Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-01116-390

Healthcare Inspection

Alleged Mental Health Access and Treatment Deficiencies Brunswick Community Based Outpatient Clinic Brunswick, Georgia

June 30, 2015

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations:
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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted a review at the request of former Representative Jack Kingston to assess allegations regarding mental health access and treatment deficiencies at the Brunswick community based outpatient clinic (CBOC), Brunswick, Georgia.

We substantiated that a patient was unable to contact or schedule an appointment with his psychiatrist over several weeks in August 2014 when the provider was on leave. It did not appear that the provider notified the My Health***e***Vet coordinator or assigned a surrogate to review secure messages in her absence. In general, however, CBOC staff responded to the secure messages the patient sent. While we cannot say that the patient always made contact when he called, it appears that the CBOC's system for receiving, transferring, returning, and documenting phone calls was reasonably effective.

We found that the process of scheduling follow-up appointments did not comply with Veterans Health Administration outpatient scheduling guidelines. The CBOC did not have a consistently effective process in place to monitor and reschedule patients who either failed to schedule their next appointment or did not come and did not cancel (no-showed) an appointment. This CBOC was also not utilizing the Recall/Reminder Software application.

We did not substantiate that the patient did not have a treatment plan for his post-traumatic stress disorder, although we did find long periods when the patient did not see his psychiatrist or social worker therapist.

While we confirmed that the patient was not prescribed an anti-anxiety medication by a VA provider for more than a year, we did not substantiate that CBOC providers withheld this medication as the complainant implied. When the patient's anti-anxiety medication expired in winter 2013, we found no evidence that he requested a new prescription from his primary care provider, nor did he contact his psychiatrist to request the medication until early spring 2014.

We substantiated that the CBOC did not offer group therapy and treatment for patients with post-traumatic stress disorder at the time of the complaint, and we substantiated that the patient was not receiving or participating in psychotherapy at the time of the complaint.

We made five recommendations.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with our recommendations and provided acceptable action plans. (See Appendixes A and B, pages 11-15, for the Directors' comments.) We will follow up on the planned actions until they are complete.

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

Purpose

At the request of former Representative Jack Kingston, the VA Office of Inspector General (OIG) Office of Healthcare Inspections reviewed allegations regarding mental health access and treatment deficiencies at the Brunswick community based outpatient clinic (CBOC), Brunswick, GA. The purpose of the review was to determine whether the allegations had merit.

Background

The CBOC is associated with the Carl Vinson VA Medical Center (facility), Dublin, GA, and is part of Veterans Integrated Service Network (VISN) 7. The CBOC is located 170 miles from the facility and provides primary care, mental health, optometry, social work, podiatry, and prosthetic services.

Post-Traumatic Stress Disorder

Post-Traumatic Stress Disorder (PTSD) is a clinically significant condition with symptoms continuing more than 1 month after exposure to a trauma that has caused significant distress or impairment in social, occupational, or other important areas of functioning.[1] Patients with PTSD often experience symptoms of anxiety, agitation, depression, poor attention, and nightmares.

Medication is a treatment option for PTSD and is often prescribed in conjunction with psychotherapy. Studies have shown that antidepressants are effective in treating patients with PTSD and are recommended as first line agents in treatment guidelines.[2] Although benzodiazepines (BZDs – mild sedatives) are widely used for symptomatic control of co-morbid conditions including insomnia, panic/anxiety, and irritability, there is no evidence that they are effective in treating the core PTSD symptoms.[3] Because of the potential for addiction and disinhibition, the routine use of BZDs in managing PTSD is not recommended.[4]

In 2012, the facility began a process to educate patients about the effects of long-term BZD use and to safely discontinue BZDs in a structured manner. Patients who had recently been prescribed a BZD and who had diagnoses of PTSD and/or other chronic anxiety disorders were sent a letter that stated, in part:

> *"…recent medical evidence indicates that the long term use of BZDs for the treatment of chronic anxiety disorders is not safe and is considered harmful. In*

[1] VA/DOD *Clinical Practice Guideline for the Management of Post-Traumatic Stress*, October 2010.
[2] Ibid.
[3] The core PTSD symptoms are intrusion, avoidance, negative alterations in cognition and mood, and arousal and reactivity.
[4] National Center for Post-Traumatic Stress Disorder, http://www.ptsd.va.gov/professional/newsletters/research-quarterly/v23n4.pdf, retrieved March 10, 2015.

light of this recent evidence, [facility] practitioners will begin the process of slowly discontinuing your prescription for BZDs for PTSD and other anxiety disorders They will work with you to determine a more safe and appropriate plan."

The medications central to this case include:

- Antidepressants (bupropion, aripiprazole[5])
- BZDs (alprazolam, clonazepam)

Mental Health Treatment Planning

Mental health care includes the evaluation, diagnosis, treatment, rehabilitation, and prevention of mental health and substance use disorders. According to Veterans Health Administration (VHA) Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, all patients receiving mental health services must have a mental health treatment plan. The 2010 VA/Department of Defense (DoD) *Clinical Practice Guideline for the Management of Post-Traumatic Stress* (Guideline) outlines a variety of treatment options for patients with PTSD.

Psychotherapy is the treatment of mental health problems by talking with a psychiatrist, psychologist, or other mental health provider. With the help of a therapist, patients learn how the past affects the way they feel now, identify what triggers stressful memories and other symptoms, and find ways to cope with intense feelings about the past. The goal of individual psychotherapy is to reduce the severity of symptoms and improve quality of life and functioning.

When patients demonstrate remission from symptoms, and there are no indications for further therapy, the Guideline recommends that the therapist consider discontinuation of psychotherapeutic treatment. Because the discontinuation process may provoke anxiety in patients, a gradual step-down approach to termination is useful. These steps may involve decreasing the frequency of appointments or transitioning patients to group therapy or peer support programs.

The Social Work Code of Ethics recommends terminating services to clients when the services are no longer required or no longer serve the clients' needs or interests. Reasonable steps should be taken to avoid "abandoning" clients who are still in need of services, and social workers should give careful consideration to all factors in the situation, take care to minimize possible effects, and assist in making arrangements for continuation of services when necessary.[6]

[5] Aripiprazole, also known as Abilify,® is an atypical antipsychotic primarily used to treat schizophrenia, bipolar disorder, and major depressive disorder. It is also prescribed to control emotional and behavioral issues including anger and irritability.
[6] Code of Ethics www.socialworkers.org, retrieved January 12, 2015.

Allegations

On November 17, 2014, former Representative Jack Kingston requested the OIG to review allegations that a patient at the Brunswick, GA, CBOC had difficulty accessing mental health care and was not receiving treatment for his PTSD. Upon interview, the patient clarified his concerns, as follows:

1) On several occasions, he attempted to reach his psychiatrist via telephone and electronic secure messaging without success, and he had difficulty getting an appointment.

2) Clinic staff do not have a treatment plan to address his PTSD. Specifically:
   a. They do not give him anything for his anxiety.
   b. They do not have a group treatment program.
   c. He is not getting any therapy.

Scope and Methodology

The period of our review was November 17, 2014, to April 7, 2015. In December 2014, January 2015, and February 2015, we conducted phone interviews with the patient; the patient's psychiatrist, primary care provider, social worker (who provided the psychotherapy), and case manager; the CBOC scheduler; and the My Health***e***Vet coordinator. We reviewed the patient's electronic health record (EHR) for the period June 2011 to January 5, 2015. We also reviewed Veterans Heath Administration (VHA) and facility policies related to outpatient scheduling processes and procedures, mental health treatment planning, and primary care mental health integration; literature regarding the long-term use of BZDs; and the National Association of Social Workers' Code of Ethics.

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

Case Summary

The patient is a male in his late 60s with a history including hypertension, depression, anxiety, and PTSD. The patient transferred mental health and primary care (PC) services from another VA CBOC to the facility in winter 2012. He had been prescribed alprazolam 0.5 mg twice daily for anxiety and bupropion for depression by his previous provider. The EHR reflects that the patient had been prescribed alprazolam by various VHA providers for more than 10 years.

At his initial PC appointment in winter 2012, the PC provider noted the patient's history of chronic depression and PTSD and consulted the Mental Health Service. The PC provider continued the patient on alprazolam and bupropion.

In spring 2012, the clinical social worker saw the patient for an initial assessment and developed a treatment plan that included monthly individual psychotherapy focusing on coping skills and stress management, with medication management to be provided by the PC provider. The patient participated in his first psychotherapy session with the social worker in early summer.

In mid-summer 2012, the clinic psychiatrist saw the patient for an initial assessment and prescribed aripiprazole to address his symptoms of anger and irritability. He remained on bupropion and alprazolam as previously ordered by the PC provider. The patient's treatment plan with the psychiatrist included the continuation of aripiprazole, counseling, and application of the stress management techniques he was learning in psychotherapy. The psychiatrist saw the patient several more times in 2012; however, no follow-up appointment was scheduled after an early winter clinic visit.

During the next 2.5 years, the patient was consistently prescribed bupropion for depression and was also prescribed aripiprazole at different times. His prescription for alprazolam expired in winter 2013; however, the patient reported having "extra" tablets because he did not always take the medication as prescribed. He saw the social worker, psychiatrist, and PC provider as displayed in Table 1. "NS" (no show) signifies that the patient did not come and did not cancel the appointment.

Table 1. Social Work/Psychotherapy, Psychiatrist, and PC Visits FY 2012 (Q2)–FY2015 (Q1)

Fiscal Year	Quarter	# of Social Work Visits	# of Psychiatry Visits	# of PC Visits
FY 2012	Q2			2
	Q3	2		1
	Q4	1	3	1
FY 2013	Q1	1	1	0
	Q2	1	0	1
	Q3	2	0	1
	Q4	1	0	0
FY 2014	Q1	1 (and 1 NS)	0	2
	Q2	0 (and 1 NS)	1	0
	Q3	0	1	1
	Q4	0	1	0
FY 2015	Q1	0	1	1

Source: OIG

In fall 2013, the social worker began discussing termination of psychotherapy, as the patient had achieved many of his treatment goals. The patient voiced concern about this and then failed to show for his next scheduled appointment. No follow-up to reschedule the patient occurred.

In early spring 2014, the patient sent a message through My Health***e***Vet secure messaging[7] stating that he was experiencing an increase in the severity of his panic attacks. At this point, the patient's alprazolam prescription had been expired for more than 1 year. Two days later, the patient saw the psychiatrist. The psychiatrist prescribed a lower dose of bupropion and prescribed alprazolam 0.5 mg once a day for 5 days (five tablets were dispensed). The patient was advised to return to clinic (RTC) in 3 months.

In spring, the psychiatrist noted improvement in the patient's mood, continued the bupropion, and advised the patient to RTC in 5 months. An appointment was scheduled for early fall. He was not prescribed another BZD.

In mid-summer, the patient sent another message through My Health***e***Vet requesting to speak with the psychiatrist about his medications. Six days later, the psychiatrist replied that she had been on vacation. The psychiatrist instructed the patient to either call or come in to the clinic after 4:00 p.m. that day; it does not appear that he did so.

It appears that the patient tried to be seen as a "walk-in" in late July, but the psychiatrist was unable to accommodate him quickly and he was not seen.[8] Approximately 2 weeks later, the patient sent several secure messages requesting to talk to his psychiatrist.

[7] My Health***e***Vet secure messaging is a method by which patients electronically communicate with their providers using a secure message feature, which is similar to e-mail and accessed through VA's website.
[8] This psychiatrist sees "walk-ins" between scheduled patient appointments.

The psychiatrist was on leave, and the My Health***e***Vet coordinator responded to those messages.

At the patient's next scheduled appointment in early fall 2014 with the psychiatrist, he expressed that alprazolam helped with his anxiety. The psychiatrist explained that, per facility policy and due to the addiction potential of BZDs, she could no longer prescribe the alprazolam. The psychiatrist continued the patient on bupropion, agreed to prescribe a 1-month supply of clonazepam (a long-acting BZD thought to have fewer addictive properties) for anxiety, and advised the patient to RTC in 2 months. At his next appointment, the patient expressed that the prescribed clonazepam was not effective in managing his anxiety and that lorazepam worked better. The psychiatrist prescribed a mood stabilizer and continued the patient on bupropion and clonazepam. In early 2015, psychotherapy was reestablished with a different social worker.[9]

Inspection Results

Issue 1: Access to Mental Health

We substantiated that a patient was unable to contact or schedule an appointment with his psychiatrist over several weeks in August 2014 when the provider was on leave. In general, however, CBOC staff or the My Health***e***Vet coordinator responded to the secure messages the patient sent.

The EHR contained three mental health secure messaging entries. The psychiatrist saw the patient within 2 days of the first entry in early spring 2014. The patient sent a second secure message in summer 2014, and when he did not get a prompt response, he sent a third message 6 days later. The psychiatrist responded to the last secure message and told the patient that she had been on vacation. The psychiatrist instructed the patient to come into the CBOC or call after 4:00 p.m.; it does not appear that he did so.

Although not included in the EHR, we found evidence that the patient sent several secure messages to his psychiatrist in late summer to which she did not respond. According to VHA guidelines, secure messages should be responded to within 72 hours. The provider did not respond to a message sent on a Friday and was then on leave for essentially the next 2 weeks. It does not appear that the psychiatrist informed the My Health***e***Vet coordinator that she would be on leave or otherwise arranged for a surrogate to review and respond to her secure messages. The My Health***e***Vet coordinator responded to the messages and, apparently unaware of the psychiatrist's leave, promised the patient that someone from the clinic would call him that day. However, several days passed before he was contacted. The My Health***e***Vet coordinator also suggested that the patient could be seen by another mental health provider in Dublin; however, the patient declined this option due to travel distance.

[9] The previous social worker no longer works at the clinic.

During this time, the patient was in contact with other providers and still had a scheduled appointment with his psychiatrist in early fall.

We also found numerous EHR entries reflecting that when the patient called the CBOC, he often either spoke with someone directly or received a return call. While we cannot say that the patient always made contact when he called, it appears that the CBOC's system for receiving, transferring, returning, and documenting phone calls was reasonably effective.

We did find, however, that the process of scheduling follow-up appointments did not comply with VHA outpatient scheduling guidelines. VHA requires that clinic schedulers arrange the follow-up appointment before the patient leaves or record in the Recall/Reminder Software if the RTC timeframe is beyond the 3–4 month scheduling window.[10]

The CBOC's practice is for the provider and the patient to agree on a RTC timeframe, which the patient is to communicate to the scheduler at the clinic's front desk. The follow-up appointment is scheduled at that time. Several of the clinic staff informed us that, at times, the clinic is busy and the staff may not notice patients passing the front desk without scheduling their follow-up appointment.[11] We noted the following:

- The CBOC did not have a consistently effective process in place to monitor and reschedule patients who either failed to schedule their next appointment or no-showed for an appointment.
- The CBOC was not utilizing the Recall/Reminder Software application.

This patient did not have an appointment with his psychiatrist for more than a year (early 2013 to winter 2014) and did not have an appointment with his social worker therapist for more than a year (late 2013 to early 2015). We acknowledge that the patient bears some responsibility for rescheduling missed appointments, and the EHR reflects that he knew how to contact the clinic and advocate for his own treatment needs.

Issue 2: Treatment Plan

We did not substantiate the allegation that the patient did not have a treatment plan for his PTSD, although we did find long periods when the patient did not see his psychiatrist or social worker therapist.

During the patient's mental health consult appointment in spring 2012, a treatment plan was developed that consisted of medication management and psychotherapy, which

[10] VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures*, June 9, 2010.
[11] One of the clinic providers estimated that 10 percent of mental health patients leave the clinic without scheduling the next appointment.

complied with the Guideline for treating PTSD. However, as shown in Table 1, the patient did not have an appointment with his psychiatrist from early 2013 to early 2014 or with his social worker therapist from late 2013 to early 2015.

Anti-Anxiety Medication

We did not substantiate that CBOC providers [intentionally] did "…not give him anything for his anxiety." While we confirmed that the patient was not prescribed an anti-anxiety medication by a VA provider for more than a year, we did not substantiate that CBOC providers withheld this medication as the complainant implied.

The patient had been prescribed bupropion, alprazolam, aripiprazole, and clonazepam over the past 3 years. When the patient's alprazolam prescription expired in winter 2013, he still had active prescriptions for bupropion and aripiprazole. While the patient did not have an active VA-prescribed BZD from spring 2013 through early fall 2014, we found no evidence that he requested another alprazolam prescription from his new PC provider (whom he started seeing in early 2013), nor did he contact his psychiatrist to request said prescription until spring 2014.

When the patient contacted his psychiatrist in spring 2014 complaining of increasing panic attacks, the psychiatrist prescribed five alprazolam tablets but did not discuss resuming psychotherapy. Psychotherapy is useful in helping patients replace anxiolytic medications with healthy coping skills.

In fall 2014, the psychiatrist prescribed a different low-dose long-acting BZD, which the patient currently takes as needed. The patient requested that the psychiatrist prescribe a different BZD; however, the psychiatrist felt that the current prescription was most appropriate and declined the request.

Group Treatment

We substantiated that the CBOC did not offer group therapy for patients with PTSD at the time of the complaint.

During the fall 2012 visit, the patient expressed an interest in attending a Vietnam Veterans group, and the EHR reflects "…did speak to counselor who will notify patient of possibility." While the social worker confirmed that she facilitated a Vietnam Veterans group, we found no documentation that the patient was referred or otherwise participated in this or any other group at the CBOC.

Psychotherapy

We substantiated that at the time of the complaint, the patient was not receiving or participating in psychotherapy.

The patient received individual psychotherapy as outlined in the treatment plan for about 18 months and had made progress towards his goals. When the social worker

therapist discussed terminating therapy, the patient became upset and did not attend his next psychotherapy appointment the following month. At this point, the social worker did not follow appropriate protocols and professional practice standards to assure the safety and ongoing care of the patient.

The patient verbalized his anxiety and desire to continue therapy. While continuing therapy in its current form may not have been appropriate (because the patient had achieved many of his goals), the social worker was obligated to discuss a modified psychotherapy schedule or alternate treatment options and to make arrangements for continued services, as appropriate. Because the patient did not attend the next scheduled psychotherapy appointment, the social worker or CBOC case manager should have contacted him to reschedule such that the social worker could continue the termination process, minimize the effects of the termination, and assure appropriate ongoing supportive services.[12] The social worker subsequently left employment at the CBOC and transferred to the Dublin facility. Upon interview, the social worker acknowledged that she should have followed up with the patient after he missed his scheduled appointment and that termination of psychotherapeutic treatment was not properly completed.

The patient did not receive psychotherapy or an alternative service from late 2013 to early 2015. Psychotherapy services have been reinitiated with a new social worker.

Conclusions

We substantiated that a patient was unable to contact or schedule an appointment with his psychiatrist over several weeks in late summer 2014 when the provider was on leave. It did not appear that the provider notified the My Health***e***Vet coordinator or assigned a surrogate to review messages in her absence. In general, however, CBOC staff or the My Health***e***Vet coordinator responded to the secure messages the patient sent. While we cannot say that the patient always made contact when he called, it appears that the CBOC's system for receiving, transferring, returning, and documenting phone calls was reasonably effective.

We found that the process of scheduling follow-up appointments did not comply with VHA outpatient scheduling guidelines. The CBOC did not have a consistently effective process in place to monitor and reschedule patients who either failed to schedule their next appointment or no-showed for an appointment. The CBOC was also not utilizing the Recall/Reminder Software application.

[12] Medical Center Memorandum 116-498, *Guidance and Process for Patients Who Fail to Attend Appointments* "No Shows," September 5, 2013.

We did not substantiate that the patient did not have a treatment plan for his PTSD, although we did find long periods when the patient did not see his psychiatrist or social worker therapist.

We did not substantiate that clinic providers did "…not give him anything for his anxiety." While the patient did not have an active VA-prescribed BZD from early spring 2013 through early fall 2014, we found no evidence that he requested another alprazolam prescription from his PC provider nor did he contact his psychiatrist to request said prescription until early spring 2014. He is currently prescribed a low-dose BZD.

We substantiated that the Brunswick mental health clinic did not offer group therapy and treatment for patients with PTSD at the time of the complaint. We also substantiated that the patient was not receiving or participating in psychotherapy at the time of the complaint. The patient received psychotherapy as outlined in the treatment plan for about 18 months and had made progress towards his goals. When the social worker discussed terminating therapy, the patient became upset and did not attend his next psychotherapy appointment the following month. At this point, the social worker did not follow appropriate protocols and professional practice standards to assure the safety and ongoing care of the patient. Subsequently, the social worker left employment at the clinic and transferred to the Dublin facility. The patient did not receive psychotherapy or an alternative service from late 2013 to early 2015.

Recommendations

1. We recommended that the Facility Director ensure that clinical staff assign surrogates to manage secure messages as required by Veterans Integrated Service Network 7 policy.

2. We recommended that the Facility Director ensure that staff comply with Veterans Health Administration policy for scheduling outpatient follow-up appointments, that staff utilize the Recall/Reminder Software application when appropriate, and that compliance be monitored.

3. We recommended that the Facility Director ensure that community based outpatient clinic staff initiate appropriate follow-up action when a patient is a "no show" or fails to schedule a follow-up appointment.

4. We recommended that the Facility Director ensure that services outlined in the treatment plan are provided and that compliance be monitored.

5. We recommended that the Facility Director ensure processes are in place to ensure continuity of the mental health treatment plan in the event of staff departure and/or reassignment and to discuss proposed changes to treatment plans with patients.

Appendix A

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: APR 30 2015

From: Director, Veterans Integrated Service Network (10N7)

Subj: Healthcare Inspection—Alleged Mental Health Access and Treatment Deficiencies, Community Based Outpatient Clinic, Brunswick, Georgia

To: Director, Atlanta Office of Healthcare Inspections (54AT)
Director, Management Review Service (VHA 10AR MRS OIG Hotline)

1. Thank you for the opportunity to review and provide comments to the above-subject report.

2. I concur with the recommendations present by the Office of Healthcare Inspections and I am in concurrence with the corrective actions as noted in the comments section of the report.

3. I appreciate the opportunity for this review as a continuing process to improve the care of our Veterans.

4. If you have any questions or require further information please contact Kelly Wilson, Acting Chief of Quality Management at 478-272-1210 ext. 2813.

Thomas C. Smith III, FACHE

Attachment

Appendix B

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: April 23, 2015

From: Acting Director, Carl Vinson VA Medical Center (557/00)

Subj: Healthcare Inspection—Alleged Mental Health Access and Treatment Deficiencies, Community Based Outpatient Clinic, Brunswick, Georgia

To: Director, Veterans Integrated Service Network (10N7)

1. Thank you for the opportunity to review and provide comments to this report.
2. I concur with the recommends presented by the Office of Healthcare Inspections and present you with corrective actions as noted in the comments section.
3. If you have any questions or need further information, please contact Kelly Wilson, Acting Chief of Quality Management at 478-272-1210 ext. 2813.

Maryalice Morro RN, MSN
Facility Director

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that the Facility Director ensure that clinical staff assign surrogates to manage secure messages as required by Veterans Integrated Service Network 7 policy.

Concur

Target date for completion: July 1, 2015

Facility response: In February 2015, the Mental Health Supervisory Psychiatrist was given the ability to assign surrogates for clinical staff. This will allow him the ability to make sure all clinical staff have surrogates assigned to them when they are on leave, reassigned, and/or resign. This will continue to be monitored and tracked on a daily basis by the Supervisory Psychiatrist to make sure that all clinical staff are assigned surrogates.

Recommendation 2. We recommended that the Facility Director ensure that staff comply with Veterans Health Administration policy for scheduling outpatient follow-up appointments, that staff utilize the Recall/Reminder Software application when appropriate, and that compliance be monitored.

Concur

Target date for completion: July 1, 2015

Facility response: Clinic staff including 3 RN Care Managers, 8 Licensed Practical Nurses, 3 Medical Support Assistants, and the Clinic Nurse Manager have received scheduling training (July 7,2014 Interim Scheduling Policy and Procedures), have the correct scheduling keys/menu options, and adhere to scheduling protocols. The Recall/Reminder Software application was implemented at CBOC Brunswick January 2015. The Vista Recall Package (CVVAMC: Dublin) automatically runs the reports and letters each night. The Recall reminder letters are to be mailed 30 days, 60 days and 90 days in advance of the entered recall desired appointment date. The clinic availability with date last recall reminder letter was mailed is monitored monthly. The Recall delinquency report is run daily by the clinic Medical Support Assistants.

The Clinic Nurse Manager and the Clinic Scheduling/CHOICE Champion will audit and monitor records weekly to ensure proper scheduling policies are adhered to and that any updates or revision to scheduling policies will be in-serviced with all CBOC Brunswick employees (to include utilization of the Return To Clinic (RTC) order by the Providers) for follow up appointments. All clinic Physicians, Specialty Clinicians, Mid-

level, and Mental Health Social Workers have been notified to utilize the Return To Clinic (RTC) order menu option for follow-up appointment and to ensure policy is followed by all staff in utilization of the Recall/Reminder.

Recommendation 3. We recommended that the Facility Director ensure that community based outpatient clinic staff initiate appropriate follow-up action when a patient is a "no show" or fails to schedule a follow-up appointment.

Concur

Target date for completion: July 1, 2015

Facility response: The Brunswick CBOC policy for "No-Show" has implemented the July 7, 2014 Interim Scheduling Policy and Procedures that replaces the rescinded VHA Directive 2010-027 Outpatient Scheduling Process and Procedures.

- A minimum of three documented attempts (on separate days) must be made to contact no-responding patients including those on the recall list and EWL

- After three attempts, the scheduler must consult with the provider for disposition. For example, the provider may discharge the patient; direct the staff to continue attempts to contact, or another action. Disposition steps must also be documented in the patient's record

A no-show letter is automatically generated by the Vista package after the "No-Show" is entered by the scheduler. The letter is mailed to the veteran.

A Mental Health high risk "no show" policy will be adhered to by CBOC Brunswick that is in accordance with the memo received August 6, 2013 from the Deputy Under Secretary for Health for Operations and Management. The memo outlines the standards and expectations that will be met when high risk mental health patients no show.

The No-Show report is run daily by the Program Support Assistant in Mental Health for all Mental Clinics (CBOC and Dublin VAMC) and is given to Licensed Practical Nurse (LPN) in Mental Health. The LPN reviews the Electronic Medical Record and audits whether or not it is documented that the veteran was contacted. If the LPN sees in the EMR that veteran was not contacted, the LPN contacts the veteran and reschedules their appointment. Compliance will be monitored by the Mental Health Business Manager to ensure appropriate follow up is provided for mental health patients who no show.

Recommendation 4. We recommended that the Facility Director ensure that services outlined in the treatment plan are provided and that compliance be monitored.

Concur

Target date for completion: July 1, 2015

Facility response: Mental Health Services offered are reviewed and monitored for compliance by the Mental Health Supervisor through the Ongoing Professional Practice

Evaluation/Focused Professional Practice Evaluation (OPPE/FPPE) Process which occurs bi-annually.

Recommendation 5. We recommended that the Facility Director ensure processes are in place to ensure continuity of the mental health treatment plan in the event of staff departure and/or reassignment and to discuss proposed changes to treatment plans with patients.

Concur

Target date for completion: August 30, 2015

Facility response: The Brunswick CBOC will increase staffing from 2 Mental Health staff to 5 Mental Health staff by August 30, 2015. This will account for an increase in staffing that will allow staff to provide patients continuity of the mental health treatment plan even with staff departures and/or reassignments. The staff will consist of 1 Licensed Clinical Social Worker, 1 Licensed Master Clinical Social Worker, a Psychologist (who will provide care ½ time in Brunswick CBOC and ½ time performing tele-mental health services to other Mental Health Clinics), a Nurse Practitioner (who will provide care ½ time in Brunswick and ½ time performing tele-mental health services to other Mental Health Clinics), and a Psychiatrist.

Appendix C

OIG Contact and Staff Acknowledgements

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Victoria Coates, LICSW, MBA Sheyla Desir, RN, MSN Jerome Herbers, MD Joanne Wasko, LCSW

Appendix D

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