PCP offered a referral to specialists for second level review as required by VA policy. We were unable to interview the subject provider due to retirement.

## Conclusions

We did not substantiate that female patients with MST were denied mental health counseling and did not receive individual counseling because of the lack of trained therapists. We did not substantiate that the system denied medical care to female patients with 100 percent MST-related MH conditions, that these patients waited months for medical treatments, or that the NVCC referral process was inefficient.

We did not substantiate that a male patient committed suicide in 2014 because he was denied MH treatment. However, we identified quality of care concerns related to chronic pain management for one patient. The PCP did not refer the patient to specialists for second level review as required by VA policy.

<sup>7</sup> VHA Directive 2009-053, *Pain Management*, October 28, 2009.

<sup>8</sup> A feeling of pain in an absent limb or a portion of a limb.

<sup>9</sup> A general feeling of discomfort, illness, or uneasiness whose exact cause is difficult to identify.

## Recommendation

1. We recommended that the System Director ensure that primary care providers follow established guidelines for referral of patients with chronic pain as required by VA policy.

## VISN Director Comments

### Department of Veterans Affairs

### Memorandum

**Date:** December 18, 2015

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

**Subj:** Healthcare Inspection—Quality of Mental Health Care Concerns, VA Long Beach Healthcare System, Long Beach, California

**To:** Director, Los Angeles Office of Healthcare Inspections (54LA)  
Director, Management Review Service (VHA 10AR MRS OIG Hotline)

1. I concur with the findings and recommendations in the report: Healthcare Inspections – Quality of Mental Health Care Concerns, VA Long Beach Healthcare System, Long Beach, California, OIG Recommendation 1.
2. If you have any questions regarding our responses and actions to the recommendations in the draft report, please contact me at (562) 826-5963.



Marie L. Weldon, FACHE

Attachment

## System Director Comments

**Department of  
Veterans Affairs**

**Memorandum**

**Date:** December 14, 2015  
**From:** Director, VA Long Beach Healthcare System (600/00)  
**Subj:** Healthcare Inspection—Quality of Mental Health Care Concerns,  
VA Long Beach Healthcare System, Long Beach, California  
**To:** Director, Desert Pacific Healthcare Network (10N22)

1. VA Long Beach Healthcare System (VALBHS) concurs with the Department of Veterans Affairs Office of Inspector General Healthcare Inspections performed from October 2014 to February 2015. We appreciate the professionalism the OIG Team demonstrated during the review process.
2. If you have any questions, please contact Dr. Norman Ge, Chief of Staff, at (562) 826-5403.



Michael W. Fisher

## Comments to OIG's Report

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

### **OIG Recommendation**

**Recommendation 1.** We recommended that the System Director ensure that primary care providers follow established guidelines for referral of patients with chronic pain as required by VA policy.

Concur

Target date for completion: February 1, 2016

Facility response:

Currently, VALBHS staffing is hired to support the Level 2 Pain Clinic. Veteran patients are seen jointly by the Primary Provider and the Pain Specialist. The Pain psychologist, pharmacist, case manager, and therapists are on staff and consulting on patients while awaiting completion of the Pain Clinic space. A comprehensive consult to facilitate referrals and a service agreement with Primary Care have been developed. Two critical policies were updated: Pain Management and Opioid use for Chronic Pain not Due to Cancer. The following actions are in process:

- Purchasing additional diagnostic and therapeutic equipment.
- Renovation of clinical space by engineering and interior design.
- Installation of IT equipment.

## OIG Contact and Staff Acknowledgments

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<b>Contact</b>	For more information about this report, please contact the OIG at (202) 461-4720.
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