



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

Office of Healthcare Inspections

Report No. 14-04655-369

Healthcare Inspection

Psychiatry Partial Hospitalization Program and Management Concerns Minneapolis VA Health Care System Minneapolis, Minnesota

August 11, 2016

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection in response to allegations received in August 2014, by Congressman Timothy J. Walz concerning the Psychiatry Partial Hospitalization (PPH) program and management concerns at the Minneapolis VA Health Care System, Minneapolis, MN. It was alleged that:

- Patients in the PPH program who were diagnosed in the community, military, or through the compensation and pension process with mental health, substance use, or post-traumatic stress disorder diagnoses were given activities such as additional psychological testing to prove their admitting diagnoses were wrong.
- Psychologists were performing inappropriate psychological testing on patients in the PPH program to meet productivity numbers.
- Supervisory staff were absent in their leadership roles, for example, not responding to staff emails, and they were not trained in the areas they supervise.

We also received, but did not address, multiple allegations that were human resource related or administrative in nature, and that did not raise quality of care issues.

We did not substantiate the allegation that patients in the PPH program who were diagnosed in the community, military, or through the compensation and pension process with mental health, substance use, or post-traumatic stress disorder diagnoses were given activities such as additional psychological testing to prove their admitting diagnoses were wrong. Since the complainant was anonymous, we were unable to clarify the allegation or identify specific patients or services that may have been the subject(s) of the complaint. Thus, we focused our review on the PPH program. We reviewed a random sample of 149 electronic health records of patients with mental health, substance use, or post-traumatic stress disorder diagnoses who were admitted in the PPH program for the period January 1, 2014, through July 8, 2015. We did not find evidence in the electronic health records that the patients' diagnoses had changed from their admission to and discharge from the PPH program or that any additional psychological testing proved that their admitting diagnoses were wrong.

We could not substantiate the allegation that psychologists were performing inappropriate psychological testing on patients in the PPH program to meet productivity numbers. We found an increase in the administration of psychological testing from quarter 2 of fiscal year (FY) 2014 to quarter 3 of FY 2014; however, full implementation of psychological testing did not begin until quarter 4 of FY 2014.

We could not substantiate the allegation that supervisory staff were absent in their leadership roles and were not trained in the areas they supervised. According to the Director of Human Resources, supervisory training is provided four times a year and

focuses on topics such as timekeeping, leave, and disciplinary actions. We also found program specific documentation of training provided to the staff in the PPH program, and while we found one complaint in the Employee Assessment Review specific to leadership not being trained in health, we did not identify specific complaints or concerns regarding supervisor training.

We made no recommendations.

COMMENTS

The Veterans Integrated Service Network and Acting System Directors reviewed the report and the Acting System Director concurred with the conclusions. (See Appendixes A and B, pages 7–8 for the Directors' comments.)



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

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection in response to allegations received in August 2014, by Congressman Timothy J. Walz concerning the Psychiatry Partial Hospitalization (PPH) program and management concerns at the Minneapolis VA Health Care System (system), Minneapolis, MN. The purpose of this inspection was to determine if the allegations had merit.

Background

The system is a tertiary care facility that provides primary, specialty, mental and behavioral health, extended care, and rehabilitative services. It also serves as the Spinal Cord Injury and Disorders referral center for Veterans integrated Service Network (VISN) 23. Primary and mental health (MH) care is also provided at community based outpatient clinics in Hayward/Rice Lake, Hibbing, South Central, Mankato, Chippewa Falls, Maplewood, Rochester, and Ramsey, MN.

PPH Program Overview

The mission of the PPH program is to provide psychiatric and/or substance use treatment for patients in the least restrictive environment. Special emphasis on treatment of post-traumatic stress disorder (PTSD) and substance use is provided.

The system's PPH program is an outpatient intensive, time-limited, group, recovery-oriented intervention that meets Monday through Friday for 4–6 hours per day and typically lasts for 3 weeks.

Several psychological tests are routinely provided to patients in the PPH program and are used for assessment, treatment, and discharge planning. The results of the tests are analyzed to determine whether PPH intervention was helpful in increasing functionality, reducing symptoms, and reducing inpatient hospitalizations.

In 2008, the Veterans Health Administration (VHA) required facilities that had day treatment centers, day hospitals, partial hospitals, or analogous programs to transform their existing programs into Psychosocial Rehabilitation and Recovery Centers.¹ However, the PPH program at the system operates under a waiver approved by VHA which does not impact on any patient testing requirements.

The program is staffed with a psychiatrist, psychologists, registered nurses, licensed practical nurses, social workers, and clerical staff such as medical support assistants or program support assistants.

¹VHA Handbook 1160.01, *Uniformed Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008. This VHA Handbook was scheduled for recertification by September 2013; it was amended on November 16, 2015 although the recertification date was not changed.

Allegations

In August 2014, the OIG received a congressional request to review allegations from an anonymous complainant concerning the PPH program and management concerns at the system. It was alleged that:

- Patients in the PPH program who were diagnosed in the community, military, or through the compensation and pension process with MH, substance use, or PTSD diagnoses were given activities such as additional psychological testing to prove their admitting diagnoses were wrong.
- Psychologists were performing inappropriate psychological testing on patients in the PPH program to meet productivity numbers.
- Supervisory staff were absent in their leadership roles, for example, not responding to staff emails, and they were not trained in the areas they supervise.

We also received, but did not address, multiple allegations that were human resource related or administrative in nature, and that did not raise quality of care issues.

Scope and Methodology

We conducted a site visit September 22–25, 2014. Since the complainant was anonymous, we were unable to clarify the allegations or identify specific patients or services that may have been the subject(s) of the complaint. Since the complainant's concerns related to the PPH, we focused our review on this program. We interviewed the System Director, Chief of Staff, Director of Human Resources, Chief of MH, PPH Program Manager, Chief of Psychology, and other staff with information relevant to the allegations.

We reviewed the system's most recent All Employee Survey, Employee Assessment Review from the September 2014 Combined Assessment Program Review, supervisory training agenda and course content, PPH quality improvement activities, productivity for psychological testing, and other relevant documents. We identified a total of 437 patients who were enrolled in the PPH program for the period January 1, 2014, through July 8, 2015. We randomly selected and reviewed the electronic health records (EHRs) of 149 patients to determine if their diagnoses were changed between admission and discharge.

In the absence of current VA/VHA policy, we considered previous guidance to be in effect until superseded by an updated or re-certified Directive, Handbook, or other policy document on the same or similar issue(s).

We **substantiate** allegations when the facts and findings support that the alleged events or actions took place. We **do not substantiate** allegations when the facts show

the allegations are unfounded. We **cannot substantiate** allegations when there is no conclusive evidence to either sustain or refute the allegation.

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

Inspection Results

Issue 1: PPH Program

Diagnoses Evaluation

We did not substantiate the allegation that patients in the PPH program who were diagnosed in the community, military, or through the compensation and pension process with MH, substance use, or PTSD diagnoses were given activities such as additional psychological testing to prove their admitting diagnoses were wrong.

Based on our interviews of the Chief of MH, Chief of Psychology, and the PPH Program Manager, we learned that patients sometimes have multiple MH, substance use, or PTSD diagnoses given by military and/or community providers during compensation and pension evaluations. System psychologists review the results of these diagnoses and may order additional psychological testing if warranted.

We reviewed a random sample of 149 EHRs of patients with MH, substance use, or PTSD diagnoses who were admitted in the PPH program for the period January 1, 2014, through July 8, 2015. We did not find evidence in the EHRs that the patients' diagnoses had changed from their admission to and discharge from the PPH program or that any additional psychological testing proved that their admitting diagnoses were wrong.

Psychological Testing

We could not substantiate the allegation that psychologists were performing inappropriate psychological testing to meet productivity numbers in the PPH program.

The Chief of MH and the PPH Program Manager indicated that they were unaware of any inappropriate use of psychological testing by psychologists in the PPH program in order to meet productivity numbers. Several psychological tests and measures are routinely provided to patients in the PPH program and are used for assessment, treatment, and discharge planning. The results of these tests and measures are then analyzed to determine whether PPH intervention was helpful in increasing functionality and reducing symptoms and inpatient hospitalizations.

We reviewed the productivity data of psychological testing for the providers assigned to the PPH for quarters 1 through 4 of fiscal year (FY) 2014 and quarters 1 through 3 of FY 2015. We found an increase in the administration of psychological testing from quarter 2 of FY 2014 to quarter 3 of FY 2014; however, the system did not require the PPH program to begin full implementation of psychological testing until quarter 4 of FY 2014. We also found that the productivity data of psychological testing remained relatively consistent for quarters 1 through 3 of FY 2015.

A patient admitted into the PPH program may decline to participate in any testing or measures without their decision impacting continued treatment or preventing them from

remaining in the program. We found that, of the 149 EHRs we reviewed, 40 patients declined psychological testing and still remained in the PPH program.

Issue 2: Management Concerns

Supervisory Leadership and Supervisory Training

We could not substantiate the allegation that supervisory staff were absent in their leadership roles, for example, by not responding to emails, and they were not trained in the areas they supervised.

The complainant did not identify a specific individual or department at the system. However, we continued to focus on the PPH program. We interviewed the System Director, Chief of Staff, and Director of Human Resources who indicated that they were unaware of any complaints regarding supervisors or supervisors not receiving adequate training.

We interviewed the Director of Human Resources who indicated that supervisory training is provided four times a year and focuses on topics such as timekeeping, leave, and disciplinary actions.

We found program specific documentation of training provided to the supervisors and staff in the PPH program. We reviewed the system's most recent All Employee Survey and the Employee Assessment Review that was conducted during the OIG's Combined Assessment Program September 2014 review. We found one complaint in the Employee Assessment Review specific to leadership not being trained in health administration but did not find complaints related to supervisors not being trained in the areas they were supervising or a lack of supervisory leadership. According to the All Employee Survey, employees rated supervisory behaviors as satisfactory, the same rating given for supervisory behaviors in VHA facilities overall.

Conclusions

We did not substantiate the allegation that patients in the PPH program who were diagnosed in the community, military, or through the compensation and pension process with MH, substance use, or PTSD diagnoses were given activities such as additional psychological testing to prove their admitting diagnoses were wrong. Our review of 149 EHRs of patients with MH, substance use, or PTSD diagnoses who were admitted in the PPH program for the period January 1, 2014, through July 8, 2015, found no evidence that patients' diagnoses had changed from their admission to and discharge from the PPH program or that additional psychological testing proved their admitting diagnoses to be wrong.

We could not substantiate the allegation that psychologists were performing inappropriate psychological testing to meet productivity numbers in the PPH program. The Chief of MH and the PPH Program Manager were unaware of any inappropriate use of psychological testing by psychologists in order to meet productivity numbers.

Our review of productivity data on psychological testing for the providers in the PPH found an increase in productivity of psychological testing from quarter 2 of FY 2014 to quarter 3 of FY 2014; however, the system did not require the PPH program to begin full implementation of testing until quarter 4 of FY 2014.

We could not substantiate the allegation that supervisors were absent in their leadership roles and they were not trained in the areas they supervised. According to the Director of Human Resources, supervisory training is provided four times a year and focuses on topics such as timekeeping, leave, and disciplinary actions. We also found program specific documentation of training provided to the staff in the PPH program, and while we found one complaint in the Employee Assessment Review specific to leadership not being trained in health, we did not identify specific complaints or concerns regarding supervisor training.

We made no recommendations.

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: March 22, 2016

From: Acting Director, VA Midwest Health Care System (10N23)

Subj: Healthcare Inspection—Psychiatry Partial Hospitalization Program and Management Issues, Minneapolis VA Health Care System, Minneapolis, Minnesota

To: Director, Denver Regional Office of Healthcare Inspections (54DV)
Director, Management Review Service (VHA 10E1D MRS Action)

1. Thank you for the opportunity to review the report from the OIG Healthcare Inspection Team.
2. Please feel free to contact the Minneapolis VA Health Care System should you have additional questions at 612-725-2101.


PATRICK J. KELLY, FACHE

System Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: March 22, 2016

From: Acting Director, Minneapolis VA Health Care System (618/00)

Subj: Healthcare Inspection—Psychiatry Partial Hospitalization Program and Management Issues, Minneapolis VA Health Care System, Minneapolis, Minnesota

To: Director, VA Midwest Health Care Network (10N23)

1. I have reviewed the draft report of the Inspector General Healthcare Inspection of the Psychiatry Partial Hospitalization Program and concur with the conclusions of the report. I appreciate the opportunity to respond.



DAVID. B. MILLER, FACHE

OIG Contact and Staff Acknowledgments

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