Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Electronic Waiting List Management for Mental Health Clinics Atlanta VA Medical Center Atlanta, Georgia

Report No. 10-02986-215

July 12, 2011

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an evaluation regarding inadequate management of the electronic waiting list (EWL) for several mental health (MH) clinics at the Atlanta VA Medical Center (facility) in Atlanta, GA. The confidential complainant alleged that as a result of excessive wait times, patients may be placed at risk. During the course of this review, we were also told of fiscal practices that negatively affected MH contract services.

We substantiated that several MH clinics had significantly high numbers of patients on their EWLs over a period of months in fiscal year (FY) 2010, and we substantiated that facility managers were aware of the EWLs but were slow in taking actions to address the condition. We are unaware of any completed suicides; however, we did find evidence of MH EWL patients who attempted suicide, were hospitalized, or presented to the emergency department. We did not evaluate whether these events occurred as a direct result of being placed on MH EWLs, or whether they would have occurred in the course of regular, ongoing treatment. Nevertheless, large MH EWLs are inherently problematic as they represent impaired access to ongoing care. While the facility has since provided resources to eliminate the MH EWLs, ongoing actions will be needed to ensure the condition does not recur.

We substantiated that FY 2010 funds were inappropriately used to pay a contractor's FY 2009 expenses and that there were delays in payments to the contractor. We found that payment delays caused by defunding FY 2009 obligations in the Health Care for Homeless Veterans program had the potential to negatively impact contract providers, particularly the small Grant and Per Diem service providers. Although we identified one case where a Grant and Per Diem provider could not relocate patients to a more suitable environment until payments were received, we did not find evidence that other referrals or patient care were actually affected.

We noted that the Veterans Health Administration's performance measure on MH clinic access refers only to the first MH clinic evaluation; it does not measure ongoing access to MH services. As such, some Veterans Health Administration's facilities may be fully compliant with the performance measure but may not be providing timely and ongoing treatment and services critical to this population's MH maintenance and recovery.

We recommended that the Medical Center Director ensure ongoing actions are taken to minimize and/or alleviate MH EWLs and that responsible staff follow fiscal guidelines.

The Acting Veterans Integrated Service Network Director, who is also the Medical Center Director, agreed with the findings and recommendations and provided acceptable action plans. We will follow up on the planned actions until they are completed.

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

TO: Director, VA Southeast Network (10N7)

SUBJECT: Healthcare Inspection – Electronic Waiting List Management for Mental Health Clinics, Atlanta VA Medical Center, Atlanta, Georgia

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an evaluation regarding inadequate management of the electronic waiting list (EWL) for several mental health (MH) clinics at the Atlanta VA Medical Center (facility) in Atlanta, GA. The confidential complainant alleged that as a result of excessive wait times, patients may be placed at risk. During the course of this review, we were also told of fiscal practices that negatively affected MH contract services. The purpose of the review was to determine whether the allegations had merit.

Background

The facility is a tertiary care facility located in Decatur, GA, that provides a broad range of inpatient and outpatient medical, surgical, geriatric, and MH services. Primary and MH care is also provided at community based outpatient clinics (CBOCs) in Smyrna, Lawrenceville, Oakwood Hall, East Point, Stockbridge, and Newnan, GA. The facility is part of Veterans Integrated Service Network (VISN) 7 and serves a veteran population of about 453,000 throughout 48 counties in GA.

In fiscal year (FY) 2009, the facility served about 71,000 patients, a 7 percent increase over the previous year. In FY 2010, the facility served about 77,000 patients, an increase of 8 percent over the previous year. Between October 2009 and May 2010, the percentage of unique patients waiting greater than 30 days for appointments in the facility's top 50 clinics rose from about 0.6 percent to about 4.5 percent. In addition to MH, we confirmed that several other clinics had EWLs, including those run by Ophthalmology, Hematology/Oncology, Physical Medicine and Rehabilitation, and Sleep Studies. Notably, patients were able to schedule timely primary care (PC) appointments during this time.

Mental Health Structure, Resources, and Workload

The Mental Health Service Line (MHSL) offers general MH and specialized programs for post-traumatic stress disorder (PTSD), military sexual trauma, substance abuse treatment and recovery, homeless and residential care, and geropsychiatry. In FY 2010, the MHSL had about 305 full time equivalent employees (FTEE). There were 39 vacancies at the end of the year, mostly in PC MH Integration,[1] the Homeless Program, and the general MH clinic (GMHC). The budget was approximately $14M.

A majority of patients receive their MH services through outpatient clinics and programs, either at the facility, in a CBOC, or at an offsite VA MH clinic location.[2] The facility contracts with local community service boards (CSBs) when demand for services exceeds MH resources. CSBs typically provide outpatient MH, developmental disability, and addiction services to residents of their defined counties. VISN 7 contracts with almost 20 different CSBs across Georgia to provide general outpatient MH services, crisis stabilization, and psychosocial rehabilitation/day treatment to patients referred by any of its 8 VA medical centers.

The facility's inpatient MH unit has undergone renovation over the past year and currently has 40 acute MH beds. The facility contracts with a local private-sector psychiatric facility (referred to as the "IP contractor" in the remainder of this report) for patients requiring hospitalization that cannot be accommodated on the facility's MH unit due to lack of available beds.

MH workload has increased 17 percent since 2008. Table 1 below shows both the facility and contractor workload variances for FY 2009–FY 2010. Inpatient workload is defined as the number of discharges from an inpatient setting. Outpatient workload reflects the number of patient encounters with MH providers.

Table 1. MH Workload FY 2009–FY 2010

	FY 2009	FY 2010	Increase (Decrease)
Inpatient (VA)	651	993	52.53 %
Inpatient (IP contractor)	899	625	(43.8 %)
Outpatient (VA)	201,915	225,017	11.44 %
Outpatient (contractors)	796	657	(17.46 %)

[1] PC MH Integration consists of psychologists, assigned to work in Primary Care clinics, who assess and treat patients with routine MH needs, thus minimizing the referrals to specialty MH clinics.
[2] Due to space constraints, some VA-staffed clinics occupy leased space in the community.

In addition to the number of new patients enrolling in VA care, facility and MHSL managers attributed the higher volume of patients seeking MH services to:

- Required follow up to positive MH-related screening questions completed by PC providers. For example, a comparison of positive depression screens (for the period October to April) that prompted referral to the GMHC rose from 3,848 in FY 2009 to 11,367 in FY 2010.
- An increase in the number of PC providers as new CBOCs opened. While professional MH staffing was approved for the CBOCs, difficulty in recruiting for some positions delayed the hiring process. CBOC patients requiring MH services were referred to the facility's GMHC.
- The addition of a "psychosocial stressors"[3] question to the mandated suicide assessment. The facility found, via its aggregate root cause analyses (RCA) process, that psychosocial stressors were an indicator of suicidal behavior. Adding this question to the screen; however, increased the number of positive responses prompting referrals to the GMHC.

EWL Guidance and Requirements

The EWL is the official Veterans Health Administration (VHA) wait list. VHA Directive 2009-070, *VHA Outpatient Scheduling Processes and Procedures*, December 17, 2009, states, "The EWL is used to list patients waiting to be scheduled, or waiting for a panel assignment. In general, the EWL is used to keep track of patients with whom the clinic does not have an established relationship (e.g. [for example], the patient has not been seen before in the clinic)." VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics,* dated September 11, 2008, states that all new patients requesting or referred for MH services "must receive an initial evaluation within 24 hours, and a more comprehensive diagnostic and treatment planning evaluation within 14 days." For measuring wait times, VHA defines a "new" patient as any patient not seen by a qualifying provider in a specific clinic within the previous 24 months. For example, an "established" PC patient referred to the MH clinic would be classified as a new patient.

In January 2010, a confidential complainant reported to the OIG that facility managers were not adequately addressing EWLs in the MH clinics. The complainant specifically alleged that:

- A high number of patients were on various MH clinic EWLs, which may place some patients at risk for negative events or outcomes.
- Despite VISN and facility management being aware of the risk to patients, no actions had been taken to resolve the issue.

[3] Psychosocial stressors include conditions such as unemployment, homelessness, or marital discord.

On January 28, we contacted a facility manager requesting information about the EWLs. Management confirmed that there were EWLs in several clinics across the facility and advised that the VISN was providing $2M to address them (the funding was received the same day). Based on this information, we deferred investigation of these complaints because the facility and VISN were taking action to resolve the condition.

On May 7, we contacted facility management to determine the status of the MH EWLs and learned that the number of patients awaiting appointments in the GMHC and substance use disorder (SUD) clinics had increased since January. We further learned that the MHSL was offered $250K from the original $2M allotment but was unable to use any of the funding due to contract negotiation issues.

During the course of this review, we also received complaints regarding MH-related fiscal matters:

- FY 2010 funds were inappropriately used to pay for FY 2009 expenses.
- IP contractor payments were delayed.
- De-funding of obligated appropriations and delays in contractor payments negatively affected MH contract service providers.

We were told that some managers had negative personal feelings about the MHSL and MH services. However, we did not evaluate these assertions as they are perceptions that cannot be objectively confirmed or refuted.

Scope and Methodology

We conducted site visits over several weeks between June 3 and August 3, 2010. Prior to our visits, we reviewed VHA Directive 2009-070 and VHA Handbook 1160.1. We interviewed the facility Director, Chief of Staff (COS), Chief Financial Officer (CFO), MHSL Chief, MHSL Administrative Officer (who is also the Contracting Officer's Technical Representative [COTR] for the IP contract), the two MHSL physicians with program responsibility for the GMHC and SUD clinic, the VISN 7 CFO, Chief of Fee Basis Services, and other facility staff knowledgeable about the issues. We also interviewed the local CSB Executive Director and Clinical Coordinator and the IP contractor's Director of Business Operations. We reviewed the MHSL's waiting list from September 2009 to November 2010; quality management, workload, and productivity reports; budgeting and vendor payment documents; email correspondence; CSB contracts; and individual patients' medical records.

This review was performed in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Inspection Results

Summary of Events

Several factors contributed to the facility's inability to meet the growing demand for MH services, including (1) the need to contract for inpatient hospitalization and its result on the MHSL budget, and (2) the lack of MH clinic capacity to manage outpatients.

Need for IP Contract. Since 2008, the facility has experienced a 17 percent increase in demand for MH services and an increase in the number of patients in crisis who required hospitalization. While the IP contract has been used for "overflow" MH patients for many years, the volume of referrals increased in 2008–2009 when the facility was undergoing renovations to increase the number of acute MH beds within the facility from 30 to 40 beds. In FY 2009, the facility paid the IP contractor approximately $6.7M for acute hospitalization and other services.[4] In July 2009, the MHSL requested and was approved for approximately $4.3M to fund the IP contract in FY 2010. The bed renovation project was initially scheduled for completion on October 1, 2009, so the budget projection of $4.3M presumed a decreased need for IP contractor beds due to the increased availability of facility acute MH beds. However, construction and plumbing problems delayed the project and completion dates were continuously revised. Beds were added in January and April, but FTEE to staff the new beds was not fully in place until July 2010.

MH Clinic Capacity. Due to space and resource limitations, the MHSL was unable to hire new FTEE to staff the on-site GMHC. During the July 2009 budget call, the MHSL requested approximately $6.8M for outpatient contract services for FY 2010. On October 14, $5M was approved. However, on November 12, the allotment was reduced to $1M. As a result, the MHSL stopped making referrals to the CSBs and actively tried to bring CSB patients back into the facility for services.

Facility staff did not make any referrals to the local CSB, which provides services to residents of the county where the facility is located and many of its patients reside, from November 2009 to May 2010 due to the lack of contract funds. The GMHC EWL began to increase in October 2009.

Facility Interim Actions

As the EWLs grew, the MHSL used the MH Assessment Team (MHAT) to assess patients referred for MH services who could not be scheduled in the desired MH clinic within 14 days due to lack of clinic capacity. The MHAT consisted of three psychiatrists

[4] Electroconvulsive shock therapy (ECT) was also discontinued at the facility during this time, requiring contracted care for that service as well.

who assessed the referred patients, and based on their clinical determination of risk, would either admit the patient to an acute MH unit (facility or IP contractor) or develop an outpatient treatment plan that could include medication, referral for other facility or community-based services, and/or placement on the desired program's EWL.

The MHSL was offered $250K in late March 2010. We received conflicting testimony on how the funds were to be used (contract care versus FTEE); however, interviewees generally agreed that the intent of the additional resources was to directly or indirectly address the EWL.

We were told that negotiations between the MHSL and local CSB staff were unsuccessful, reportedly due to the CSB's concerns about the timeliness of past payments and the structure of approved services (which included one initial assessment and two medication reconciliation appointments). Because the MHSL could not spend the $250K quickly, facility managers reallocated the funds to other services.

In mid-May, the MHSL was told they would be receiving $2.3M and to proceed with negotiations with the local CSB. The additional funding permitted a restructuring of contracted services to include one initial assessment and six follow-up visits. The facility resumed referrals to CSBs on May 29, and the MHSL officially received the $2.3M on June 2.

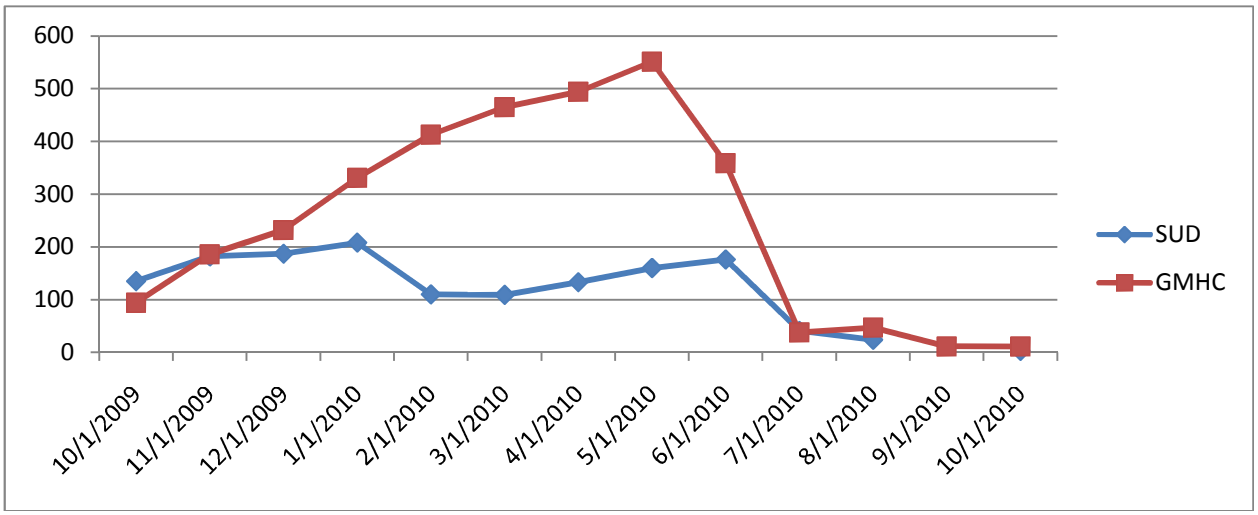
Managers were also taking actions to hire additional FTEE. In an effort to reduce the number of referrals to the GMHC, "integration psychologists" were added to the PC teams to address MH issues within the CBOCs. As of February 2, 2011, the facility had hired 11 integration psychologists. In addition, most CBOCs[5] were staffed with some combination of a psychiatrist, psychologist, and/or social worker to manage MH needs within that setting, when appropriate.

Issue 1: EWL and Patient Safety Concerns

We substantiated the allegation that a "high" number of patients were on various MH clinic EWLs during the timeframe referenced by the complainant. While several MH clinics had EWLs (mostly of 50 patients or less), we found the SUD and GMHC clinics to be most concerning as: (1) their EWLs exceeded 100 patients; (2) they were more likely to serve patients not already being followed by another MH provider; and/or (3) the patients waiting for appointments in these clinics were more likely to be considered at risk due to diagnosis or lack of an established MH provider.

[5] One CBOC does not have a MH team onsite yet.

Table 2. Substance Use Disorder and General Mental Health Clinic EWLs (FY 2010)



The SUD EWL exceeded 100 patients from October 1, 2009, through June 1, 2010, and some of those patients were on the EWL for the entire 8-month period. Over the past several years, MHSL leaders had attempted to evaluate the access and timeliness issues in the SUD program and had implemented actions to improve these conditions. However, according to the SUD clinic's leadership, demand for services continued to increase, resulting in an EWL for "initial assessment" for SUD treatment. A System Redesign team evaluated the SUD program, and in its February 2010 report, made several recommendations to improve program efficiency and patient flow. As processes were restructured, the EWL began to improve. In July, the SUD EWL dropped to 41, and by October, it was down to 3 patients.

MHSL managers reported, and fiscal data confirmed, that the GMHC EWL began to increase when resources were no longer available to fund CSB referrals. The GMHC EWL quintupled, from 94 patients on October 1, 2009, to 551 patients on May 1, 2010. Some of those patients had been on the EWL for the entire 8-month period. During this time, facility clinicians did not refer any patients to the local CSB. In mid-May, after the MHSL was informed additional funding was forthcoming, referrals to the CSB resumed. On June 1, the GMHC EWL was 359, and by October 1, it was down to 11 patients.

The following data supports concerns that some of the EWL patients may have been at risk for negative outcomes or events before they could be seen by the MH clinic for which they were awaiting an appointment:

- From October 1, 2009, to March 31, 2010, there were 419 patient admissions to contract facilities for MH reasons; 38 (9 percent) of those admissions involved patients on a MH EWL. During the same period, 44 patients on a MH EWL were admitted to the facility's acute MH unit. This data implies that the patients' clinical conditions deteriorated while they were on EWLs.

- From July 1, 2009, through March 31, 2010, there were 211 facility patients who either self-reported or were observed to display suicidal behavior. Of those, 148 (70 percent) were categorized as "attempters" and 63 were categorized as patients with serious suicidal ideation. Of the 211 patients, 24 (11 percent) were on one of the MH EWLs at the time of the event, and 16 (67 percent) of the 24 patients actually attempted suicide. There were no completed suicides of patients on the MH EWLs.

While the conditions noted above appear serious, we could not say with certainty that those events would have been prevented had the patients been scheduled promptly into the appropriate MH clinics. Our medical review of MH EWL patients reflected that the MHAT was assessing patients and developing interim treatment plans pending the scheduling of an appointment in the desired MH clinic.

We reviewed the medical records of 67 patients assessed by the MHAT and placed on a MH EWL during February 2010.[6] Our sample included 30 randomized patients and 37 patients with specific diagnoses, such as PTSD or psychosis, which would typically warrant closer follow-up. Our medical record review focused on the following questions:

- While on a specified MH EWL, were patients seen or followed by another MH clinic or provider?
- If not followed by MH, were the MH EWL patients being followed by the PC provider?
- Did any of the MH EWL patients have any unusual events or needs while on the EWL? We included suicidal gestures and related contacts, and hospital admissions and emergency department (ED) visits related to a MH condition.

Table 3. Medical Record Review Results

	Seen by MH	Seen by PC	Patients Experiencing Events or Special Needs	
Randomized records (N=30)*	26	3	5	• 3 Suicide Prevention Hotline (SPH) calls • 2 ED visits related to MH condition
Diagnosis-specific records (N=37)	36	1	8	• 3 high risk suicide flags placed/continued • 1 SPH call • 2 admissions for MH-related reasons • 2 high-risk cases prompting safety actions

* *One patient did not show for a follow-up appointment and efforts to reach him were unsuccessful.*

[6] GMHC=26; SUD=18; Trauma Recovery=9; Compensated Work Therapy=7; HCHV=4; and Substance Abuse Trauma Recovery=3

We found that even though these patients were on a MH EWL, they were still receiving some level of service or follow-up through another MH provider or through PC. For example, a patient could have been followed by clinicians in the Homeless Program while also on the SUD EWL. Eleven (16 percent) of the 67 patients were started on psychiatric medications while on a MH EWL, and documentation reflected that reasonable monitoring occurred. We noted that ED visits were typically for medication refills and non-emergent MH issues. MHAT assessments were completed, and interim treatment plans reflected that MH EWL patients were offered information and support through facility and non-VA resources while awaiting more specialized facility MH treatment modalities. PC progress notes also contained evidence that providers were generally aware of their patients' MH conditions and EWL status.

We are unaware of any completed suicides among the 67 patient medical records we reviewed; however, we did find evidence of MH EWL patients who attempted suicide, were hospitalized, or presented to the ED. We did not evaluate whether these particular events occurred as a direct result of being placed on MH EWLs, or whether they would have occurred in the course of regular, ongoing treatment. Large MH EWLs are inherently problematic as they represent impaired access to ongoing care.

As of October 2010, the GMHC and SUD EWLs had largely been resolved. However, leadership needs to assure ongoing actions are taken to minimize and/or alleviate MH EWLs.

Issue 2: Responsiveness of Facility Leaders

We confirmed that VISN and facility managers were aware of the increasing MH EWLs and the potential vulnerability of patients as early as November 25, 2009, when the MHSL briefed the VISN and facility managers on the "clinical urgency to address the EWLs" and sought funding for contracts and to staff vacancies. Over the next several months, managers were alerted to the ongoing EWL concerns, but it appeared that they were slow to take action:

1. A January 7, 2010, VISN team report about MH services identified a priority challenge as "preventing patients needing MH services from waiting a significant time to receive them." The VISN team recommended reallocating resources in the outpatient programs, including hiring a three-person team to manage patients awaiting MH care. This three-person team was not approved until June 2010.[7]
2. On January 28, facility management said that the VISN was providing $2M in funding to address EWLs in several outpatient clinics. The funding was received on station the same day; however, funding was not offered to the MHSL until late March.

[7] Because of space limitations, the team could not be co-located. This condition has resulted in fewer patients being seen than originally projected.

3. An aggregate RCA on suicide behaviors signed by facility managers on February 4 reflected a root cause/contributing factor as "EWLs creating a vulnerable period when those patients do not have access to adequate MH care."

Facility leaders later told us that the decision on how to allocate the initial $2M was based on clinical Service chiefs presenting their "cases" to the COS. The COS told us that he believed the MHAT was appropriately triaging patients and that patients on the MH EWLs were safe. The COS reported that he prioritized based on clinical need and available resources. In late March, facility managers sent an e-mail offering the MHSL $250K to reduce EWLs; however, the funds were returned as the CSB contract was still being negotiated.

In June, the VISN provided another $5M to address EWLs across the facility's outpatient clinics; the MHSL received $2.3M. With this infusion of funding, referrals to the CSB recommenced. This action, coupled with the addition of new MH staff and primary care integration psychologists, resulted in the GMHC EWL largely being eliminated. Again, leadership needs to assure ongoing actions are taken to minimize MH EWLs in the future.

Issue 3: Payment of FY 2009 Expenses with FY 2010 Funds

We substantiated the allegation that FY 2010 funds were inappropriately used to pay for FY 2009 expenses. This condition occurred because there were insufficient obligations recorded at the end of FY 2009. The facility paid approximately $589,000 for FY 2009 MH inpatient expenses with FY 2010 annual appropriations, contrary to VA guidance.

The procedures for recording obligations for outside hospitalization costs is covered under VA Controller Policy, MP4, Part V, Chapter 3; 3A.07.

VA Financial Policies and Procedures, Volume II, Chapter I, page 4, states that VA's policies for the administrative control of funds must:

> Prescribe a system for positive administrative control of funds designed to ensure that obligations and expenditures in each appropriation account or fund do not exceed the amount available, are made for the period for which funds are available, and are used for proper purposes….

Appropriations are categorized as annual, multi-year, or no-year. No-year appropriations allow the facility to obligate funds for an indefinite period of time. Appropriated funds are legally available to be obligated subject to the following criteria:

- Obligation or expenditure must be authorized.
- Obligation must occur within the time limits applicable to the appropriation.
- Obligation and expenditure must be within the amounts established by Congress.

The facility has a no-year appropriations account for MH services. No-year appropriations may be funded with additional appropriations, if available, so that obligations can be matched to the proper year's appropriations.

In September 2009, Fiscal Service managers redirected unobligated MH appropriations to other appropriations accounts as a part of the year-end budgetary process. During the period September 15–November 22, 2009, managers stopped payments to the IP contractor because of year-end closing procedures. Meanwhile, outstanding bills were left unpaid and additional bills accumulated because of continued patient referrals to the IP contractor. Facility officials were unable to pay all of the FY 2009 bills because there were insufficient funds available from FY 2009 appropriations. On November 23, 2009, the facility began payment of FY 2009 bills to the IP contractor.

We reviewed FY 2010 IP contractor payment histories for inpatient stays in association with vendor history data from VSSC. Our analysis resulted in identifying approximately $589,000 in expenses incurred prior to September 30, 2009, which were paid under the FY 2010 Obligation Code OC1001.

Several internal facility emails verified this condition:

- On November 19, 2009, a facility budget analyst reported that an additional $500,000 would be required to pay for FY 2009 invoices. Later that morning, a supervisory budget analyst confirmed that these FY 2009 invoices would be paid with FY 2010 funds.
- On March 3, 2010, the Assistant Chief, Purchase Care Fee Basis, confirmed with the COTR that an FY 2010 obligation code (OC1001) would be used to pay for FY 2009 invoices.
- Also on March 3, the Chief of Fee Basis Services confirmed that FY 2010 funds were used because there were no more FY 2009 MH funds available.

Fiscal Service managers' actions and the series of emails confirmed the intent to use FY 2010 funds to pay FY 2009 bills. In April 2010, the CFO requested additional FY 2009 funds to pay additional claims presented by the IP contractor.

Issue 4: Delays in Payments to the IP Contractor

We determined there were significant delays in FY 2010 payments to the IP contractor for inpatient stay billings from FY 2009 to FY 2010. The IP contract included a provision about the Prompt Payment Act, which requires agencies to pay commercial obligations within certain time periods and to pay interest penalties when payments are late. Review of the IP contractor's FY 2010 payment history through September 2010 revealed that the facility paid interest totaling $5,048 on 249 out of 838 inpatient stay invoices totaling $6.365M. Causes for the delays included Fiscal Service's moratorium

on payments from mid-September through late-November 2009 and difficulties reconciling outstanding payments owed between the IP contractor and the facility.

We reviewed emails between the IP contractor and the facility for the period October 2009–March 2010. A sample of these emails discussed the facility's hold placed on payment of funds, delays in payment of outstanding claims, and increased levels of concern by the contractor over non-payment.

- On October 14, 2009, the Chief of Fee Basis informed the COTR that the accounting department had not allowed them to release any payments since before September 18, 2009, and there was no official release date in the future.
- On March 19, 2010, a budget analyst informed the Chief of Fee Basis that there was $825,000 in outstanding pending IP contractor claims with dates of service in FY 2009.
- On November 16, 2009, the IP contractor's CFO requested definitive updates from the Chief of Fee Basis because of communication problems with facility personnel regarding the status of unpaid invoices in excess of $1.0M. In prior communications, the CFO emphasized that senior corporate personnel had concerns over non-payment of outstanding invoices.

We found no evidence that the IP contractor refused to accept VA contract patients during the non-payment period. However, the substantial amount owed, accumulating over several months, may have negatively affected the VA-IP contractor referral relationship and reduced the availability of this emergent service.

Issue 5: Defunding of Obligated Appropriations

We substantiated the allegation that defunding of obligated appropriations and delays in contractor payments could have negatively affected contract service providers, specifically, the Health Care for Homeless Veterans (HCHV) Grant and Per Diem (G&PD) program.

Fiscal Service managers de-funded amounts obligated for the G&PD program in September 2009, resulting in delayed payments to contractors. Due to these delays, a contractor was unable to relocate veterans from unsuitable housing in a timely manner. Internal facility emails confirmed that previously appropriated and obligated funds were de-funded.

On October 14, 2009, the HCHV Director summarized the funding issues for the Associate Director facility in a chain of emails dating back to August 14, 2009.

- On September 9, 2009, the HCHV Director informed a budget analyst that there was approximately $322,000 in pending G&PD bills for FY 2009 with $134,000 in invoices received.

- On September 10, a budget analyst requested that the HCHV Director decrease obligations of funds to allow for payment of $134,000 of invoices and a $5,000 cushion.
- On September 11, the HCHV Director decreased obligations at the request of the budget analyst by approximately $246,000. This resulted in $246,000 of unobligated funds directed to other appropriations accounts, which left no funds available for pending bills.

Other emails confirmed that these funding issues still existed nearly a month later. On October 8, the COTR informed Fiscal Service that the MHSL had many FY 2009 invoices that were being rejected for payment because funds were de-obligated. On October 9, the HCHV Director informed the MHSL Chief and COTR that there was still approximately $320,000 in unpaid FY 2009 invoices. Additionally, the HCHV Director reported that a contractor who supplied community housing for homeless veterans was unable to relocate veterans from sub-standard housing due to lack of payment.

Issue 6: Incidental Concern – Adequacy of Performance Measure

In October 2010, VHA implemented a new performance measure relative to wait times for new MH patients. This measure tracks the percent of new patients waiting to be seen within 14 days of their desired appointment date. The intent of the new performance measure was to ensure that patients were promptly seen by a MH professional to evaluate clinical risk and initiate intervention for patients with acute MH needs. Thus, the performance measure calculates the timeliness of access to a qualified MH provider for a single evaluation and treatment plan. However, VHA currently does not have a measure tracking whether there is consistent and ongoing access to care, such as time to second appointment. Because of this limitation, the facility was able to achieve 100 percent compliance with the access measure for the first three quarters of FY 2010 in spite of having hundreds of patients on various MH EWLs.

We suggest that VHA consider this issue when developing future MH-related performance measures.

Conclusions

We substantiated that several MH clinics had significantly high numbers of patients on their EWLs over a period of months in FY 2010, and we substantiated that facility managers were aware of the EWLs but were slow in taking actions to address the condition. We are unaware of any completed suicides; however, we did find evidence of MH EWL patients who attempted suicide, were hospitalized, or presented to the ED. We did not evaluate whether these events occurred as a direct result of being placed on MH EWLs or whether they would have occurred in the course of regular, ongoing treatment. However, large MH EWLs are inherently problematic as they represent impaired access

to ongoing care. While the facility has since provided resources to eliminate the MH EWLs, ongoing actions will be needed to ensure the condition does not recur.

We substantiated that FY 2010 funds were inappropriately used to pay FY 2009 IP contractor expenses and that there were delays in the timely payment of the IP contractor's invoices. Defunded FY 2009 HCHV obligated appropriations resulted in payment delays that had the potential to negatively impact contract providers, particularly the small homeless GPD service providers. Although we identified one case where a GPD provider could not relocate patients to a more suitable environment until payments were received, we did not find evidence that other referrals or patient care were actually affected.

We noted that VHA's performance measure on MH clinic access refers only to the first MH clinic evaluation; it does not measure ongoing access to MH services. As such, some VHA facilities may be fully compliant with the performance measure, but may not be providing timely and ongoing treatment and services critical to this population's MH maintenance and recovery.

Recommendations

Recommendation 1. We recommended that the VISN Director, in conjunction with the Medical Center Director, ensure ongoing actions are taken to minimize and/or alleviate MH EWLs.

Recommendation 2. We recommended that the VISN Director, in conjunction with the Medical Center Director, require that Fiscal Service monitors and enforces the provision to match expenditures with the proper year's appropriations as outlined in VA Financial Policies and Procedures. Obligations should be recorded in accordance with the guidance in the VA Controller Policy. The CFO should follow administrative procedures to ensure that FY 2009 expenditures are reported in the appropriate fiscal year.

Recommendation 3. We recommended that the VISN Director, in conjunction with the Medical Center Director, require the Chief of Fee Basis to establish procedures to ensure that all invoices received by the facility are appropriately tracked, including date of receipt, and that invoices are reconciled with vendor records and paid in a timely manner.

Recommendation 4. We recommended that the VISN Director, in conjunction with the Medical Center Director, require that Fiscal Service ensure that properly obligated HCHV funds are not defunded.

Comments

The Acting VISN Director, who is also the Medical Center Director, agreed with the findings and recommendations and provided acceptable action plans (see Appendixes A and B, pages 16–21 for the full text of their comments). The Medical Center Director has implemented processes to ensure that ongoing needs of all clinical services are discussed with appropriate service line managers and resolutions/actions implemented to minimize and/or alleviate MH EWLs and all other EWLs. Fiscal Services has monitors to match expenditures with prior year's appropriations, and the Fee Chief will ensure invoices are tracked and documented upon receipt and certification by the COTR. Purchased Care will process payments authorized by the COTR within 20 days of receipt, and the cover sheet will be annotated accordingly. Financial Management has implemented a Specific Purpose funding tracking system to ensure all special program funds are monitored for appropriate funding and timely obligations.

We will follow up until the planned actions are completed.

(original signed by:)

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

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 15, 2011

From: Acting Director, VA Southeast Network, (10N7)

Subject: **Healthcare Inspection – Electronic Waiting List Management for Mental Health Clinics, Atlanta VA Medical Center, Atlanta, Georgia**

To: Director, Atlanta Office of Healthcare Inspections (54AT)

Thru: Director, VHA Management Review Service (10A4A4)

I concur with the findings and recommendations of this report. We will manage the Electronic Waiting list (EWL) per VHA guidance and based on facility/VISN resources.

(original signed by:)
James A. Clark, MPA
Acting Director, VA Southeast Network (10N7))

Appendix B

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 15, 2011

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

Subject: **Healthcare Inspection – Electronic Waiting List Management for Mental Health Clinics, Atlanta VA Medical Center, Atlanta, Georgia**

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

1. We appreciate the OIG's review to ensure that MH EWL receives the attention needed from senior management as well as other EWL issues for the Medical Center. We would like to reiterate that the healthcare inspection did not present evidence that significant negative outcomes occurred as a direct result of being on the MH EWL. In addition, the report confirmed that although the patients were on a MH EWL, they were still receiving some level of service or follow-up through another MH provider or through PC. However, we agree that EWLs represent a barrier to care and should be minimized. Management closely monitors all patients on the EWL to ensure timely treatment/care occur based on medical necessity.

2. Although additional funds were received from the VISN to remedy temporarily the EWL, the amount received did not adequately match our increase in patients served from 2009 to 2010. The Medical Center experienced 7 and 8 percent growth respectively from 2009 to 2010. We project another 7–8 percent growth for fiscal year 2012.

4. The Medical Center prioritizes the needs of our veterans to ensure that they receive care based on medical necessity and priority scheduling. With regard to unit cost per patient, the Medical Center is ranked 9th among other VA facilities, 1st in VISN 7, and 1st with all other 1A facilities (Unit Cost Report 1-Fiscal Year 2011Q1). In addition, the Medical Center is -13.57 percent below the National mean for cost efficiency (Unit Cost Report 1-Fiscal Year 2011Q1). We will continue to utilize our finite resources to ensure quality care is delivered, second to none, and that

management continues to address systems improvements through operational efficiencies.

5. One of the causes of delays in payment to the vendor was untimely receipt of completed invoices. VHA staff picked up the invoices January 29, 2010, from the vendor to assist with timely reconciliation. Some of the invoices included several dates of services for fiscal year 2009. Additional time was needed to process and reconcile these invoices.

The Medical Center will continue to provide ongoing support for all EWLs. Priorities are based on input from our clinical Service Line Mangers and discussed with our Chief of Staff.

We concur with the recommendations and have provided our response and action plans.

(original signed by:)
James A. Clark, MPA
Director, Atlanta VA Medical Center (508/00)

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

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

OIG Recommendation

Recommendation 1. We recommended that the VISN Director, in conjunction with the Medical Center Director, ensure ongoing actions are taken to minimize and/or alleviate MH EWLs.

Concur **Target Completion Date:** Completed

Facility's Response:

EWL support/resources are provided to all areas of our clinical services, and clinical judgment of the Chief of Staff is supported by input from his Service Line Managers. We will work to minimize/eliminate all EWL entries prioritized by medical need and within available resources and request additional support from the VISN/VACO if necessary.

The Atlanta leadership has implemented processes to ensure that ongoing needs of all clinical services are discussed with appropriate service line managers, and resolutions/actions implemented to minimize and/or alleviate MH EWLs and all other EWLs. This includes weekly discussions with the Medical Center Pentad, Financial Manager, Administrative Officers, Chief of Health Administration Services, Administrative Assistant to Chief of Staff, and other senior leaders as appropriate to review service line input on EWLs and prioritization of needed resources. Resources are approved based on clinical priorities.

The Medical Center will continue best use of its finite resources to ensure care and services are provided timely, implement management efficiencies in areas needing systems improvements, and support our clinical services to address all EWLs adequately.

Recommendation 2. We recommended that the VISN Director, in conjunction with the Medical Center Director, require that Fiscal Service monitors and enforces the provision to match expenditures with the proper year's appropriations as outlined in VA Financial Policies and Procedures. Obligations should be recorded in accordance with the

guidance in the VA Controller Policy. The CFO should follow administrative procedures to ensure that FY 2009 expenditures are reported in the appropriate fiscal year.

Concur **Target Completion Date:** Completed

Facility's Response:

Fiscal Services have monitors and enforces the provision to match expenditures with prior year's appropriations as outlined in VA Financial Policies and Procedures. In FY2009, an interim solution was necessary to pay mental health vendor for services provided without funding because our contractual obligations exceeded appropriated funds. The Atlanta VAMC [VA Medical Center] experienced a very high volume of veterans requiring mental health services, especially inpatient mental health admissions to our contracted vendor due to our internal bed capacity limitations. The leadership at the Atlanta VAMC met frequently to ensure patient care was provided to our mental health patients timely. In addition, approximately $850,000 of additional institutional claims was submitted by the vendor during January 2010.

The CFO consulted our VISN CFO regarding the need to utilize FY10 funds to pay for prior year's expenditures until the FY09 funds became available.

Prior year funds were requested and identified for the Atlanta VAMC during April 2010. At that time, transfers were processed to reflect expenditures appropriately to the FY09 appropriation. This interim solution was necessary to prevent disruption in services to not only our mental health high-risk patients but also all other veterans served by the Atlanta VAMC.

Financial Management and Health Administration has implemented steps to ensure Mental Health Managers stay within their allocated budget or takes appropriate actions to request additional funds prior to authorization of services. Steps include monthly face-to-face meetings with Mental Health Managers, monthly Financial Update and Projection reports, developed estimating and tracking tool for Service Line's use, and weekly Non-VA Purchase Care projection reported to Medical Center Leadership.

Recommendation 3. We recommended that the VISN Director, in conjunction with the Medical Center Director, require the Chief of Fee Basis to establish procedures to ensure that all invoices received by the

facility are appropriately tracked, including date of receipt, and that invoices are reconciled with vendor records and paid in a timely manner.

Concur **Target Completion Date: May 31, 2011**

Facility's Response:

Fee Chief will coordinate and communicate with MH COTR to ensure invoices are tracked and documented as the invoices are initially received and certified/reconciled with vendor records as appropriate for payment by the SL COTR. The SL MH COTR or designee will develop a cover sheet that contains the information described herein and forwarded to the Fee Chief to ensure accuracy of information and timely payment.

Purchased Care will process payments authorized by the COTR within 20 days of receipt of the valid invoice in the Purchased Care Unit. The Cover Sheet will be annotated with the date of receipt in Purchased Care and will be maintained in accordance with records control requirements.

Recommendation 4. We recommended that the VISN Director, in conjunction with the Medical Center Director, require that Fiscal Service ensure that properly obligated HCHV funds are not defunded.

Concur **Target Completion Date: Completed**

Facility's Response:

During the End of Year close-out process, Service Line Managers are required to review each obligation to ensure funding is committed by any outstanding invoices. Financial Management conducts a review of unliquidated balances on each obligation to prevent the loss of expired funds and requests justification from each Service Line. HCHV program was inadvertently included in this review. Financial Management was notified of the error in early October, funds were restored, and the obligation was increased on October 14, 2009.

Financial Management has implemented steps to prevent this from reoccurring by instituting a Specific Purpose funding tracking system to ensure all special program funds are monitored for appropriate funding, timely obligations, and for review of any requests to the Program Office for additional funds or return of excess funds.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Victoria Coates, LICSW Darlene Conde-Nadeau, NP Thomas Seluzicki, CPA Michael Shepherd, MD

Appendix D

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