DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Inadequate Inpatient Psychiatry Staffing and Noncompliance with Inpatient Mental Health Levels of Care at the VA Central Western Massachusetts Healthcare System in Leeds

HEALTHCARE INSPECTION | REPORT #19-09669-236 | AUGUST 20, 2020

The mission of the Office of Inspector General is to serve veterans and the public by conducting effective oversight of the programs and operations of the Department of Veterans Affairs through independent audits, inspections, reviews, and investigations.

In addition to general privacy laws that govern release of medical information, disclosure of certain veteran health or other private information may be prohibited by various federal statutes including, but not limited to, 38 U.S.C. §§ 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, the OIG adheres to privacy and confidentiality laws and regulations protecting veteran health or other private information in this report.

Report suspected wrongdoing in VA programs and operations to the VA OIG Hotline:

www.va.gov/oig/hotline

1-800-488-8244

Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to determine the validity of a complaint regarding psychiatrist and medical provider staffing on inpatient mental health units, length of stay on the acute inpatient mental health unit (acute unit), and medical clearance assessments of patients on the acute unit at the VA Central Western Massachusetts Healthcare System (facility) in Leeds. Senator Elizabeth Warren also referred similar concerns to the OIG regarding the inpatient mental health unit. During the inspection, facility staff alleged inappropriate prescribing practices among inpatient mental health psychiatrists. The OIG also identified and reviewed the following three additional concerns: deficient nurse staffing methodology, inadequate recovery-oriented programming, and noncompliance with Veterans Health Administration (VHA) inpatient mental health levels of care.[1]

The OIG substantiated that from October 1, 2017, through September 30, 2019, acute and subacute unit psychiatry staffing was below the expected 3.6 full-time equivalent clinical psychiatrists.[2] As of January 17, 2020, 2.6 full-time equivalent psychiatrists staffed the acute and subacute units. Facility leaders told the OIG that they faced recruitment difficulties due to location, salary, and nationwide psychiatry shortages when they actively recruited for an inpatient mental health unit psychiatrist. Mental health leaders first posted the one vacant psychiatry position in January 2018 and were unsuccessful in filling the position. As of January 17, 2020, it remained open.

The OIG was unable to determine if medical provider staffing on the inpatient mental health units was inadequate because VHA does not provide guidelines for medical staffing. Facility leaders and staff offered contrary opinions about the need for additional medical staff for the inpatient mental health units. The facility's Chief of Staff completed analyses of workload and productivity, concluded that the medical staffing was sufficient, and did not recruit additional medical staff. Given the contrary opinions, the OIG determined that ongoing monitoring and evaluation of medical provider staffing on the inpatient mental health units was warranted. During interviews with the OIG, facility leaders and staff denied any adverse clinical outcomes related to medical coverage on mental health inpatient units.[3] Of the 225 patient safety incidents

---

[1] VHA Handbook 1160.06, *Inpatient Mental Health Services,* September 16, 2013. Recovery-oriented programming is therapeutic intervention to aid individuals to "improve their health and wellness, live a self-directed life, and strive to reach their full potential."

[2] VHA Directive 1406, *Patient Centered Management Module (PCMM) for Primary Care,* June 20, 2017. A full-time equivalent represents the hours worked by an employee in a normal 80-hour pay period. The value ranges from 0.0 to 1.0, with 1.0 representing 80 hours worked in a pay period. Acute and subacute unit psychiatry staffing was below the expected 3.6 full time equivalent clinical psychiatrists for 618 of 730 days (85 percent).

[3] Within the context of this report, the OIG considered an adverse clinical outcome to be death, a progression of disease, worsening prognosis, suboptimal treatment, or a need for higher-level care.

reported from October 1, 2017, through September 30, 2019, 48 included involvement of a medical provider. However, OIG team analysis did not find that insufficient medical provider staffing contributed to the 48 patient safety incidents.

The OIG did not substantiate that patients had increased lengths of stay due to insufficient psychiatry staffing. Facility inpatient mental health staff and leaders denied increased lengths of stay due to staffing. Analysis of median monthly length of stay on the acute unit from October 1, 2017, through September 30, 2019, did not indicate an association between length of stay and psychiatry staffing. While the OIG did not substantiate increased lengths of stay due to psychiatry staffing, the OIG found that from October 1, 2017, through September 30, 2019, facility staff did not complete the VHA-required number of utilization management reviews to ensure clinical justification for inpatient mental health admissions.[4] The Quality Manager told the OIG that staff turnover and temporary workload demands contributed to the failure to complete the required number of admission and continued stay reviews.[5] Failure to complete utilization reviews of admissions and continued stay days may result in patients receiving treatment at inappropriate levels of care and increased lengths of stay. However, from October 1, 2019, through January 31, 2020, utilization management staff exceeded the VHA-required number of reviews of at least 80 percent of admissions and continued stay days. The Quality Manager attributed improvements in completion of admission and continued stay utilization reviews to the assignment of additional staff.

The OIG did not substantiate that patients remained on the acute unit after psychiatric stabilization to treat medical issues that were overlooked during the admission process. The medical clearance assessment for admission to the acute unit was complete for 29 out of the 34 admissions (85 percent). Three medical officers on duty completed five medical clearance assessments that either lacked a physical examination or lacked assessment of alcohol withdrawal risk factors. All of the patients with incomplete medical clearance assessments were either evaluated timely by the attending physician or physician assistant or transferred to an outside hospital for reasons unrelated to the assessment process. Further, the OIG did not identify adverse medical outcomes related to the incomplete medical assessment during the admission process.

The OIG did not substantiate that inpatient psychiatrists inappropriately prescribed selective serotonin reuptake inhibitor antidepressant medications and vitamin B12 injections.[6]

---

[4] VHA Directive 1117(2), *Utilization Management Program,* July 7, 2014, amended April 30, 2019.

[5] VHA Directive 1117(2). Every inpatient mental health unit admission and each subsequent day of a patient's continued inpatient stay is subject to utilization management review.

[6] Selective serotonin reuptake inhibitors are a class of medications used primarily in the treatment of depression and include fluoxetine, sertraline, and escitalopram. Alan F. Schatzberg and Charles DeBattista, *Schatzberg's Manual of Clinical Psychopharmacology,* 9th ed. (American Psychiatric Association Publishing, 2019), 16 - 20.

From 2017 through 2019, facility leaders failed to complete nurse staffing methodology as required by VHA. Failure to implement required staffing methodology may result in insufficient nurse staffing levels that may contribute to quality of care deficiencies, increased utilization of nursing overtime, nurse burnout, and low morale. Facility nurse leaders told the OIG that nurse staffing was generally adequate. Due to an extended absence of the Associate Director of Patient Care Services, an Acting Associate Director of Patient Care Services was in the role in 2016 and 2017. Additionally, the Associate Nurse Executive position was vacant for two years prior to November 2018.[7] During this time, the nurse staffing methodology was not completed. In November 2018, the Associate Nurse Executive began developing the nurse staffing methodology, consulted with Veteran Integrated Service Network (VISN) and national nursing leaders, and in January 2020, facility leaders approved the nurse staffing methodology.

The OIG found that inpatient mental health unit managers did not ensure the required acute unit recovery-oriented programming on Sundays, and acute and subacute unit programming did not consistently occur when scheduled.[8] An inpatient mental health staff member told the OIG that groups sometimes do not occur as scheduled due to a lack of contingency plan for group coverage. Failure to provide programming consistently or as scheduled on the inpatient mental health units may result in staff and patient confusion, inconsistent access to treatment, and failure to provide sufficient programming as required by VHA.[9]

Facility leaders failed to comply with VHA requirements to convert sustained treatment and rehabilitation (STAR) and specialized inpatient posttraumatic stress disorder (PTSD) beds to acute or residential beds.[10] Prior to 2013, VHA utilized STAR beds for inpatient care greater than 90 days. After the introduction of recover-oriented, evidence-based outpatient treatment options, VHA required facility leaders to consider transitioning STAR beds to acute or mental health residential rehabilitation treatment program beds.[11] In 2015, VHA required specialized inpatient PTSD beds to be converted to mental health residential rehabilitation treatment program beds by September 30, 2016, and STAR beds to be completely "phased out" by January 29, 2017.[12]

From 2015 through 2019, VHA leaders repeatedly offered consultation and solicited updates from facility leaders regarding the transition of STAR and specialized inpatient PTSD unit beds.

---

[7] The current Associate Nurse Executive served in an acting role beginning November 2018 and was assigned permanently in May 2019.

[8] VHA Handbook 1160.06.

[9] VHA Handbook 1160.06.

[10] VHA Handbook 1160.06.

[11] VHA Handbook 1160.06. VHA Handbook 1000.01, *Inpatient Bed Change Program and Procedures*, December 22, 2010. VHA Directive 1043, *Restructuring of VHA Clinical Programs*, November 2, 2016.

[12] Deputy Under Secretary for Health for Operations and Management Memorandum, *Inpatient Mental Health Services Handbook Implementation Guidance*, July 29, 2015. VHA Handbook 1000.01; VHA Directive 1043.

On November 7, 2019, December 19, 2019, and January 8, 2020, Office of Mental Health and Suicide Prevention leaders attempted to get an update from the VISN 1 Mental Health Director regarding the facility's transition of STAR beds with no response. In an interview with the OIG, the VISN 1 Mental Health Director acknowledged receiving the emails but not responding because of the volume of emails received. The Facility Chief of Mental Health told the OIG team that business plans were in development to transition both the subacute and specialized inpatient PTSD units to mental health residential rehabilitation treatment programs. Facility leaders said that this was not done, however, because of challenges to completing the business plans, including physical space and staffing issues. As of January 2020, the business plans were not complete and had not been submitted for VISN approval. The OIG also found that continued use of STAR beds resulted in staff's failure to complete required utilization reviews as STAR beds were considered "obsolete" and, thus, non-reviewable.

Ongoing use of STAR beds on the acute unit may result in longer than necessary lengths of stay, and failure to facilitate timely transition to an appropriate recovery-oriented outpatient level of care. Facility and VISN leaders failed to comply with VHA's mandated transition of subacute and specialized inpatient PTSD unit beds to mental health residential rehabilitation treatment program beds, contributing to patients being placed in a higher level of care than treatment needs indicated. Additionally, utilization management staff's lack of oversight of STAR bed admission and continued stay days may result in longer than necessary lengths of stay at an inappropriate level of care.

The OIG made seven recommendations related to inpatient mental health staffing, utilization management reviews, medical clearance assessments, nurse staffing methodology, recovery-oriented programming, and inpatient mental health levels of care.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with the recommendations and provided an acceptable action plan (see appendixes A and B). The OIG considers all recommendations open and will follow up on the planned and recently implemented actions to allow time for the facility to submit documentation of actions taken and to ensure that they have been effective and sustained.

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

Contents

Executive Summary i
Abbreviations vi
Introduction 1
Scope and Methodology 2
Inspection Results 3
1. Inpatient Psychiatry Staffing 3
2. Inpatient Mental Health Units Medical Provider Staffing 5
3. Acute Unit Length of Stay 6
4. Medical Assessment and Management During Admission and Throughout Treatment 9
5. Inpatient Mental Health Prescribing Practices 10
6. Inpatient Mental Health Nurse Staffing Methodology 10
7. Inpatient Mental Health Unit Programming 11
8. Noncompliance with Inpatient Mental Health Levels of Care 12
Conclusion 13
Recommendations 1–7 14
Appendix A: VISN Director Memorandum 16
Appendix B: Facility Director Memorandum 18
OIG Contact and Staff Acknowledgments 23
Report Distribution 24

Abbreviations

OIG	Office of Inspector General
PTSD	posttraumatic stress disorder
STAR	sustained treatment and rehabilitation
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection in response to a referral from Senator Elizabeth Warren and to determine the validity of a complaint regarding (1) psychiatrist and medical provider staffing on the acute inpatient mental health unit (acute unit), subacute inpatient mental health unit (subacute unit), and specialized inpatient posttraumatic stress disorder (PTSD) unit; (2) length of stay on the acute unit; and (3) medical assessment and management of patients on the acute unit at the VA Central Western Massachusetts Healthcare System (facility) in Leeds.

Background

The facility, part of Veteran Integrated Service Network (VISN) 1, provides primary, specialty, and mental health care including psychiatric and PTSD services. The facility had 85 behavioral health beds including 20 acute unit, 40 subacute unit, and 25 specialized inpatient PTSD unit beds.[13] From October 1, 2017, through September 30, 2018, the facility served 27,997 patients.

Prior OIG Report

The OIG published one report containing similar issues in the past three years, the *Comprehensive Healthcare Inspection of the VA Central Western Massachusetts Healthcare System* report published January 13, 2020. The OIG made recommendations regarding insufficient nurse staffing and provider backup call schedules in the Urgent Care Center.[14]

Allegations and Related Concerns

On February 12, 2019, the OIG Office of Healthcare Inspections received a congressional referral from Senator Elizabeth Warren requesting review of alleged wrongdoings including the facility having limited the number of patients admitted to the acute and subacute units. Facility leaders responded sufficiently to an inquiry from the OIG about the wrongdoings and the OIG considered the referral closed. On August 28, 2019, the OIG received an anonymous complaint alleging "compromised care" and increased patient length of stay due to lack of adequate psychiatric and medical provider staffing. The OIG then opened a hotline inspection due to continued concerns about quality of care and staffing.

---

[13] U.S. Department of Veterans Affairs, "VA Central Western Massachusetts Healthcare System," About the VA Central Western Massachusetts Healthcare System. https://www.centralwesternmass.va.gov/about/index.asp. (The website was accessed on March 3, 2020.)

[14] VA Office of Inspector General, *Comprehensive Healthcare Inspection of the VA Central Western Massachusetts Healthcare System*, Report No. 19-00038-63, January 13, 2020.

The purpose of the inspection was to determine the validity of the following allegations regarding inpatient mental health:

- Insufficient psychiatry staffing,
- Insufficient medical provider staffing,
- Increased length of stay due to insufficient psychiatry staffing, and
- Inadequate assessment and management of medical conditions during admission and throughout treatment.

During the OIG inspection, facility staff alleged that inpatient mental health psychiatrists inappropriately prescribed antidepressant medications and vitamin B12 injections.[15]

The OIG identified and reviewed the following three additional related concerns regarding inpatient mental health:

- Deficient nurse staffing methodology,
- Inadequate programming on the acute and subacute units, and[16]
- Noncompliance with Veterans Health Administration (VHA) inpatient mental health levels of care.

Scope and Methodology

The OIG conducted a site visit from November 4 through November 7, 2019.

The OIG team interviewed facility leaders, inpatient mental health unit staff, Urgent Care Center staff, the local recovery coordinator, patient safety and quality management staff, a human resource manager and staffing supervisor, the VISN 1 Mental Health Service Line Director, and Office of Mental Health and Suicide Prevention leaders. The OIG team toured the Urgent Care Center and acute, subacute, and specialized inpatient PTSD units.

The OIG team reviewed VHA directives, handbooks, memoranda, and facility policies and procedures in effect from October 1, 2017, through November 30, 2019.

For October 1, 2017, through November 1, 2019, the OIG team reviewed: (1) acute and subacute unit daily census, (2) psychiatry staffing levels, (3) median patient length of stay on the acute unit, (4) inpatient mental health unit patient safety incidents, and (5) utilization management

[15] Vitamin B12 injections may be indicated in management of severe alcohol withdrawal.

[16] VHA Handbook 1160.06, *Inpatient Mental Health Services,* September 16, 2013. Recovery-oriented programming is therapeutic intervention to aid individuals to "improve their health and wellness, live a self-directed life, and strive to reach their full potential."

data.[17] The OIG team also reviewed a random selection of 30 of the 154 patients admitted to the acute unit from August 1, 2019, through October 31, 2019, which resulted in a total of 34 admissions.[18] Electronic health record reviews were conducted to evaluate timeliness of history and physical examinations, adequacy of medical admission assessment, frequency of psychiatry documentation, and psychiatric prescribing practices.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

The OIG substantiates an allegation when the available evidence indicates that the alleged event or action more likely than not took place. The OIG does not substantiate an allegation when the available evidence indicates that the alleged event or action more likely than not did not take place. The OIG is unable to determine whether an alleged event or action took place when there is insufficient evidence.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, Pub. L. No. 95-452, § 7, 92 Stat 1105, as amended (codified at 5 U.S.C. App. 3). The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

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

Inspection Results

1. Inpatient Psychiatry Staffing

The OIG substantiated that from October 1, 2017, through September 30, 2019, acute and subacute unit psychiatry staffing was below the expected 3.6 full-time equivalent clinical

[17] VHA Directive 1117 (2), *Utilization Management Program,* July 9, 2014, amended April 30, 2019. Utilization Management is a quality management tool used consisting of (1) admission reviews to determine appropriateness of admission to a specific level of care and, (2) continued stay reviews to determine the appropriateness of continued treatment at the level of care. Median was used to measure length of stay because, unlike the mean, the median is unaffected by extreme values such as patients with very long lengths of stay. Siddharth Deshpande, Nithya J Gogtay, and Urmila M. Thatte, "Measures of Central Tendency and Dispersion," Journal of The Association of Physicians of India 64 (July 2016): 64-66.

[18] The OIG determined the timeframe for review based on staffing. Three psychiatrists were staffed to the acute and subacute units as of May 2019. The selected time frame allowed for onboarding and training to occur. The OIG team agreed that a quarter of data is sufficient in determining appropriate psychiatry practices. Of the 30 patients, three had more than one admission to the inpatient mental health unit.

psychiatrists.[19] As of January 17, 2020, 2.6 full-time equivalent psychiatrists staffed the acute and subacute units. Mental health leaders first posted the one vacant psychiatrist position in January 2018, but were unsuccessful in filling the position, and as of January 17, 2020, it remained open.

VHA requires interdisciplinary inpatient mental health staffing to include nursing, social work, psychology, and psychiatry services. VHA does not provide specific psychiatry staffing requirements, although staffing must be adequate to provide a "safe and therapeutic environment" including patient evaluation and medication management.[20] Office of Mental Health and Suicide Prevention leaders told the OIG team that a reasonable "rule of thumb" is one psychiatrist for every 12 to 14 patients.

The facility mental health organizational chart included 3.6 full-time equivalent clinical psychiatry positions for the acute and subacute units.[21] Facility leaders and staff consistently reported to the OIG that 3.6 full-time equivalent psychiatrists were sufficient to provide adequate patient care if the units were at full capacity of 60 patients, which equates to an average caseload of approximately 17 patients per psychiatrist.

From October 1, 2017, through September 30, 2019, 1.6 to 3.6 full-time equivalent psychiatrists provided coverage to the acute and subacute units.[22] For approximately seven months from September 10, 2018, to April 14, 2019, two or fewer psychiatrists provided coverage for the acute and subacute units. During that time, facility leaders reduced the number of operational acute unit beds from 20 to 15 beds from September 12, 2018, to November 30, 2018, and then to 10 beds from December 1, 2018, to April 14, 2019.[23] Facility leaders told the OIG team that they reduced the number of beds due to psychiatry vacancies and to "ensure that all patients served would receive safe and quality care."

[19] VHA Directive 1406, *Patient Centered Management Module (PCMM) for Primary Care,* June 20, 2017. A full-time equivalent represents the hours worked by an employee in a normal 80-hour pay period. The value ranges from 0.0 to 1.0, with 1.0 representing 80 hours worked in a pay period. Acute and subacute unit psychiatry staffing was below the expected 3.6 full time equivalent clinical psychiatrists for 618 of 730 days (85 percent).

[20] VHA Handbook 1160.06.

[21] The Mental Health Service Line organization chart included four full-time psychiatrists. The Mental Health Service Line Chief and Labor mapping indicated that three psychiatrists were dedicated full time to clinical duties and one psychiatrist was dedicated to 0.6 clinical and 0.4 administrative duties.

[22] Due to a one day overlap of a departing psychiatrist and an onboarding psychiatrist, there was one day when there were 4.0 full time equivalent psychiatrists providing coverage to the acute unit.

[23] Bed capacity on the subacute unit is 40 and there was no limit placed on subacute unit admissions.

Table 1. Acute Unit Bed Capacity and Psychiatry Staffing

Time Frame	Acute Unit Bed Capacity	Psychiatry Full-Time Equivalent Employees	Actual Acute and Subacute Unit Psychiatry Caseload
September 10, 2018 – September 11, 2018	20	2	21.25
September 12, 2018 – November 30, 2018	15	2	20.28
December 1, 2018 – January 13, 2019	10	2	15.41
January 14, 2019 – April 14, 2019	10	1.6	18.91

Source: Bed capacity and staffing information provided by VISN and facility leaders

Based on actual unit admissions during that time, psychiatrist caseloads ranged from 11–17 patients, which was within the expected caseload. However, each psychiatrist, if the units were at full capacity, would have been responsible for approximately 23 patients. Inadequate psychiatry staffing may result in larger caseloads, contribute to staff burn out, and limit patients' access to psychiatric assessment and treatment. On April 15, 2019, facility leaders detailed a psychiatrist to the acute and subacute units to assign 2.6 full-time equivalent psychiatrists, and reinstated the 20-bed acute unit capacity.

The Resource Management Committee approved filling the psychiatrist position on January 10, 2018, and the position was posted several times with unsuccessful hiring attempts.[24] Facility leaders told the OIG that they faced recruitment difficulties due to location, salary, and nationwide psychiatry shortages when they actively recruited for an inpatient mental health unit psychiatrist. As of January 17, 2020, inpatient psychiatry staffing included one vacant position.

2. Inpatient Mental Health Units Medical Provider Staffing

The OIG was unable to determine if medical provider staffing on the inpatient mental health units was inadequate because VHA does not provide guidelines for medical staffing. Facility leaders and staff offered contrary opinions about the need for additional medical staff for the inpatient mental health units. The facility Chief of Staff completed analyses of workload and productivity, concluded that medical staffing was sufficient, and did not recruit additional medical staff.

VHA requires that acute inpatient mental health services include treatment of chronic, non-acute medical conditions that can be safely managed on the inpatient mental health unit. Although VHA does not provide guidance on medical staffing levels for inpatient mental health units,

[24] Facility leaders extended offers to two individuals. However, one candidate declined the offer and the other failed to complete required documentation; thus, neither selection resulted in a filled position.

staffing must be adequate to provide required services including comprehensive assessment and evaluation.[25] Further, facility policy requires completion of a history and physical examination within 24 hours of a patient's admission.[26]

In 2017, 2.5 full-time equivalent medical providers covered the inpatient mental health units that included a 1.0 physician and 1.0 and 0.5 full-time equivalent physician assistants. The Chief of Staff told the OIG that, at that time, workload and productivity was assessed with provider input. In June 2019, the 0.5 full-time equivalent physician assistant position became vacant. The Chief of Staff reportedly conducted a subsequent January 2020 analysis of provider workload and productivity, discussed the analysis with the inpatient medical providers, and determined that there was no support to hire for the vacated position. Further, the Chief of Staff and facility staff reported that poor time management and unnecessarily extensive medical reviews contributed to a perception that there was insufficient medical provider coverage. Given the contrary opinions, the OIG determined that ongoing monitoring and evaluation of medical provider staffing on the inpatient mental health units was warranted.

During interviews with the OIG, facility leaders and staff denied any adverse clinical outcomes related to medical coverage on the mental health inpatient units.[27] Of the 225 patient safety incidents reported from October 1, 2017, through September 30, 2019, 48 included involvement of a medical provider. However, OIG team analysis did not find that insufficient medical provider staffing contributed to the 48 patient safety incidents.

3. Acute Unit Length of Stay

The OIG did not substantiate that patients had increased lengths of stay due to insufficient psychiatry staffing. Facility inpatient mental health staff and leaders denied increased lengths of stay due to staffing. Analysis of median monthly lengths of stay on the acute unit from October 1, 2017, through September 30, 2019, did not indicate an association between length of stay and psychiatry staffing.

VHA inpatient mental health care guiding principles include the least restrictive treatment environment, timely treatment, and prompt discharge planning. The objective of inpatient mental health treatment is to provide intensive treatment, psychiatric stabilization, and transition to a lower level of care as soon as clinically appropriate.[28] Office of Mental Health and Suicide Prevention leaders suggested that, although particularly complex patients may require longer

[25] VHA Handbook 1160.06.

[26] Facility Policy 136-37, *Health Record Documentation,* September 28, 2017.

[27] Within the context of this report, the OIG considered an adverse clinical outcome to be death, a progression of disease, worsening prognosis, suboptimal treatment, or a need for higher level care.

[28] VHA Handbook 1160.06.

lengths of stay, a typical length of stay for acute mental health admission would be two weeks or less.

In interviews with the OIG, facility leaders and staff also denied any association between length of stay and psychiatry staffing deficits. The OIG team reviewed acute unit median monthly length of stay data from October 1, 2017, through September 30, 2019. Median monthly length of stay ranged from 3.70 to 5.36 days, consistent with VHA expectations. Analysis of the data indicated no systematic relationship between length of stay and the psychiatry staffing level.

Utilization Management Reviews

While the OIG did not substantiate increased lengths of stay due to psychiatry staffing, the OIG found deficits in facility staff completion of utilization management reviews to ensure clinical justification for inpatient mental health admissions, as required by VHA.[29]

Utilization management is a tool used to manage "quality and resource utilization." VHA's utilization management program aims to ensure "the right care, in the right setting, at the right time, for the right reason."[30] Utilization management staff identify whether patients are receiving the appropriate level of care, inform the decision-making process for care management and discharge coordination, and detect delays in treatment. A decreased length of stay is one of the primary desired results.[31]

Every inpatient mental health unit admission and each subsequent day of a patient's continued inpatient stay is subject to utilization management review. The review must be performed within one business day of admission to determine the appropriateness of the patient's admission to a specific level of care. Each day of continued inpatient stay must be reviewed to determine the appropriateness of continued admission at a specific level of care.[32]

Beginning in 2014, VHA required a review of a minimum of 75 percent of acute inpatient admissions and subsequent days of care. In April 2019, VHA increased the required review of acute inpatient admissions and subsequent days of care to 80 percent.[33] The Facility Director was responsible for ensuring that the facility utilization management plan included all VHA requirements. However, the facility policy continued to require review of 75 percent of admissions and continued stays and did not reflect the VHA's increase to 80 percent. A facility utilization management staff member told the OIG that utilization management staff were aware

[29] VHA Directive 1117(2), *Utilization Management Program,* July 7, 2014, amended April 30, 2019.
[30] VHA Directive 1117(2).
[31] VHA Directive 1117(2).
[32] VHA Directive 1117(2).
[33] VHA Directive 1117(2).

of the VHA-required increase. The facility policy is scheduled for recertification in November 2020, and the recertified policy will accurately reflect the VHA requirement.[34]

The OIG team reviewed facility utilization management data from October 1, 2017, through September 30, 2019. Utilization management staff reviewed 40.5 percent of acute unit admissions from October 1, 2017, through September 30, 2018, and therefore did not meet VHA requirements. However, from October 1, 2018, through September 30, 2019, facility staff reviewed 99.6 percent of acute unit admissions. Utilization management staff did not complete the required percentage of continued stay reviews at any point from October 1, 2017, through September 30, 2019. Although utilization management staff did not complete the required number of reviews, over 95 percent of patients reviewed met the criteria for admission or continued stay at the level of care (see table 2).[35] The Quality Manager and a staff member told the OIG that staff turnover and temporary workload demands contributed to the failure to complete the required number of admission and continued stay reviews. However, from October 1, 2019, through January 31, 2020, utilization management staff exceeded the VHA-required number of reviews. The Quality Manager attributed improvements in completion of admission and continued stay utilization reviews to the assignment of additional staff. Failure to complete reviews of at least 80 percent of admissions and continued stay days may result in patients receiving treatment at inappropriate levels of care and increased lengths of stay.

Table 2. Utilization Reviews of Acute Admissions and Continued Stays

Time Frame	Admission Reviews		Continued Stay Reviews	
	Percent Reviewed	Percentage Criteria Met	Percent Reviewed	Percentage Criteria Met
October 1, 2017 – September 30, 2018	40.5	99.4	26.8	99.4
October 1, 2018 – September 30, 2019	99.6	95.4	62.6	98.4
October 1, 2019 – January 31, 2020	95.1	99.0	97.1	94.3

Source: OIG analysis of facility's utilization management data

[34] Facility Policy, 00-59, *Utilization Management Policy*, November 30, 2017.

[35] VHA uses InterQual criteria based on the principles of evidence-based medicine to determine the appropriateness and management of clinical care. Diagnostic coding determines level of care and length of stay for behavioral health programs.

4. Medical Assessment and Management During Admission and Throughout Treatment

The OIG did not substantiate that patients remained on the acute unit after psychiatric stabilization to treat medical issues that were overlooked during the admission process.

A medical provider must evaluate and clear patients for admission to the acute unit. Medical clearance for admission to an inpatient mental health unit includes a history, screening physical examination, and if relevant, assessment of risk factors for alcohol withdrawal symptoms.[36] Once admitted, timely medical care must be available for acute unit patients. Medical and mental health providers must collaborate to ensure the patients' overall needs are being met in the most appropriate setting. If the acuity of a patient's medical needs exceeds the capabilities of the inpatient unit, providers must coordinate the patient's transfer to a medical unit.[37]

An attending internal medicine physician (attending physician) and a physician assistant provided medical coverage for the acute, subacute, and specialized inpatient PTSD units. Inpatient medical providers told the OIG that during business hours, the attending physician and physician assistant evaluated patients in the Urgent Care Center and completed medical clearance for admission to the inpatient mental health units. After regular duty hours, the medical officer on duty completed patients' medical clearances for admission. Inpatient staff told the OIG that patients with medical concerns that could not be adequately addressed on the inpatient mental health units were transferred to other VA or non-VA facilities for medical stabilization prior to facility inpatient mental health admission. Inpatient mental health staff asserted that the attending physician and physician assistant appropriately triaged patients' medical conditions and that patients admitted to the inpatient medical units were generally medically stable.

Facility inpatient mental health staff generally denied that patients received insufficient medical care. However, staff expressed concerns about two patients' medical care. The OIG determined that both patients received prompt and appropriate attention to medical issues that arose during their stays on the inpatient mental health units. There was no evidence that the patients' medical issues were overlooked during the admission process or that they contributed to the patients' lengths of stay.

To further evaluate adequacy of medical assessment on the acute unit, the OIG team reviewed the electronic health records of a random sample of 34 separate admissions to the acute unit between August 1, 2019, and October 31, 2019.[38] The medical clearance assessment for

[36] Facility Standard Operating Procedure 116-10, *Criteria for Admission,* June 19, 2015.

[37] VHA Handbook 1160.06.

[38] The 34 admissions reviewed were from a random selection of 30 of the 154 patients admitted to the acute unit from August 1, 2019, through October 31, 2019. Of the 30 patients, three had more than one admission to the inpatient mental health unit.

admission to the acute unit was complete for 29 out of the 34 admissions (85 percent).[39] The OIG found that three medical officers on duty completed five medical clearance assessments that either lacked a physical examination or lacked assessment of alcohol withdrawal risk factors. All of the patients with incomplete medical clearance assessments were either evaluated timely by the attending physician or physician assistant or transferred to an outside hospital for reasons unrelated to the assessment process. Further, the OIG did not identify adverse clinical outcomes related to the five incomplete medical assessments during the admission process.

The OIG found that medical providers completed a medical clearance assessment upon admission in most cases. Further, in cases when there was an incomplete medical clearance assessment upon admission, coverage on the acute unit was sufficient to address medical conditions timely or transfer patients for needed medical care. However, the failure to perform complete medical clearance assessments may contribute to increased risk of adverse clinical events for patients admitted to the acute unit.

5. Inpatient Mental Health Prescribing Practices

The OIG did not substantiate that inpatient psychiatrists inappropriately prescribed selective serotonin reuptake inhibitor antidepressant medications and vitamin B12 injections.[40] VHA requires that inpatient mental health units provide evidence-based medication management in conjunction with available clinical practice guidelines and appropriate clinical judgment.[41] During the OIG team site visit, acute unit staff reported concerns with psychiatrists' prescribing practices, specifically the simultaneous use of multiple selective serotonin reuptake inhibitor antidepressant medications and giving all admitted patients an intramuscular vitamin B12 injection.

The OIG team reviewed a random sample of 34 patient admissions to the acute unit between August 1, 2019, and October 31, 2019. The OIG team's review did not identify inappropriate prescribing of selective serotonin reuptake inhibitor antidepressant medications or intramuscular vitamin B12 injections.

6. Inpatient Mental Health Nurse Staffing Methodology

The OIG found that, from 2017 through 2019, facility leaders failed to complete nurse staffing methodology as required by VHA. Failure to implement required staffing methodology may result in insufficient nurse staffing levels that may contribute to quality of care deficiencies,

---

[39] Seven medical officers on duty performed 23 of the 34 medical clearance assessments and the attending physician or physician assistant completed 11.

[40] Selective serotonin reuptake inhibitors are a class of medications used primarily in the treatment of depression and include fluoxetine, sertraline, and escitalopram. Alan F. Schatzberg and Charles DeBattista, *Schatzberg's Manual of Clinical Psychopharmacology,* 9th ed. (American Psychiatric Association Publishing, 2019), 16–20.

[41] VHA Handbook 1160.06.

increased utilization of nursing overtime, nurse burnout, and low morale. Facility nurse leaders told the OIG that nurse staffing was generally adequate.

In 2017, VHA developed a standardized methodology to determine the individualized nursing staffing needs in specific patient care settings, including the ideal number and skill mix of staff. VHA facilities were required to develop individualized nurse staffing plans to provide safe and accessible healthcare. The staffing methodology must be reviewed annually and redeveloped every two years.[42]

Facility nursing leaders told the OIG that facility leaders last approved a nurse staffing methodology in 2016. Due to an extended absence of the Associate Director of Patient Care Services, an Acting Associate Director of Patient Care Services was in the role in 2016 and 2017. Additionally, the Associate Nurse Executive position was vacant for two years prior to November 2018.[43] During this time, the nurse staffing methodology was not completed. In November 2018, the Associate Nurse Executive began developing the nurse staffing methodology, consulted with VISN and national nursing leaders, and in January 2020, facility leaders approved the nurse staffing methodology.

7. Inpatient Mental Health Unit Programming

The OIG found that inpatient mental health unit managers did not ensure the required acute unit recovery-oriented programming on Sundays, and acute and subacute unit programming did not consistently occur when scheduled.[44]

Inpatient mental health units must provide a full range of mental health services including a minimum of four hours of recovery-oriented group programming per day.[45] The OIG team reviewed acute and subacute unit group schedules and found, generally, that four or more hours of recreation, peer support, and evidence-based clinical programming was offered. However, on Sundays, staff provided only two hours and thirty minutes of programming on the acute unit. Additionally, facility staff told the OIG that groups did not consistently occur as scheduled, and when the OIG team toured the acute and subacute units, groups were not in progress as scheduled. An inpatient mental health staff member told the OIG that groups sometimes do not occur as scheduled due to a lack of contingency plan for group coverage. Failure to provide programming consistently or as scheduled on the inpatient mental health units may result in staff

[42] VHA Directive 1351, *Staffing Methodology for Nursing Personnel*, December 20, 2017.

[43] The current Associate Nurse Executive served in an acting role beginning November 2018 and was assigned permanently in May 2019.

[44] VHA Handbook 1160.06.

[45] VHA Handbook 1160.06.

and patient confusion, inconsistent access to treatment, and failure to provide sufficient programming as required by VHA.[46]

8. Noncompliance with Inpatient Mental Health Levels of Care

The OIG found that facility leaders failed to comply with VHA requirements to convert sustained treatment and rehabilitation (STAR) and specialized inpatient PTSD beds to acute or residential beds.[47]

Prior to 2013, VHA utilized STAR beds for inpatient care greater than 90 days. After the introduction of recovery-oriented, evidence-based outpatient treatment options, VHA required facility leaders to consider transitioning STAR beds to acute or mental health residential rehabilitation treatment program beds.[48] In 2015, VHA required specialized inpatient PTSD beds to be converted to mental health residential rehabilitation treatment program beds by September 30, 2016, and STAR beds to be completely "phased out" by January 29, 2017. VHA outlined the necessary steps for facility leaders to restructure programs to meet the requirement and instructed facility directors to submit a business plan for approval by the VISN Director and Under Secretary for Health.[49]

The OIG found that, from October 1, 2017, through September 30, 2019, 63 percent of facility acute unit admissions and all subacute unit admissions were STAR beds. Facility leaders did not phase out STAR beds by January 29, 2017, as required by VHA. From 2015 through 2019, VHA leaders repeatedly offered consultation and solicited updates from facility leaders regarding the transition of STAR and specialized inpatient PTSD unit beds. On November 7, 2019, December 19, 2019, and January 8, 2020, Office of Mental Health and Suicide Prevention leaders attempted to get an update from the VISN 1 Mental Health Director regarding the facility's transition of STAR beds with no response. In an interview with the OIG, the VISN 1 Mental Health Director acknowledged receiving the emails but not responding because of the volume of emails received. The Facility Chief of Mental Health told the OIG team that business plans were in development to transition both the subacute and specialized inpatient PTSD units to mental health residential rehabilitation treatment programs; however, facility leaders identified challenges to completing the business plans, including physical space and staffing issues. As of January 2020, the business plans were not complete and had not been submitted for VISN approval.

The OIG also found that continued use of STAR beds resulted in staff's failure to complete required utilization reviews as STAR beds were considered "obsolete" and, thus, non-

[46] VHA Handbook 1160.06.

[47] VHA Handbook 1160.06.

[48] VHA Handbook 1160.06. VHA Handbook 1000.01, *Inpatient Bed Change Program and Procedures*, December 22, 2010. VHA Directive 1043, *Restructuring of VHA Clinical Programs*, November 2, 2016.

[49] Deputy Under Secretary for Health for Operations and Management Memorandum, *Inpatient Mental Health Services Handbook Implementation Guidance*, July 29, 2015. VHA Handbook 1000.01; VHA Directive 1043.

reviewable. A VISN 1 leader and Office of Mental Health and Suicide Prevention leaders expressed expectations that facilities that continued use of STAR beds at least included these patients in utilization management reviews.

Ongoing use of STAR beds on the acute unit may result in longer than necessary lengths of stay, and failure to facilitate timely transition to appropriate recovery-oriented outpatient level of care. Facility and VISN leaders failed to comply with VHA's mandated transition of subacute and specialized inpatient PTSD unit beds to mental health residential rehabilitation treatment program beds contributing to patients being placed in a higher level of care than treatment needs indicated. Additionally, utilization management staff's lack of oversight of STAR bed admissions and continued stay days may result in longer than necessary lengths of stay at an inappropriate level of care.

Conclusion

The OIG substantiated that from October 1, 2017, through September 30, 2019, acute and subacute unit psychiatry staffing was below the expected 3.6 full-time equivalent clinical psychiatrists.[50] As of January 17, 2020, 2.6 full-time equivalent psychiatrists staffed the acute and subacute units. Mental health leaders first posted the one vacant position in January 2018, but were unsuccessful in filling the position, and as of January 17, 2020, the position remained open.

The OIG was unable to determine if medical provider staffing on the inpatient mental health units was inadequate because VHA does not provide guidelines for medical staffing. Facility leaders and staff offered contrary opinions about the need for additional medical staff for the inpatient mental health units. The Chief of Staff completed analyses of workload and productivity and concluded that the medical staffing was sufficient and did not recruit additional medical staff.

Patients did not have increased lengths of stay due to insufficient psychiatry staffing. However, facility staff did not complete the VHA-required number of utilization management reviews to ensure clinical justification for inpatient mental health admissions.

Patients did not remain on the acute unit after psychiatric stabilization to treat medical issues that were overlooked during the admission process. Medical providers completed medical clearance assessments upon admission in most cases. Further, in cases when there was an incomplete medical clearance assessment upon admission, coverage on the acute unit was sufficient to address medical conditions timely or transfer patients for needed medical care. Inpatient

[50] A full-time equivalent represents the hours worked by an employee in a normal 80-hour pay period. The value ranges from 0.0 to 1.0, with 1.0 representing 80 hours worked in a pay period. VHA Directive 1406. Acute and subacute unit psychiatry staffing was below the expected 3.6 full time equivalent clinical psychiatrists for 618 of 730 days (85 percent).

psychiatrists did not inappropriately prescribe selective serotonin reuptake inhibitor antidepressant medications and vitamin B12 injections.[51]

The OIG found that, from 2017 through 2019, facility leaders failed to complete nurse staffing methodology as required by VHA. In November 2018, the Associate Nurse Executive began developing the nurse staffing methodology, consulted with VISN and national nursing leaders, and in January 2020, facility leaders approved the nurse staffing methodology.

Inpatient mental health unit managers did not ensure clinical programming occurred consistently or as scheduled.[52]

The OIG found that facility leaders failed to comply with VHA requirements to convert STAR and specialized inpatient PTSD beds to acute or residential beds.[53] Continued use of STAR beds resulted in staff's failure to complete required utilization reviews as STAR beds were considered "obsolete" and, thus, non-reviewable. From 2015 through 2019, VHA leaders repeatedly offered consultation and solicited updates from facility and VISN leaders regarding the transition of STAR and specialized inpatient PTSD unit beds.

Recommendations 1–7

1. The VA Central Western Massachusetts Healthcare System Director ensures adequate psychiatry staffing to afford providers adequate time for direct patient care on the acute and subacute inpatient mental health units.

2. The VA Central Western Massachusetts Healthcare System Director provides ongoing monitoring and evaluation of acute and subacute unit medical provider staffing.

3. The VA Central Western Massachusetts Healthcare System Director ensures that the utilization management plan accurately reflects and is compliant with all Veterans Health Administration requirements.

4. The VA Central Western Massachusetts Healthcare System Director makes certain medical officers on duty complete inpatient mental health admission medical clearance assessments in accordance with Central Western Massachusetts Healthcare System and Veterans Health Administration policies.

5. The VA Central Western Massachusetts Healthcare System Director makes certain that recovery-oriented programming occurs as scheduled and consists of at least four hours per day.

---

[51] Selective serotonin reuptake inhibitors are a class of medications used primarily in the treatment of depression and include fluoxetine, sertraline, and escitalopram. Alan F. Schatzberg and Charles DeBattista, *Schatzberg's Manual of Clinical Psychopharmacology,* 9th ed. (American Psychiatric Association Publishing, 2019), 16 - 20.

[52] VHA Handbook 1160.06.

[53] VHA Handbook 1160.06.

6. The VA New England Health Care System Director develops business plans for restructuring of clinical programs to include transitioning sustained treatment and rehabilitation beds, subacute unit beds, and specialized inpatient posttraumatic stress disorder beds as required by the Veterans Health Administration.

7. The VA Central Western Massachusetts Healthcare System Director consults with Veterans Integrated Service Network 1 leaders to determine and implement a process to monitor clinical appropriateness for patients in all inpatient mental health beds, including sustained treatment and rehabilitation beds until restructuring of clinical programs is complete.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: July 27, 2020

From: Director, VA New England Healthcare System (10N01)

Subj: Healthcare Inspection— Inadequate Inpatient Psychiatry Staffing and Noncompliance with Inpatient Mental Health Levels of Care at the VA Central Western Massachusetts Healthcare System in Leeds (631)

To: Director, Office of Healthcare Inspections (54MH00)
Director, GAO/OIG Accountability Liaison Office (VHA 10EG GOAL Action)

1. Thank you for the opportunity to review the draft report, Inadequate Inpatient Psychiatry Staffing and Noncompliance with Inpatient Mental Health Levels of Care at the VA Central Western Massachusetts Healthcare System, Leeds, MA.
2. I have reviewed the facility's action plan and am confident OIG recommendations will be implemented efficiently and effectively.
3. I have also requested the business plan for restructuring the sustained treatment and rehabilitation beds as well as the specialized Post Traumatic Stress Disorder beds and will ensure compliance with VHA Handbook 1160.06.

(*Original signed by:)*

Ryan S. Lilly, MPA
Network Director
VA New England Health Care System

VISN Director Response

Recommendation 6

The VA New England Health Care System Director develops business plans for restructuring of clinical programs to include transitioning sustained treatment and rehabilitation beds, subacute unit beds, and specialized inpatient posttraumatic stress disorder beds as required by the Veterans Health Administration.

Concur.

Target date for completion: August 15, 2020

Director Comments

VA Central Western MA Healthcare System will submit business plans for restructuring of clinical programs by August 3, 2020 to VISN 1: VA New England Healthcare. Finalized business plans will be submitted from VISN 1 to VA Central Office by August 15, 2020.

OIG Comment

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

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: July 27, 2020

From: Duane B. Gill, FACHE, Medical Center Director

Subj: Healthcare Inspection— Inadequate Mental Health Services and Noncompliance with Inpatient Mental Health Levels of Care at the VA Central Western Massachusetts Healthcare System in Leeds

To: Director, VA New England Healthcare System (10N01)

1. Thank you for the opportunity to review the draft of Inadequate Inpatient Psychiatry Staffing and Noncompliance with Inpatient Mental Health Levels of Care at the VA Central Western Massachusetts Healthcare System, Leeds, MA report.
2. I concur with the report and recommendations. Attached is the facility's corrective action plan for the recommendations.
3. VA Central Western Massachusetts Healthcare System continues in its ongoing efforts to provide safe, efficient, and quality services to our Veterans.

(*Original signed by*:)

Duane B. Gill, FACHE
Medical Center Director
VA Central Western Massachusetts Healthcare System

Facility Director Response

Recommendation 1

The Veterans Affairs Central Western Massachusetts Healthcare System Director ensures adequate psychiatry staffing to afford providers adequate time for direct patient care on the acute and subacute inpatient mental health units.

Concur.

Target date for completion: June 1, 2020

Director Comments

VA Central Western Massachusetts Healthcare System has ensured that adequate psychiatry staff have been afforded to provide direct patient care on the acute and subacute units. Mental Health leadership meets twice weekly to discuss all operational needs in the service, to include inpatient census, acuity, and amount of psychiatry coverage. If the Mental Health leadership team makes the determination that there is not adequate staffing and they are not able to shift resources, then the Medical Center Director is notified and a determination of the need to cap inpatient census is made. The Inpatient Mental Health Program Manager reviews and manages psychiatry workload and discusses workload capacity with inpatient staff Psychiatrists. The facility has ongoing recruitment strategies to fill these difficult to fill positions. During instances where a vacancy occurred for inpatient psychiatry providers, the facility made adjustments to keep the census at a safe ratio. "From October 1, 2017, through September 30, 2019, 1.6 to 3.6 full-time equivalent psychiatrists provided coverage to the acute and subacute units. For approximately seven months from September 10, 2018, to April 14, 2019, two or fewer psychiatrists provided coverage for the acute and subacute units. During that time, facility leaders reduced the number of operational acute unit beds from 20 to 15 beds from September 12, 2018, to November 30, 2018, and then to 10 beds from December 1, 2018, to April 14, 2019. Facility leaders told the OIG team that they reduced the number of beds due to psychiatry vacancies and to "ensure that all patients served would receive safe and quality care." The average daily census for fiscal year (FY) 18 was 12 on the acute mental health unit; and 25 on the subacute unit. For FY19, the average daily census was 12 on the acute unit; and 24 on the subacute unit; yielding 26-27 patients on average for the two mental health units. Although the "Office of Mental Health and Suicide Prevention leaders told the OIG team that a reasonable 'rule of thumb' is one psychiatrist for every 12 to 14 patients," there is no VHA Directive, VISN Policy or local policy that specifies a maximum number of patients that one inpatient psychiatrist can safety manage. Furthermore, the "rule of thumb" most likely refers to the number of acute mental health patient ratio, as STAR level of care has been phased out at other VA facilities (as noted in this OIG report). It should be noted

that there have been no patient safety reports filed during FY18 or FY19 related to inpatient psychiatry short staffing.

OIG Comment

The OIG considers this recommendation open and will follow up on the recently implemented actions provided by the Veterans Affairs Central Western Massachusetts Healthcare System Director to allow time for the facility to submit documentation of actions taken and to ensure that corrective actions have been effective and sustained.

Recommendation 2

The Veterans Affairs Central Western Massachusetts Healthcare System Director provides ongoing monitoring and evaluation of acute and subacute unit medical provider staffing.

Concur.

Target date for completion: September 30, 2021

Director Comments

Chief of Staff (COS) office will review workload data (Relative Value Units [RVUs] - and Encounters) for inpatient medical services bi-annually (April and October each year). The workload will be compared to that of primary care physicians and hospitalists. In the event that the workload is out of proportion to peers, adjustments will be made to staffing for medical care of Veterans in the inpatient Mental Health units. COS, or designee, will review data with inpatient medical providers at mid-year and end-of-year proficiencies. COS will continue to monitor for incidents of medical complications and determine if such incidents are related to workload.

Recommendation 3

The Veterans Affairs Central Western Massachusetts Healthcare System Director ensures that the utilization management plan accurately reflects and is compliant with all Veterans Health Administration requirements.

Concur.

Target date for completion: September 30, 2020

Director Comments

As of May 1, 2020, the Department of Quality Management has updated the facility Utilization Management policy to reflect all Veterans Health Administration requirements.

Recommendation 4

The Veterans Affairs Central Western Massachusetts Healthcare System Director makes certain medical officers on duty complete inpatient mental health admission medical clearance assessments in accordance with Central Western Massachusetts Healthcare System and Veterans Health Administration policies.

Concur.

Target date for completion: September 30, 2020

Director Comments

Chief of Staff (COS) office and Medical Records Review Committee will audit medical admission notes and assess Medical Officer of the Day (MODs) compliance for completing admission medical clearance assessment. All MODs will receive education about requirements to complete medical clearance assessment per VA Central Western Massachusetts Healthcare System policy. Current MODs will be re-educated about VA Central Western Massachusetts Healthcare System's requirements for proper documentation requirements for admission medical clearance assessment. Completion of training will be documented on MOD's competency assessment folder.

Deadline: From July 1, 2020 to September 30, 2020, 100% of all admission notes, for Veterans admitted to VA Central Western Massachusetts Healthcare System, will be reviewed for admission medical clearance assessment, with a compliance goal of 90%. If compliance falls below 90%, re-education and re-training of providers and MODs will commence. Monthly chart audits will be performed until a rate of compliance reaches 90% for 6 consecutive months, by June 31, 2021.

Recommendation 5

The Veterans Affairs Central Western Massachusetts Healthcare System Director makes certain that the recovery-oriented programming occurs as scheduled and consists of at least four hours per day.

Concur.

Target date for completion: December 31, 2020

Director Comments

A minimum of four hours of recovery-oriented programming is offered on the acute psychiatric unit each day. Cross-coverage, in the event of staff absences, is provided by both Mental Health and Nursing staff. The Nurse Manager and the Mental Health Inpatient Program Manager are responsible for ensuring that programming is offered each day, and they will monitor this

weekly. They will provide a report to Quality, Safety, and Value (QSV) Committee on a monthly basis, to include the number of days at least four hours of recovery-oriented programming was provided on the acute psychiatric unit, by week. Monitoring will continue until the goal of four hours of programming per day is achieved for 6 consecutive months.

Recommendation 7

The VA Central Western Massachusetts Healthcare System Director consults with Veterans Integrated Service Network 1 leaders to determine and implement a process to monitor clinical appropriateness for patients in all inpatient mental health beds, including sustained treatment and rehabilitation beds until restructuring of clinical programs is complete.

Concur.

Target date for completion: September 30, 2021

Director Comments

All Veterans who are admitted to High Intensity General Psychiatry Inpatient treating specialty at VA Central Western Massachusetts HCS [Healthcare System] will be compliant with all Veterans Health Administration utilization management review requirements, where all inpatient admissions to High Intensity General Psychiatry Inpatient treating specialty will be reviewed for inpatient utilization management review, with a minimum of 80% monthly total bed days reviewed.

All Veterans who are transferred from High Intensity General Psychiatry Inpatient treating specialty to sustained treatment and rehabilitation (STAR) treating specialty will be monitored for treatment planning and clinical appropriateness, wherein, 10 charts will be randomly reviewed monthly, with the goal of 80% monthly compliance.

All Veterans who are in a Specialized Inpatient PTSD Unit (SIPU) treating specialty will be monitored for treatment planning and clinical appropriateness, wherein, 10 charts will be randomly reviewed monthly, with the goal of 80% monthly compliance.

Numerator = number of randomly selected charts compliant with up-to-date treatment planning and clinical appropriateness. Denominator = 10 charts randomly reviewed monthly.

The data will be sent monthly to the VISN 1 Quality Manager and VISN 1 Mental Health Lead for feedback and approval until the data shows compliance of 80% or greater for 6 consecutive months.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Terri Julian, PhD, Director Dawn Dudek, LCSW Brandon LeFlore-Nemeth, MBA Meggan MacFarlane, LCSW Amber Singh, PhD Elizabeth Winter, MD
Other Contributors	Sheyla Desir, MSN, RN Chastity Osborn, DNP, RN Dawn Rubin, JD

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, VA New England Healthcare System (10N01)
Director, VA Central Massachusetts Healthcare System, Edward P. Boland VA Medical Center (631)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate:
Massachusetts: Edward Markey, Elizabeth Warren
U.S. House of Representatives:
Massachusetts: Katherine Clark, William Keating, Joseph Kennedy III, Stephen F. Lynch, Jim McGovern, Seth Moulton, Richard E. Neal, Ayanna Pressley, Lori Trahan

OIG reports are available at www.va.gov/oig.