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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Traumatic Brain Injury Services and Leaders' Oversight at the Southeast Louisiana Veterans Health Care System in New Orleans

HEALTHCARE INSPECTION | REPORT # 21-00669-176 | JUNE 30, 2021

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the request of Chairman Mark Takano, House Committee on Veterans' Affairs, to assess patient evaluation and treatment of traumatic brain injury (TBI) at the Southeast Louisiana Health Care System (facility) in New Orleans.[1]

The purpose of the inspection was to assess allegations that facility staff failed to adequately evaluate and treat TBI for patients who served in Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND).[2]

The OIG reviewed facility, Veterans Integrated Service Network (VISN) 16, and Veterans Health Administration (VHA) TBI benchmark data in addition to conducting an independent electronic health record review of facility patients who had a positive TBI screen and consented to a comprehensive traumatic brain injury evaluation (CTBIE) between October 1, 2017, and September 30, 2020.[3] The OIG also reviewed facility leaders' response to the media outlet's assertions.[4]

VHA requires a one-time TBI screening for all OEF/OIF/OND patients during their initial visit to a VA medical center or clinic. VHA requires providers to place a CTBIE consult for all patients who receive a positive TBI screen and agree to further evaluation.[5] CTBIE consults should be completed within 30 days of the positive TBI screen.[6]

To evaluate and measure a facility's effectiveness in TBI screening, VHA identified an internal benchmark of a 95 percent screening completion rate. The OIG team reviewed facility, VISN 16, and VHA's initial TBI screening completion rates, as generated from the VHA Support Service

[1] TBI, usually resulting from a blow or jolt to the head or body, can have a wide range of physical and psychological effects. Mayo Clinic, *Traumatic Brain Injury*, accessed March 22, 2021, https://www.mayoclinic.org/diseases-conditions/traumatic-brain-injury/symptoms-causes/syc-20378557.

[2] VHA identified the need to conduct TBI screening on OEF/OIF/OND veterans to ensure TBI was diagnosed and treated as TBI is a common form of injury within this population.

[3] The OIG team reviewed fiscal years 2018, 2019, and 2020 to include relevant TBI service providers, to assess the effectiveness of current services, and ensure continuity of data and methodology. The OIG did not have access to, or review, the patient list referenced by the former facility psychologist featured in the November 2020 media outlet article.

[4] For the purposes of this report, the OIG considered facility leaders to include senior level executives, service chiefs, and chief medical officers.

[5] VHA Directive 1184. The CTBIE, used to substantiate or rule out a diagnosis of TBI, establishes the origin of the patient's injury, assesses neurobehavioral symptoms through a physical examination, and when appropriate, develops a treatment plan.

[6] VHA Directive 1232(2), *Consult Processes and Procedures*, August 24, 2016. VHA Directive 1184.

Center.[7] The OIG found the facility's patient TBI screening rate generally met or exceeded the national benchmark with the exception of falling slightly below the benchmark for three quarters during fiscal year 2019.

The OIG did not substantiate the allegation that facility staff failed to adequately evaluate and treat TBI for OEF/OIF/OND patients. The OIG conducted an independent data review of 327 electronic health records (EHRs) to determine if patients who had an initial positive TBI screen, and did not decline a CTBIE referral, received further evaluation.[8] The OIG found that of the 327 patient EHRs analyzed, 172 (52.60 percent) CTBIEs were completed within 30 days and overall, 243 (74.31 percent) CTBIEs were completed. Of the 327 patient EHRs, 84 did not have a completed CTBIE. Scheduling challenges contributed significantly to why CTBIEs were not completed per VHA requirements.[9]

Regarding TBI diagnosis and treatment, the OIG found that of the 243 CTBIEs completed, 181 patients (74.49 percent) were diagnosed as having a TBI. When reviewing the CTBIE plans of care, the OIG noted that clinical services were indicated for 175 of the 181 patients (96.69 percent) who received a TBI diagnosis and clinical services were initiated for 162 of the 175 patients (92.57 percent). The OIG found that the plans of care were thorough, as evidenced by multiple treatment consults and referrals for individual patients, referrals for case management services to assist in the care coordination, and recommendations for integrated polytrauma care plans.

The OIG team also assessed the EHRs for patients who met one of the following three criteria: no completed CTBIE documented; completed CTBIE documented, but greater than 60 days from the date of the positive TBI screen; diagnosed with TBI and clinical services were indicated, but not initiated.[10] Twenty-two patient EHRs met one of these criteria. The OIG reviewed these patient EHRs and did not identify adverse clinical outcomes.

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[7] VHA Support Service Center is an internal VHA database that generates reports on patient care. VA Open Data Portal, *VHA Support Service Center Capital Assets (VSSC),* accessed on April 6, 2021, https://www.data.va.gov/dataset/VHA-Support-Service-Center-Capital-Assets-VSSC-/2fr5-sktm.

[8] The OIG team identified 379 patient EHRs for review including 372 from the VHA Corporate Data Warehouse; and 7 additional patients from the VSSC database. Of the 379 patient EHRs, 52 of the EHRs reviewed were excluded leaving 327 EHRs for further analysis. The OIG excluded patient EHRs when the CTBIE had been completed previously and patient did not have a new service period since completion, the TBI screen was a duplicate, the patient did not serve in OEF/OIF/OND, or the patient was ineligible for VHA health care.

[9] Scheduling challenges were primarily patient causal factors such as patient preference, cancellations, no-shows, and the inability to contact the patient.

[10] The OIG team determined that greater than 60-day delay of CTBIE completion warranted a review for potential adverse clinical outcomes. Specific to reviewing records for indications of possible adverse clinical outcomes, the team reviewed four EHRs with no completed CTBIE, 17 EHRs with CTBIEs completed greater than 60 days after the positive TBI screen, and one EHR that clinical services were indicated but not initiated. 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.

During the inspection, the OIG team found several areas in which facility staff exceeded VHA standards and demonstrated a commitment to patient evaluation and care needs. Despite multiple patient appointment cancellations, no-shows, and challenges contacting patients, facility staff made efforts to ensure patients received CTBIEs within 30 days from positive TBI initial screens.

Additionally, the OIG found that in response to an October 2020 inquiry from the media outlet, facility leaders met VHA requirements and initiated an issue brief. Facility leaders also oversaw two facility EHR reviews of the assessment and evaluation of TBI patients. The facility reviews determined that 100 percent of eligible patients received TBI screening and referrals for CTBIEs. The OIG reviewed the facility leaders' updates to the issue brief and found that facility leaders provided updates when additional information became available, per VHA requirements.

The OIG made no recommendations.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with the report (see appendixes B and C). No further action is required.

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Contents

Abbreviations

CTBIE	Comprehensive Traumatic Brain Injury Evaluation
EHR	electronic health record
OEF	Operation Enduring Freedom
OIF	Operation Iraqi Freedom
OMI	Office of the Medical Inspector
OND	Operation New Dawn
OIG	Office of Inspector General
PM&R	Physical Medicine and Rehabilitation
TBI	traumatic brain injury
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VSSC	VHA Support Service Center

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection, at the request of Chairman Mark Takano, House Committee on Veterans' Affairs, to assess patient evaluation and treatment of traumatic brain injury (TBI) at the Southeast Louisiana Health Care System (facility).[1]

Background

The facility, part of Veterans Integrated Service Network (VISN) 16, consists of a medical center in New Orleans, Louisiana, and seven community-based outpatient clinics located in Slidell, Hammond, St. John Parish, Houma, Franklin, Bogalusa, and Baton Rouge. The facility operates 116 hospital beds and 50 community living center beds. From October 1, 2019, through September 30, 2020, the facility served 45,561 patients. The Veterans Health Administration (VHA) classifies the facility as a Level 1b, high complexity facility.[2]

VHA's Polytrauma and TBI Services

According to VHA, service members who served in Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn (OEF/OIF/OND) often experienced a common form of injury known as a TBI.[3] "Exposure to Improvised Explosive Devices (IED), motor vehicle crashes, and other events contributed to a 20 percent estimated incidence of TBI in Service Members who were deployed in OEF/OIF/OND."[4] VHA identified the need to conduct TBI

[1] TBI, usually resulting from a blow or jolt to the head or body, can have a wide range of physical and psychological effects. Mayo Clinic, *Traumatic Brain Injury*, accessed March 22, 2021, https://www.mayoclinic.org/diseases-conditions/traumatic-brain-injury/symptoms-causes/syc-20378557.

[2] VHA Office of Productivity, Efficiency, and Staffing, Facility Complexity Model, accessed on December 10, 2020, http://opes.vssc.med.va.gov/Pages/Facility-Complexity-Model.aspx. "The Facility Complexity Model classifies VHA facilities at levels 1a, 1b, 1c, 2, or 3 with level 1a being the most complex and level 3 being the least complex."

[3] VHA Directive 2007-013, *Screening and Evaluation of Possible Traumatic Brain Injury in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) Veterans*, April 13, 2007. This directive was in effect from 2007 through 2010 when it was rescinded and replaced by VHA Directive 2010, *Screening and Evaluation of Possible Traumatic Brain Injury in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) Veterans*, March 8, 2010, which was in effect until 2017 when it was replaced by VHA Directive 1184, *Screening and Evaluation of Traumatic Brain Injury (TBI) in Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) Veterans*, April 6, 2017. The war in Afghanistan, known as OEF, started in 2001; the war in Iraq included conflicts known as OIF and OND that began in 2003 and 2010 respectively. VA Community Provider Toolkit, Military Conflicts and Eras (Dates & Names of Conflicts), accessed on April 5, 2021, https://www.mentalhealth.va.gov/communityproviders/docs/conflicts.pdf.

[4] VHA Directive 1184, *Screening and Evaluation of Traumatic Brain Injury (TBI) in Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) Veterans*, April 6, 2017.

screening on veterans who served in these military operations to ensure TBI was diagnosed and treated. In response to this need, VHA established an interdisciplinary task force who developed both a TBI screening tool and a protocol for further evaluation and treatment for patients whose screening results were positive. By 2007, VHA incorporated the screening tool into a national clinical reminder and mandated all patients who served in OEF/OIF/OND must have a deployment-related TBI screening upon initial presentation to VHA for services.[5] By 2010, the VHA task force developed the Comprehensive Traumatic Brain Injury Evaluation (CTBIE), a comprehensive evaluation template that includes the origin of the injury, an assessment of neurobehavioral symptoms, a targeted physical examination, and a follow-up treatment plan. VHA required providers to use the CTBIE template for all TBI evaluations and to document the diagnostic conclusion of the occurrence of TBI.[6]

Polytrauma "occurs when a person experiences injuries to multiple body parts and organ systems often, but not always, as a result of blast-related events. TBI frequently occurs in polytrauma in combination with other disabling conditions."[7] VHA developed a nationwide system of dedicated rehabilitation programs, the Polytrauma System of Care, within VHA facilities to treat polytrauma and TBI.[8] The National Director of Physical Medicine and Rehabilitation (PM&R) Services is responsible for the development and maintenance of policy and rehabilitation standards of care for the Polytrauma System of Care.[9] The Polytrauma System of Care is categorized into four levels based upon complexity. The levels of care range from least complex to most complex in the following order: Polytrauma Point of Contact, Polytrauma Support Clinic Team, Polytrauma Network Site, and Polytrauma Rehabilitation Center.[10]

[5] A clinical reminder displays in the EHR to assist providers with tracking, documenting, and directing patient care. VHA Office of Information and Technology, *Clinical Reminders Manager's Manual*, March 2005, revised January 2021. VHA Directive 2007-013, *Screening and Evaluation of Possible Traumatic Brain Injury in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) Veterans*. This directive was in effect from 2007 through 2010 when it was rescinded and replaced by VHA Directive 2010-012, *Screening and Evaluation of Possible Traumatic Brain Injury in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) Veterans*, March 8, 2010, which was in effect until 2017 when it was replaced by VHA Directive 1184, *Screening and Evaluation of Traumatic Brain Injury (TBI) in Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) Veterans*, April 6, 2017.

[6] VHA Directive 2010-012; VHA Directive 1184.

[7] VA Polytrauma/TBI System of Care, *What is Polytrauma?,* accessed on April 5, 2021, https://www.polytrauma.va.gov/understanding-tbi/definition-and-background.asp.

[8] VHA Handbook 1172.01, *Polytrauma System of Care*, March 20, 2013. This handbook was rescinded and replaced by VHA Directive 1172.01, *Polytrauma System of Care*, January 24, 2019. These policies have similar language and requirements.

[9] VHA Handbook 1172.01; VHA Directive 1172.01.

[10] VHA Handbook 1172.01; VHA Directive 1172.01.

Facility Polytrauma and TBI Services

In 2013, the facility was categorized as a Polytrauma Point of Contact, referring TBI patients to other polytrauma care programs. On December 22, 2017, VHA designated the facility as a Polytrauma Network Site, responsible for providing inpatient and outpatient rehabilitation care and coordinating polytrauma and TBI consultative services throughout VISN 16.[11]

The Chief of PM&R Services serves as the facility's Medical Director of the Polytrauma Network Site, and in this capacity, serves as the "clinical leader for TBI and polytrauma rehabilitation care" and functions as the subject matter expert at the VISN and facility level. As the Medical Director of the Polytrauma Network Site, the Chief of PM&R is a member of the facility's polytrauma team, which also includes a program coordinator, case manager, physicians, and other essential rehabilitation staff. Collectively, polytrauma team members are responsible for ensuring that care is provided in a prompt and efficient manner, evaluating program effectiveness, overseeing data management, tracking performance measures, and coordinating care.[12]

Congressional Request for Review

On November 16, 2020, Chairman Mark Takano requested the OIG review assertions contained in a media outlet article dated November 12, 2020, related to TBI screening, evaluation, and treatment. The media outlet asserted Iraq and Afghanistan veterans were not properly assessed, diagnosed, or treated for TBI at the facility.[13] On November 18, 2020, the OIG opened a new hotline inspection.

The purpose of the inspection was to specifically assess allegations that facility staff failed to adequately evaluate and treat TBI for patients who served in OEF/OIF/OND. Additionally, the OIG team reviewed the facility leaders' response to the allegations presented by the media outlet.[14]

Prior Relevant Reviews

In 2018, three entities reviewed the facility staff's screening, evaluation, and treatment of OEF/OIF/OND patients for TBI: the OIG Office of Healthcare Inspections, VISN 16, and VHA Office of the Medical Inspector (OMI) through a request from the U.S. Office of Special Counsel

[11] VHA Handbook 1172.01; VHA Directive 1172.01.

[12] VHA Handbook 1172.01; VHA Directive 1172.01.

[13] CBS News, *Whistleblower: VA failed to properly assess hundreds of veterans for traumatic brain injuries*, accessed on November 18, 2020, https://www.cbsnews.com/news/veterans-traumatic-brain-injuries-va-new-orleans-whistleblower/, November 12, 2020. The CBS article cited allegations made by a former facility psychologist.

[14] For the purposes of this report, the OIG considered facility leaders to include senior level executives, service chiefs, and chief medical officers.

(see appendix A for a detailed timeline).[15] The reviews resulted in updated facility tracking and documenting processes for TBI consults and evaluations.

Scope and Methodology

The OIG initiated the inspection on November 18, 2020, and conducted a virtual site visit from January 13–28, 2021.

The OIG interviewed the National PM&R Program Manager; staff from VHA Support Service Center (VSSC); a staff member from VISN 16; the facility's Director, Chief of Staff, Deputy Chief of Staff, Chief of Psychology, Chief of PM&R, TBI Program Coordinator; facility staff from social work, transitional care management, and health informatics; and a former facility psychologist.[16]

The OIG reviewed VHA policies and handbooks, facility TBI and polytrauma standard operating procedures, organizational charts, external reviews of facility TBI services along with resulting action plans, an issue brief, facility internal reviews, and facility TBI data. The OIG retrieved and reviewed patient data obtained from VHA's VSSC and the VHA's Corporate Data Warehouse.[17]

While aware the media outlet article referenced patient data and that the facility leaders performed internal reviews in October 2020, the OIG did not assess the facility internal review data, nor data referenced in the media outlet article, for accuracy or completeness, but elected to conduct an independent review of data and policies.[18]

The OIG also conducted an independent electronic health record (EHR) review of OEF/OIF/OND patients who had a positive TBI screen conducted at the facility from October 1,

[15] The VHA Office of the Medical Inspector is responsible for investigating clinical concerns submitted by current and former VA employees. This includes conducting internal reviews as well as responding to referrals from Congress, the VA OIG and the U.S. Office of Special Counsel. Department of Veteran Affairs, *Organizational Excellence*, Office of the Medical Inspector, accessed on February 26, 2021, https://www.va.gov/HEALTHCAREEXCELLENCE/about/organization/office-of-the-medical-inspector.asp.

[16] VSSC is an internal VHA database. Department of Veteran Affairs Open Data Portal, *VHA Support Service Center Capital Assets (VSSC),* accessed on April 6, 2021, https://www.data.va.gov/dataset/VHA-Support-Service-Center-Capital-Assets-VSSC-/2fr5-sktm.

[17] The Corporate Data Warehouse is a large-scale data warehouse—collecting real-time health care data from VHA's EHR system—used to create industry benchmarks for and improve patient care. Department of Veteran Affairs, Health Services Research and Development, *Corporate Data Warehouse*, accessed on April 14, 2021, https://www.hsrd.research.va.gov/for_researchers/vinci/cdw.cfm.

[18] The OIG did not have access to, or review, the patient list referenced by the former facility psychologist featured in the November 2020 media outlet article. The psychologist asserted that a search for potential patients for a pilot study identified that patients were not receiving CTBIEs. The psychologist also reported to the OIG that he did not have TBI expertise. Despite the self-reported lack of TBI expertise, the psychologist did not seek additional information or clarification from facility leaders or program office personnel to understand the TBI assessment process and data.

2017, through September 30, 2020, and who did not decline a CTBIE referral. The OIG team reviewed fiscal years 2018, 2019, and 2020 to encompass relevant TBI service providers, assess the quality of current services, and ensure continuity of data and methodology.[19] Using the VHA's Corporate Data Warehouse, the OIG team identified 372 patient EHRs for review. When comparing the patient list obtained from the Corporate Data Warehouse with a patient list from the VSSC database, the OIG team identified and reviewed seven additional patient EHRs for a combined total of 379 EHR reviews.[20] Of the 379 patient EHRs, 52 of the EHRs reviewed were excluded from the data analysis.[21]

In total, the OIG analyzed the EHRs of the 327 patients to determine if patients who had a positive TBI screen and consented to further evaluation received a CTBIE and if the CTBIE was completed within 30 days. Further, if a completed CTBIE yielded a positive TBI diagnosis, the OIG analyzed the patient EHR to determine if clinically indicated services were initiated. The OIG team reviewed and analyzed data to determine the facility's outcomes related to CTBIE completion, timeliness of completion, causal factors affecting completion, and the frequency of TBI diagnosis. The OIG also assessed patients' EHRs for indications of adverse clinical outcomes related to the lack of or delay of the CTBIE completion or the clinically indicated treatment not being initiated, or both.[22]

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

[19] The OIG determined a review of care for the veteran mentioned in the media outlet's November 12, 2020, article was not within the scope of this project. The inspection focused on systemic issues concerning the screening and evaluation of TBI patients within the facility, rather than any one patient.

[20] The seven additional patients were identified in VSSC but not in the CDW data pulled by OIG. The OIG identified various reasons why they were not in the CDW, including registration errors related to service dates. Further review was outside the scope of this inspection.

[21] The OIG team identified 379 patient EHRs for review including 372 from the VHA Corporate Data Warehouse; and 7 additional patients from the VSSC database. Of the 379 patient EHRs, 52 of the EHRs reviewed were excluded leaving 327 EHRs for further analysis. The OIG excluded patient EHRs when the CTBIE had been completed previously and patient did not have a new service period since completion, the TBI screen was a duplicate, the patient did not serve in OEF/OIF/OND, or the patient was ineligible for VHA health care. Patient EHRs reviewed do not equate to unique patients but rather episodes of care when initial TBI screens were completed. There are circumstances that require more than one screen and evaluation process to be completed on one patient.

[22] 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. The OIG recognizes that in addition to the potential for adverse clinical outcomes, avoidable delays, and cancellations associated with the deficiencies discussed in this report may impact the convenience and quality of care received by veterans. This report focuses on patient harm in terms of adverse clinical outcomes.

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, 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. TBI Screening, Evaluation, and Treatment

The OIG did not substantiate the allegations that the facility polytrauma program failed to adequately evaluate and treat TBI for patients who served in OEF/OIF/OND.

TBI Screening Data

VHA requires a one-time TBI screening for all patients who served in OEF/OIF/OND during their initial visit to a VHA facility.[23] VHA's internal benchmark to evaluate and measure a facility's effectiveness in TBI screening is a completion rate of 95 percent of this patient population.[24] The OIG team did not independently review the facility's TBI screening data; however, table 1 compares facility, VISN, and VHA's initial TBI screening completion rates per quarter and fiscal year over a three-year period, as generated from VSSC.[25]

Table 1 reflects that the facility's patient TBI screening rate generally met or exceeded the national benchmark of 95 percent, with the exception of falling slightly below the benchmark for three quarters during fiscal year 2019.

[23] VHA Directive 1184.

[24] VHA internal benchmarks were confirmed with VHA's PM&R Program Office.

[25] The data in table 1 is reported by fiscal year versus calendar year. The fiscal year begins on October 1 of any given year and ends on September 30 of the following year. "Quarters" refer to three-month segments within the fiscal year: quarter 1 includes October through December; quarter 2 includes January through March; quarter 3 includes April through June; and quarter 4 includes July through September. VSSC data is based on a 100 percent electronic data capture, which excludes patients who were previously screened and is a cumulative quarterly report "designed for trending."

Table 1. Percentage of Patients Screened for TBI

Fiscal Year 2020	Quarter	Facility %	VISN %	VHA %
October 1, 2019, through September 30, 2020	4	95.24	95.25	94.01
	3	96.10	95.48	94.29
	2	96.99	95.88	94.62
	1	97.13	95.92	94.69
Fiscal Year 2019	**Quarter**	**Facility %**	**VISN %**	**VHA %**
October 1, 2018, through September 30, 2019	4	94.28	95.30	94.68
	3	94.54	95.47	94.78
	2	94.84	95.44	94.83
	1	95.00	95.35	94.83
Fiscal Year 2018	**Quarter**	**Facility %**	**VISN %**	**VHA %**
October 1, 2017, through September 30, 2018	4	95.41	95.96	95.61
	3	96.79	97.21	97.06
	2	96.72	97.23	97.09
	1	96.63	97.19	97.11

Source: VSSC.
Note: The OIG did not assess VA's data for accuracy or completeness.

Independent Data Review

The OIG conducted an independent data review of 327 patient EHRs to determine if patients who had an initial positive TBI screen, and did not decline referral, received further evaluation and treatment services.[26] Specifically, the OIG conducted an EHR review and data analysis to determine if OEF/OIF/OND patients who had a positive initial TBI screen conducted at the facility from October 1, 2017, through September 30, 2020, received a CTBIE, and if the CTBIE was completed within 30 days. Additionally, the OIG reviewed the frequency in which patients were diagnosed with a TBI during the CTBIE, and when indicated, evaluated whether clinical services were initiated. Causal factors that contributed to percentages of CTBIE completion and the initiation of treatment services were also reviewed. The OIG used VHA requirements when

[26] The OIG team did not include the 52 excluded patient EHRs in the data analyses sections of this report but focused on the remaining 327 patient EHRs.

reviewing the EHR results and evaluating the facility's polytrauma program's effectiveness in the evaluation and treatment of TBI.

VHA requires providers to place a CTBIE consult for all patients who receive a positive TBI screen and agree to further evaluation.[27] CTBIE consults should be completed within 30 days of the positive TBI screen.[28] When a patient receives a TBI diagnosis during the course of the CTBIE, the evaluating provider refers the patient (with consent) to clinically indicated treatment services that are documented and incorporated into the patient's plan of care.[29]

VHA uses the following internal benchmarks to assess and measure a facility's effectiveness of evaluating patients for TBI:

- CTBIE completion rate of 50 percent within the first 30 days of a positive initial TBI screen
- Overall completion rate of 75 percent[30]

The OIG cautions the reader against comparing the OIG's independent data review and analysis to VHA's TBI benchmarks for CTBIE completion, as the criteria for patient inclusion or exclusion may or may not be the same.

Table 2 includes a summary of the three-year time frame as well as a breakdown by fiscal year of the 327 EHR reviews of patients with a positive TBI screen. Table 2 summarizes the number and percentage of CTBIEs completed within 30 days of the positive TBI screen and the overall number and percentage of the CTBIEs completed.

[27] VHA Directive 1184. The CTBIE, used to substantiate or rule out a diagnosis of TBI, establishes the origin of the patient's injury, assesses neurobehavioral symptoms through a physical examination, and when appropriate, develops a treatment plan.

[28] VHA Directive 1232(2), *Consult Processes and Procedures*, August 24, 2016. VHA Directive 1184.

[29] VHA Comprehensive TBI Evaluation – FAQ Document, accessed January 4, 2021, http://vaww.rehab.va.gov/docs/Comprehensive_TBI_Evaluation_FAQ_Guidance_v4_July_24_2012.pdf. (This is an internal VA website that is not publicly accessible).

[30] VHA internal benchmarks were confirmed with VHA's PM&R Program Office.

Table 2. CTBIE Completion by Fiscal Year

Fiscal Year	Number of Patients with a Positive TBI Screen (EHRs Reviewed)	Number of CTBIEs Completed Within 30 Days of Positive TBI Screen	Completion Within 30 Days %	Overall Number of CTBIEs Completed	Completion %
Combined 3 Years: October 1, 2017, to September 30, 2020	327	172	52.60	243	74.31
October 1, 2019 to September 30, 2020	114	57	50.00	88	77.19
October 1, 2018 to September 30, 2019	99	60	60.06	76	76.77
October 1, 2017 to September 30, 2018	114	55	48.25	79	69.30

Source: VA OIG analysis of Corporate Data Warehouse, VSSC data, and EHR reviews for patients who screened positive on TBI screen from October 1, 2017, through September 30, 2020.

Note: The OIG did not assess VSSC data for accuracy or completeness.

Table 3 outlines the reasons, as documented in EHR reviews, why CTBIEs were not completed or were not completed within 30 days of the positive initial TBI screen. Because of the similarities found across the three-year time frame, the results in the table are reported cumulatively. The results are categorized by facility, patient, or unknown causal categories.[31]

[31] Facility factors included reasons such as no CTBIE consult placed, clinic cancellation, or limited information regarding scheduling attempts. Patient factors included patient-initiated appointment cancellations, appointment no-show, unable to contact, preferred a later appointment date, or a combination of these factors. The unknown category was utilized when no documented reason was found.

Table 3. Reasons for CTBIE Not Completed or Not Completed Within 30 Days (October 1, 2017, through September 30, 2020)

	Total Number EHRs	Facility Causal Factor	Patient Causal Factor	Causal Factor Unknown
Number of CTBIE's Not Completed	84	4	80	0
Number of CTBIE's Completed Greater than 30 Days After Initial Positive TBI Screen	71	14	49	8

Source: VA OIG analysis of Corporate Data Warehouse, VSSC data, and EHR reviews for patients who received a positive TBI screen from October 1, 2017, through September 30, 2020.
Note: The OIG did not assess VSSC data for accuracy or completeness.

Table 4 provides a summary of clinically indicated services identified and initiated for patients whose CTBIE identified or confirmed a TBI diagnosis. The OIG team considered clinically indicated services as treatment or evaluation needs identified during the CTBIE. The receipt of clinically indicated services included evidence that a consult or treatment or both identified during the CTBIE evaluation (considering patient preference) was initiated.[32]

Table 4. Clinical Services Indicated and Initiated (October 1, 2017, through September 30, 2020)

Number of patients diagnosed with a TBI	Number of patients diagnosed with TBI with clinical services indicated	Percentage of patients diagnosed with TBI with clinical services indicated	Number of patients with clinical services initiated	Percentage of patients with clinical services initiated
181	175	96.69	162	92.57

Source: VA OIG analysis of Corporate Data Warehouse, VSSC data, and EHR reviews for patients who screened positive on TBI screen from October 1, 2017, through September 30, 2020.
Note: The OIG did not assess VSSC data for accuracy or completeness.

OIG Data Summary and Analysis

The OIG team's independent data review of 327 EHRs of patients who served in OEF/OIF/OND and had a positive initial TBI screen conducted at the facility from October 1, 2017, through

[32] In addition to consult completion, the OIG considered evidence of other methods of referral such as a hand-off to mental health, consideration of existing services, or evidence in the EHR that the service was initiated. The OIG found a series of patient EHRs considered "partial initiation" as the patients were referred for multiple services and some, but not all, were initiated. The OIG considered these "partial initiation," and because the reasons all services were not initiated were predominantly patient causal factors (unable to contact, patient canceled, no-show), these were included in the services-initiated category.

September 30, 2020, provided an understanding of the facility's polytrauma team's CTBIE evaluation and treatment efforts. Overall, the OIG found that of the 327 patient EHRs included in the final data analysis, 243 (74.31 percent) CTBIEs were completed and 172 (52.60 percent) CTBIEs were completed within 30 days. Through EHR reviews, the OIG found scheduling challenges, primarily patient causal factors (patient preference, cancellations, and no-shows, and the inability to contact the patient) contributed significantly to why CTBIEs were not completed or not completed within 30 days of positive TBI screen. When reviewing the data by fiscal year, the OIG noted both the lowest rate of CTBIE completion and CTBIE completion within 30 days of the positive screen was in fiscal year 2018 (October 1, 2017, through September 30, 2018). The OIG noted that the facility's polytrauma level of care progressed from a Polytrauma Point of Contact to a Polytrauma Network Site on December 22, 2017, and TBI evaluation responsibilities shifted to the polytrauma team; CTBIE completion rates improved in subsequent years.[33]

Regarding TBI diagnosis and treatment, the OIG found that of the 243 CTBIEs completed, 181 patients (74.49 percent) were diagnosed as having a TBI. When reviewing the CTBIE plans of care, the OIG noted that clinical services were indicated for 175 of the 181 patients (96.69 percent) who received a TBI diagnosis; clinical services were initiated for 162 of the 175 patients (92.57 percent). The OIG found that the plans of care were thorough, as evidenced by multiple treatment consults and referrals for individual patients, referrals for case management services to assist in the care coordination, and recommendations for integrated polytrauma care plans. Although not identified in the data tables in this report, the OIG found this pattern to be evident in plans of care in CTBIE evaluations that did not result in a positive TBI diagnosis.

The OIG team also assessed patients' EHRs for indications of adverse clinical outcomes to include death, a progression of disease, worsening prognosis, suboptimal treatment, or a need for higher level care. Specifically, patient EHRs assessed included patients who did not have a CTBIE completed (facility causal factor), all patients who had the CTBIE completed greater than 60 days from the date of the positive TBI screen, and patients who were diagnosed with TBI and for whom clinical services were indicated but not initiated (facility or other causal factor).[34] In the 22 patient EHRs that met the above criteria, the OIG did not identify adverse clinical outcomes.

[33] The facility began formally tracking TBI referrals in August 2017. A polytrauma social worker was hired in March of 2018 to assist with tracking TBI measures and to monitor follow-up as the facility transferred to a Polytrauma Network Site.

[34] The OIG team determined that greater than 60-day delay of CTBIE completion warranted a review for potential adverse clinical outcomes. Specific to reviewing records for indications of possible adverse clinical outcomes, four EHRs with no completed CTBIE, 17 EHRs with CTBIEs completed greater than 60 days after the positive TBI screen, and one EHR that clinical services were indicated but not initiated.

During the inspection, the OIG team found several areas that the facility's polytrauma team and administrative staff exceeded VHA standards and demonstrated a commitment to patient evaluation and care needs. Despite multiple patient appointment cancellations, no-shows, and challenges contacting patients, the polytrauma team and administrative staff maintained rigorous efforts to ensure patients received CTBIEs within 30 days from the positive TBI screen. Although VHA requires that the facility make two documented attempts to contact patients to schedule a CTBIE consult, the OIG found that three or more attempts to contact were made in 80 percent of patients who did not receive a CTBIE.[35]

Further, the OIG team learned of the Chief of PM&R's dedication and commitment to the patients and polytrauma program. During OIG interviews with the Facility Director, Chief of Staff, and Deputy Chief of Staff, the Chief of PM&R was described as conscientious, thorough, skilled, patient-centered, and as using a personal approach to work, adding that he has gained the confidence of the national program office. In addition to the responsibilities inherent to the position, the OIG team found that the Chief of PM&R conducted 84 percent of all completed CTBIEs reviewed.

2. Facility Leaders' Response

On September 9, 2020, a media outlet contacted a facility PM&R provider regarding the care provided to facility TBI patients.[36] On October 7, 2020, the facility's Community and Public Relations Service received a request from the media outlet to interview staff. In response to the October inquiry, facility leaders initiated an issue brief and oversaw two facility EHR reviews of the screening and evaluation of TBI patients. The facility reviews found that all patients who had a positive TBI screen were offered a referral for CTBIE.

Per VHA, issue briefs provide VHA leaders with specific information about a situation or event that may impact care or "generate media interest." Issue brief updates are required "as new information develops," and should include actions taken and any planned changes to facility processes and policies. Updates to the issue brief continue until the issue is resolved.[37] The OIG learned that facility leaders initiated an issue brief on October 20, 2020, and provided VISN and VHA leaders with specific information about the facility's TBI screening and assessment processes.

[35] VHA Directive 1232(2).

[36] On the same day, the VA's Office of Public and Intergovernmental Affairs' Director contacted the media outlet who noted they were not pursuing anything at that time. The facility's Public Affairs Officer then notified the Facility Director.

[37] Deputy Under Secretary for Health for Operations and Management (10N), *Guide to VHA Issue Briefs*, June 26, 2017.

The OIG also reviewed the facility leaders' updates to the issue brief. The OIG found that facility leaders provided updates as soon as additional information became available, and the updates continued until November 16, 2020.

Facility's EHR Reviews of TBI Patients

The OIG reviewed the October 20, 2020, issue brief and found that in response to the media outlet's inquiry, facility leaders oversaw an October 2020 review of all OEF/OIF/OND patients who screened positive for TBI from 2009 to 2018.[38] Although confident that the data used by the media outlet was inaccurate, facility leaders told the OIG that they initiated EHR reviews to ensure all patients who consented to a CTBIE received TBI evaluation and care.[39] The facility review showed that 100 percent of the patients who screened positive for TBI during that time frame were offered a CTBIE.

The November 16, 2020, issue brief update noted that an additional facility EHR review was conducted for fiscal years 2019 and 2020 to make certain that all TBI patients in that period were screened and referred for CTBIEs. The review showed that all patients who screened positive for TBI were referred for CTBIEs.[40] The OIG concluded that facility leaders met VHA requirements by initiating an issue brief that included two EHR reviews of facility TBI patients and also captured pertinent updates.

Conclusion

The OIG did not substantiate the allegations that the facility polytrauma program failed to adequately evaluate and treat TBI for patients who served in OEF/OIF/OND. The OIG found that of the 327 patient EHRs analyzed, 243 (74.31 percent) CTBIEs were completed and 172 (52.60 percent) CTBIEs were completed within 30 days. The OIG noted that clinical services were indicated for 175 (96.69 percent) patients who received a TBI diagnosis and were initiated for 162 (92.57 percent) of these patients. Plans of care were thorough, evidenced by multiple treatment consults and referrals for individual patients, referrals for case management services to assist with coordination of care, and recommendations for integrated polytrauma care plans.

[38] The media outlet inquiry included a former facility psychologist's assertions regarding clinical services provided during a 2009–2018 timeframe; therefore, facility leaders used those parameters for the first EHR review.

[39] The issue brief documented that the media outlet used inaccurate data to report conclusions regarding facility TBI assessments. Specifically, the issue brief noted that the TBI metrics used were "not accurately capturing the number of CTBIE's completed at [the facility] from the years of 2009 – 2013. This tracker was changed in 2013 and now captures data more accurately." Facility leaders prepared responses to the questions asked by the media outlet prior to publication, including a clarification on the data concerns; however, the response reached the media outlet after the publication of the article, due to an extended review by VA's Office of Public and Intergovernmental Affairs and the National PM&R Services Office.

[40] The OIG team did not verify the accuracy of results of the two facility reviews, but rather conducted an independent review of TBI evaluation and treatment.

The OIG found several areas where the facility's polytrauma team and administrative staff exceeded VHA standards and whose efforts demonstrated a commitment to patient evaluation and care needs. These efforts were evidenced by rigorous scheduling attempts, evaluation and coordination of care for patients who had previously completed a CTBIE, the referral to and initiation of clinical services, and polytrauma leadership engagement demonstrated by the Chief of PM&R who conducted 84 percent of all CTBIEs completed during this review.

In September and October 2020, a media outlet contacted a facility PM&R provider regarding the care provided to facility TBI patients. In response to the October inquiry, facility leaders initiated an issue brief on October 20, 2020, and provided VISN and VHA leaders with specific information about the facility's TBI screening and assessment processes. The OIG found facility leaders met VHA requirements by initiating the issue brief, which also captured pertinent updates. Also, in October 2020, facility leaders oversaw two EHR reviews of the assessment and evaluation of facility TBI patients. The facility reviews found that all eligible patients received screening and a referral for CTBIE.

The OIG made no recommendations.

Appendix A: Timeline of Oversight Reviews

Table A.1. OIG's Timeline of Oversight Reviews Conducted Regarding Screening, Evaluation, and Treatment of TBI Patients at the Facility

Date	Action
2/26/18	The OIG received a complaint, alleging facility staff were not properly screening and evaluating OEF/OIF/OND patients for TBI. The OIG requested additional information from the complainant but did not receive a response.
3/6/18	The OIG received an anonymous complaint alleging facility staff did not properly screen, evaluate, or treat OEF/OIF/OND patients for TBI.
4/12/18	The OIG sent an inquiry to VISN 16 requesting a review of and response to the complaints.
5/25/18	VISN 16 sent two subject matter experts and the VISN 16 Special Populations Manager to perform a site visit at the facility on May 16, 2018. The visit led to a VISN-developed action plan that resulted in five facility recommendations to improve TBI processes and outcomes. VISN 16 sent the action plan to the OIG.
6/7/18	The OIG asked VISN 16 for an update to the action plan.
6/26/18	The U.S. Office of Special Counsel sent a referral to the OIG stating whistleblowers alleged that OEF/OIF/OND patients did not receive mandated TBI screening, evaluation, or appropriate follow-up care (as the OIG was already examining this matter, the OIG closed the referral from the U.S. Office of Special Counsel).
7/23/18	The OIG received an action plan update from VISN 16. The OIG determined the response adequate and closed the complaints.
8/6/18–8/9/18	The Executive in Charge, Office of the Under Secretary for Health tasked VHA's OMI to review the facility whistleblowers' allegations.
3/21/19	VHA's OMI review did not substantiate that OEF/OIF/OND patients did not receive TBI screening. However, VHA's OMI made nine recommendations to improve TBI processes and outcomes.
11/27/19	VISN 16 provided an action plan update, comprised of the recommendations, to VHA's OMI.
2/7/20	VHA's OMI determined that "all action items are complete and closed."

Source: OIG analysis of previous OIG complaints, inquiries, and tasked responses, as well as the March 21, 2019, OMI Report of the Southeast Louisiana Veterans Health Care Systems, New Orleans, Louisiana.

Appendix B: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: June 8, 2021

From: Director, South Central VA Health Care Network (10N16)

Subj: Healthcare Inspection—Traumatic Brain Injury Services and Leaders' Oversight at the Southeast Louisiana Veterans Health Care System in New Orleans

To: Director, Office of Healthcare Inspections (54HL07)
Director, GAO/OIG Accountability Liaison Office (VHA 10BGOAL Action)

1. The South Central VA Health Care Network Leaders have reviewed the draft report in its entirety and concurs with the report as written.

The OIG removed point of contact information prior to publication.

(*Original signed by*:)

Skye McDougall, PhD
VISN 16 Network Director

Appendix C: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: June 7, 2021

From: Director, Southeast Louisiana Veterans Health Care System (629)

Subj: Healthcare Inspection—Traumatic Brain Injury Services and Leaders' Oversight at the Southeast Louisiana Veterans Health Care System in New Orleans

To: Director, South Central VA Health Care Network (10N16)

1. I concur with the information contained in this report and have no concerns.

The OIG removed point of contact information prior to publication.

(*Original signed by*:)

Fernando O. Rivera, FACHE
SLVHCS Medical Center Director

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