



Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 16-00354-201

Healthcare Inspection
Follow-Up Review of Mismanagement of
Mental Health Consults and
Other Access to Care Concerns
VA Maine Healthcare System
Augusta, Maine

April 20, 2017

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the request of Senators Susan M. Collins and Angus S. King, Jr., and Representatives Chellie Pingree and Bruce Poliquin to follow up on recommendations made in our original report, *Healthcare Inspection—Mismanagement of Mental Health Consults and Other Access to Care Concerns*, VA Maine Healthcare System, Augusta, Maine (Report No. 14-05158-377, June 17, 2015). The purpose of this follow-up inspection was to evaluate the progress VA Maine Healthcare System (system) managers made in implementing the action plans created in response to three of the report's eight recommendations.

We conducted the original inspection in October 2014 at the request of former Representative Michael Michaud, the then-Ranking Member of the House Committee on Veterans' Affairs, in response to allegations of mismanagement of mental health (MH) consults and other access to care concerns at the system. We found that processes used to refer patients within the MH service made it difficult to track whether patients' requests for services were met and that some patients had unmet needs.

We also described how the system was noncompliant with the Veterans Health Administration (VHA) scheduling directive¹ when scheduling MH appointments. The June 2015 report made eight recommendations.

1. Remove the language in the Computerized Patient Record System outpatient psychological testing consult that may be interpreted as instructing providers not to enter a consult.
2. Reevaluate and make the appropriate changes to the methods for referring patients for MH care, including the extent to which the consult package is being used appropriately.
3. Ensure that MH consults are reviewed and closed in accordance with VHA policy.
4. Ensure that VHA appointment scheduling guidance is followed and that schedulers utilize the electronic waiting list and give priority to service connected veterans, as appropriate.
5. Review all existing MH wait lists to identify patients who may be at risk because of a delay in the delivery of MH care and provide the appropriate care.
6. Expand access to MH services, particularly required evidence-based psychotherapy and intensive case management services.

¹ VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures*, June 9, 2010. This Directive was in effect at the time of our review; it was rescinded and replaced by VHA Directive 1230, *Outpatient Scheduling Processes and Procedures*, July 15, 2016.

7. Ensure that MH staff is available in the Emergency Department as required by VHA and local policy to avoid potential delays in admission to the inpatient psychiatry unit.
8. Review guidance provided to staff about meeting performance measures and confer with the Office of Human Resources and the Office of General Counsel to determine the appropriate administrative action to take, if any.

Recommendation 1 was closed at the time the 2015 report was published, and the system developed action plans for the remaining seven recommendations.

In October 2015, the system provided OIG with documentation of progress made in implementing the action plans for the seven remaining recommendations. After review of the system's October 2015 progress report, we focused our follow-up inspection on evaluating the system's progress in implementing action plans for the following three prior recommendations:

- Prior Recommendation 2: Reevaluate and make appropriate changes to the methods for referring patients for MH care, including the extent to which the consult package is being used appropriately.
- Prior Recommendation 3: Ensure that MH consults are reviewed and closed in accordance with VHA policy.
- Prior Recommendation 4: Ensure that VHA appointment scheduling guidance is followed and that schedulers utilize the electronic waiting list (EWL) and give priority to service connected veterans, as appropriate.

Prior Recommendations 5, 7, and 8 were closed in February 2016, and prior Recommendation 6 was closed in August 2016.

During our January 2016 onsite follow-up review, we found the system implemented corrective actions to improve consult package usage for patients referred for MH services. We found that system consult review and closure processes were consistent with VHA policy.² However, the system was noncompliant with the VHA requirement to make direct contact with patients when scheduling MH appointments.³ MH service agreements were not in use and documentation of medical support assistant initial and annual scheduling competencies was missing or incomplete. As the system was able to schedule MH appointments for service-connected veterans timely, use of the EWL was not needed. Therefore, we were unable to determine if staff responsible for scheduling MH appointments utilized the EWL correctly.

As of November 2016, the system continued to sustain compliance with the use of and correct closing of consults when referring patients for MH services. The system

² VHA Directive 2008-056, *VHA Consult Policy*, September 16, 2008. This Directive was in effect at the time of our review; it was rescinded and replaced by VHA Directive 1232, *Consult Processes and Procedures*, August 23, 2016; amended September 23, 2016.

³ VHA Directive 2010-027, page 7.

provided one month of data documenting 100 percent compliance with MH schedulers making direct contact with patients prior to scheduling appointments and did not plan to continue to monitor this process. We determined that one month of data was insufficient to determine a sustained improvement. MH service agreements have been developed and implemented, and patients are able to access MH appointments timely.

We recommended the System Director ensure (1) that MH schedulers consistently make direct contact with patients prior to scheduling appointments and that compliance is monitored for a minimum of three months and (2) training and competencies are documented, complete, and up to date for all staff responsible for scheduling Mental Health appointments.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with our recommendations and provided acceptable action plans. (See Appendixes A and B, pp. 13-15 for the Directors' comments.) We will follow up on the planned actions until they are completed.

OIG update: Based on information provided to us in November 2016, we consider prior Recommendations 2 and 3 closed.



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

Purpose

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the request of Senators Susan M. Collins and Angus S. King, Jr., and Representatives Chellie Pingree and Bruce Poliquin to follow up on recommendations made in our report, *Healthcare Inspection—Mismanagement of Mental Health Consults and Other Access to Care Concerns, VA Maine Healthcare System, Augusta, Maine* (Report No.14-05158-377, June 17, 2015). The purpose of this inspection was to evaluate the progress VA Maine Healthcare System (system) managers made in implementing the action plan for three of the eight recommendations outlined in response to the 2015 report.

Background

The system is part of Veterans Integrated Service Network 1 and comprises a medical center in Augusta (Togus facility) and Community Based Outpatient Clinics in Bangor, Calais, Caribou, Rumford, and Saco, ME. The system provides acute medical and surgical care as well as outpatient mental health (MH) services for the patients in Augusta and surrounding areas.

We conducted the original October 2014 onsite inspection at the request of former Representative Michael Michaud, the then-Ranking Member of the House Committee on Veterans' Affairs in response to allegations of mismanagement of MH consults and other access to care concerns at the VA Maine Healthcare System, Augusta, ME. We found that processes used to refer patients within the MH service made it difficult to track whether patients' requests for services were met and that some patients had unmet needs. We also described how the system was noncompliant with the Veterans Health Administration (VHA) scheduling directive⁴ when scheduling MH appointments. The June 2015 report made eight recommendations.

1. Remove the language in the Computerized Patient Record System outpatient psychological testing consult that may be interpreted as instructing providers to not enter a consult.
2. Reevaluate and make appropriate changes to the methods for referring patients for MH care, including the extent to which the consult package is being used appropriately.
3. Ensure that MH consults are reviewed and closed in accordance with VHA policy.

⁴ VHA Directive 2010-027, VHA *Outpatient Scheduling Processes and Procedures*, June 9, 2010. This Directive was in effect at the time of our review; it was rescinded and replaced by VHA Directive 1230, *Outpatient Scheduling Processes and Procedures*, July 15, 2016.

4. Ensure that VHA appointment scheduling guidance is followed and that schedulers utilize the electronic waiting list (EWL) and give priority to service connected (SC) veterans,⁵ as appropriate.
5. Review all existing MH wait lists to identify patients who may be at risk because of a delay in the delivery of MH care and provide the appropriate care.
6. Expand access to MH services, particularly for required evidence-based psychotherapy and intensive case management services.
7. Ensure that MH staff is available in the Emergency Department as required by VHA and local policy to avoid potential delays in admission to the inpatient psychiatry unit.
8. Review guidance provided to staff about meeting performance measures and confer with the Office of Human Resources and the Office of General Counsel to determine the appropriate administrative action to take, if any.

Recommendation 1 was closed at the time that the report was published.

In October 2015, the system provided documentation on progress made in implementing the action plans associated with the remaining seven prior recommendations.

After review of the system's October 2015 progress report, we focused our January 2016 follow-up review on evaluating the system's progress in implementing action plans for the following three prior recommendations.

- Prior Recommendation 2: Reevaluate and make appropriate changes to the methods for referring patients for MH care, including the extent to which the consult package is being used appropriately.
- Prior Recommendation 3: Ensure that MH consults are reviewed and closed in accordance with VHA policy.
- Prior Recommendation 4: Ensure that VHA appointment scheduling guidance is followed and that schedulers utilize the EWL and give priority to SC veterans, as appropriate.

Prior Recommendations 5, 7, and 8 were closed in February 2016 and prior Recommendation 6 was closed in August 2016.

⁵ Service connection or "service-connected" refers to the VA determination that a condition or disability was incurred, in or has been aggravated by, military service.

Consult Management

According to VHA Directive 2008-056, *VHA Consult Policy*,⁶ September 16, 2008, a clear and solid consultation process is vital to patient care. The consultation process works best when there is a relationship between the sending and receiving services, and where defined workflow rules exist. A consult is typically an electronic document that facilitates and communicates consultative and non-consultative service requests and subsequent activities. VHA requires that providers use the Computerized Patient Record System to initiate, manage, and communicate clinical consultations.⁷

A clinical consultation is a response to a request for advice on the management of a specific patient problem with an expectation that a reply is provided in a timely fashion.⁸ System policy requires routine outpatient requests for consultations to be received, triaged, and scheduled within 7 days of the request.⁹

Consults can be resolved in a number of ways.¹⁰

- Scheduled – Used when the appointment date has been established and linked to the consult.
- Canceled – Used when the service is not available.
- Discontinued – Used when the service is no longer needed or when the service is refused.
- Completed – Used when appropriate documentation is available within the Computerized Patient Record System and linked to the consult.¹¹

⁶ VHA Directive 2008-056, *VHA Consult Policy*, September 16, 2008. This Directive was in effect during the time of our review; it was rescinded and replaced by VHA Directive 1232, *Consult Processes and Procedures*, August 23, 2016; amended September 23, 2016. Current VHA Directive 1232 states, “a clinical consult is a consult document in CPRS used as two-way communication on behalf of a patient consisting of a physician or provider (sender) request seeking opinion, advice, or expertise regarding evaluation or management of a specific problem answered by a physician or other health care provider (receiver). The CPRS consult package must be used for all clinical consultations.”

⁷ VHA Directive 2008-056, page 4. Current VHA Directive 1232 states, “In order to improve the management of clinical consultation processes, VHA is standardizing certain aspects of electronic consultation. These standards aim to improve transparency and timeliness of consult completion while preserving the freedom to use the consult package for administrative uses, prosthetics, and other purposes.”

⁸ VHA Directive 2008-056, page 1. Current VHA Directive 1232 states, “A clinical consult is a consult document in CPRS used as two-way communication on behalf of a patient consisting of a physician or provider (sender) request seeking opinion, advice, or expertise regarding evaluation or management of a specific problem answered by a physician or other health care provider (receiver).”

⁹ VA Maine Healthcare System Circular 00-15-49, *Consult Management*, December 16, 2015, page 4.

¹⁰ VHA Consult Business Rules. At the time of our review, the rules were posted on an internal VA website. The rules were incorporated into VHA Directive 1232, Appendix B.

¹¹ For the purposes of this report, the term “completing” a consult is equivalent with “closing” a consult.

Appointment Scheduling

VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures*, states:

It is VHA's commitment to provide clinically appropriate quality care for eligible Veterans when they want and need it. This requires the ability to create appointments that meet the patient's needs with no undue waits or delays.¹²...The goal is to schedule an appointment on, or as close to the [veteran's] desired date as possible....The desired date is defined by the patient without regard to schedule capacity. Once the desired date has been established, it must not be altered to reflect an appointment date the patient acquiesces to accept for lack of appointment availability on the desired date....[VA staff] is to offer and schedule an appointment on or as close to the desired date as possible.¹³

VHA requires direct contact with patients to schedule appointments.¹⁴ The system guidance at the time of our review in 2016 required schedulers to negotiate appointment dates with the veteran by direct contact either in person or via the telephone. After two unsuccessful attempts to contact the patient on different days, the patient was to receive a letter by mail.¹⁵ The referring provider was notified to take action as clinically appropriate if the veteran did not respond within 14 days of mailing the letter. The system guidance also stated, “[s]ending a letter with an appointment time that has not been negotiated with the patient is not permitted.”¹⁶

EWL

According to VHA, “[t]he EWL is the official VHA wait list.” The EWL, used to list patients waiting for an appointment or waiting for a panel assignment, keeps track of patients who are new to the clinic.¹⁷ This list is for patients with whom the provider does not yet have an established relationship and appointments are not available within target timeframes. When patients on the EWL receive an appointment, priority is given to those whose condition or disability is 50 percent SC or greater, or veterans less than 50 percent SC requiring care for a SC disability.

¹² VHA Directive 2010-027, *VHA Outpatient Scheduling Processes and Procedures*, June 9, 2010, page 1. This directive was in effect at the time of our review; it was rescinded and replaced by VHA Directive 1230, *Outpatient Scheduling Process and Procedures*, July 15, 2016 which states, “It is VHA policy that Veterans’ appointments are scheduled timely, accurately, and consistently with the goal of scheduling appointments no more than 30 calendar days from the date an appointment is deemed clinically appropriate by a VA health care provider (Clinically Indicated Date), or, in the absence of a Clinically Indicated Date (CID), 30 calendar days from the date the Veteran requests outpatient health care service (Preferred Date).”

¹³ VHA Directive 2010-027, page 7. Current VHA Directive 1230 states, “the preferred date (PD) is the date the patient communicates they would like to be seen. The PD is established without regard to existing clinic schedule capacity.”

¹⁴ VHA Directive 2010-027, page 8. Current VHA Directive 1230 states, “schedule all patient appointments with patient’s input...[d]o not blind schedule appointments.”

¹⁵ VA Maine Healthcare System Circular 00-15-49(11), *Consult Management*, December 16, 2015, page 4.

¹⁶ *Ibid.*

¹⁷ VHA Directive 2010-027, page 3. Current VHA Directive 1230 states, “the Electronic Wait List (EWL) is VHA’s official list to track patients who have been waiting for more than 90 calendar days for an appointment. Requests on the EWL consist of patients who have not been seen within 24 months (new patients) and established patients seen within 24 months but referred for a new clinical problem.”

Service Agreements

A service agreement¹⁸ is a written agreement made between two or more parties, outlining the workflow rules. According to the 2008 VHA Consult Directive, service agreements are developed by consensus, signed by service chiefs from involved services, reviewed and updated annually, and typically include the timeframe expected for a response.¹⁹ For example, a provider, requesting a consult for MH services would check the MH service agreement to see if any pre-visit preparation is required and what documentation, in addition to what is listed in the electronic health record (EHR), is needed. The service agreement defines expectations and responsibilities of the referring provider and consultant and promotes an effective patient centered referral process.

Staff Competency

System medical support assistants (MSAs) who schedule MH appointments may be located at the Togus facility or at the Community Based Outpatient Clinics. Community Based Outpatient Clinic MSAs are supervised by Primary Care (PC) administrative staff, and MH MSAs at the Togus facility are supervised by the Business Service Line administrative staff. VHA requires that all VA employees involved in the scheduling process be placed on the Master Scheduler List,²⁰ successfully complete VHA Scheduler training, and have an annual competency assessment related to their scheduling responsibilities, including entries into the EWL.²¹

Scope and Methodology

We conducted our inspection from December 2015 through April 2016. We requested and reviewed updated information in November 2016. We conducted an onsite review January 11–15, 2016.

We reviewed VHA directives, system policies and procedures, administrative documents, quality management data, and other relevant documentation. We performed an EHR review of consults submitted between June and December 2015 that included patients placed on the EWL. We selected this time period to allow 6 months following the publication of the 2015 report for system managers to implement their action plans.

¹⁸ Service agreements are also known as Care Coordination agreements.

¹⁹ VHA Directive 2008-056, page A-1. Current VHA Directive 1232 refers to service agreements as care coordination agreements and states “a care coordination agreement is an agreement or understanding between two or more services within or between facilities, one of which sends work to the other(s), defining the work flow rules. This is a written document that is developed based on discussion and consensus between the involved services and facilities. The care coordination agreement is signed by service chiefs from the involved services.”

²⁰ The Scheduler Master list identifies all individuals with menu options to create appointments.

²¹ VHA Directive 2010-027, page 9. Current VHA Directive 1230 states, “each staff member involved in the scheduling of outpatient appointments, use of Electronic Wait List (EWL), and Recall Reminder (RR) and the individual’s supervisor must successfully complete training.”

We focused our follow-up review on prior recommendations 2, 3, and 4. Recommendation 1 was closed at the time that the prior report was published; Recommendations 5, 7, and 8 were closed in February 2016; and Recommendation 6 was closed in August 2016.

We took the following steps related to each prior recommendation:

Prior Recommendation 2: Reevaluate and make appropriate changes to the methods for referring patients for MH care, including the extent to which the consult package is being used appropriately.

- Scope: We interviewed the System Director, leaders, and providers in MH and PC, including those who provided direct care to patients. We also interviewed staff responsible for auditing the consult process.
- Methodology: We reviewed the EHRs of 30 patients with MH appointments to determine if consults were used to refer patients, including when referring between MH specialties.

Prior Recommendation 3: Ensure that MH consults are reviewed and closed in accordance with VHA policy.

- Scope: We interviewed the System Director, leaders, and providers in MH and PC. We also interviewed staff responsible for auditing the closing of consults.
- Methodology: We reviewed the EHRs of 30 patients to determine if consults were reviewed and closed in accordance with VHA directive.

Prior Recommendation 4: Ensure that VHA appointment scheduling guidance is followed and that schedulers utilize the EWL and give priority to SC veterans, as appropriate.

- Scope: We interviewed the System Director, schedulers in MH and PC, and supervisors for the Business Line and PC.
- Methodology: We reviewed the EHRs of 30 patients scheduled for MH appointments to determine if VHA scheduling guidance was followed. Additionally we reviewed the EHRs of 50 veterans on the EWL to determine if schedulers utilized the EWL and gave priority to SC veterans in accordance with VHA requirements.²²

For the EHR reviews described above, we selected patients who had their first appointment in MH between June and December 2015. We excluded follow-up appointments and appointments for medication refills.

We concurred with the system's reported progress when facts supported that appropriate actions were implemented. We did not concur with the system's reported

²² VHA Directive 2010-027. Current VHA Directive 1230 states, "Appointments are made from EWL requests beginning with highest priority level...then by chronological date...."

progress when the facts did not support that implementation actions improved processes.

In the absence of current VA/VHA policy, we 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 recommendation(s).

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.

Inspection Results

Prior Recommendation 2: Reevaluate and make appropriate changes to the methods for referring patients for MH care, including the extent to which the consult package is being used appropriately.

In response to this prior recommendation, system managers planned to do the following:

- Identify MH Access Champions (ACs) to assist with educating staff in the Community Based Outpatient Clinics on the method for consult tracking and providing weekly updates to the MH leadership.
- Educate all staff on the use of the MH consult package when referring patients for MH services as well as when referring from one MH service to another.
- Audit new and existing MH patient records each month for compliance with consult usage until 95 percent compliance was achieved for 3 consecutive months. An ongoing audit to assure target compliance is maintained.

We determined that system leadership implemented corrective actions and made progress to ensure consults were used to refer patients for MH services, including referrals between MH specialties.

System leadership stated that ACs received education and training on the correct use of the consult package, which included the method for consult tracking. MH leadership received weekly updates on progress made with the training and designated a staff member to complete monthly audits of new and existing MH EHRs. According to system-provided data from June to December 2015, 42 of 45 (93 percent) of the EHRs reviewed were compliant with the use of consults when referring patients for MH services.

To validate reported compliance, we did not rely on the record sample used by the system. Instead, we randomly selected and independently reviewed 30 EHRs and determined that all of the records (100 percent) had documentation of consult use when referring patients for MH services. This supported the system's reported compliance with the use of consults.

OIG update: Based on information provided to us in November 2016, we determined the system has sustained compliance with the use of the consult package when referring patients for MH services. We consider prior Recommendation 2 closed.

Prior Recommendation 3: Ensure that MH consults are reviewed and closed in accordance with VHA policy.

In response to this recommendation, system managers planned to do the following:

- MH leadership would ensure that the ACs in MH received consult management training consistent with VHA policy to include the correct method for closing consults.
- Beginning June 2015, system staff would audit 30 new and existing MH patient records each month for compliance with correct closing of consults until 95 percent compliance was achieved for 3 consecutive months.
- Continue ongoing audits to assure that targets are maintained.

We determined that the system implemented corrective actions and made progress to ensure consults were reviewed and closed in accordance with VHA policy.

ACs in MH and scheduling staff in both PC and MH received consult management training, which included the correct method for closing consults. We found that a system-designated staff member audited 45 new and existing patient EHRs monthly between June and December 2015 for compliance with the correct closing of consults. The system staff found that 40 of 45 (89 percent) of the EHRs reviewed were compliant with the correct closing of consults.

To validate the system's reported compliance data, we independently reviewed 30 EHRs and determined that 28 of 30 (93 percent) were closed correctly. Although the system did not meet the target compliance rate of 95 percent, the results of our independent EHR review indicated the system was making progress with closing consults in accordance with VHA policy.

OIG Update: Based on information provided to us in November 2016, we determined the system met the target compliance rate of 95 percent with the correct closing of consults. We consider prior Recommendation 3 closed.

Prior Recommendation 4: Ensure that VHA appointment scheduling guidance is followed and that schedulers utilize the EWL and give priority to SC veterans, as appropriate.

In response to this recommendation system managers planned to do the following:

- Business Service Line and MH Service would provide training to new and refresher training to existing MH schedulers on proper utilization of the EWL in accordance with VHA policy giving priority to SC veterans, as appropriate.
- Proper utilization of the EWL would be audited by the MSA Clinic Management Committee beginning June 2015. Each audit will include review of 30 random appointments for appropriate use of EWL, and occur monthly until at least 95 percent compliance for 3 consecutive months has been achieved, at which time the reviews will shift to the Supervisor of Inpatient and MH Clinic MSAs as

part of the routine performance reviews with periodic oversight by the MSA Clinic Management Committee.

We determined that the system was not following VHA guidance when scheduling MH appointments.²³

MSA Clinic Management Committee minutes for December 2015 included a discussion on blind scheduling. The discussion described how blind scheduling was not allowed and that the MSA must negotiate an appointment with patient.²⁴

System staff told us that MSAs frequently offered patients specific appointment times rather than negotiating an acceptable appointment date and time and that patients received letters for those appointments without anyone talking to them. If the patient did not initiate the request for a follow-up appointment, the scheduler sent the patient a letter with the date and time for the next appointment. If the patient initiated a request for a follow-up appointment, the scheduler viewed the provider's schedule grid and told the patient the date of the next available appointment and asked, "will this work for you?" Both of these processes were not compliant with the system's requirement to make direct contact with the patient and allow the patient to determine his or her desired appointment date and time.²⁵

We found a lack of documentation of negotiation with the patient before appointment scheduling in 15 of 30 (50 percent) of the EHRs we reviewed.²⁶ Twenty-three of 30 (77 percent) of EHRs had no documentation of the patient's desired appointment date.

OIG Update: Based on information provided to us in November 2016, we determined that a one-month period of 100 percent compliance is not sufficient to ensure that schedulers consistently make contact with veterans prior to scheduling appointments.

Service Agreements

The 2008 VHA consult directive stated that each facility Director, or designee, ensure the effective use of service agreements, a well-designed communication process, and effective electronic templates are in place in order to reduce the need for additional review of consults prior to scheduling.²⁷ We found the system had no active MH service

²³ VHA Directive 2010-027.

²⁴ Blind scheduling is the term commonly used by VHA to describe the process of making an appointment without negotiating a day and time with the patient.

²⁵ VA Maine Healthcare System Circular 00-15-49, *Consult Management*, December 16, 2015, page 6.

²⁶ VHA Directive 2010-027, page 8. Current VHA Directive 1230 states, "schedule all patient appointments with patient's input...[d]o not blind schedule appointments."

²⁷ VHA Directive 2008-056. Current VHA Directive 1232 refers to service agreements as care coordination agreements and states, "a care coordination agreement is an agreement or understanding between two or more services within or between facilities, one of which sends work to the other(s), defining the work flow rules. This is a written document that is developed based on discussion and consensus between the involved services and facilities. The care coordination agreement is signed by service chiefs from the involved services."

agreements. While onsite, we were told that system managers planned to embed the service agreement into the electronic consult template. A system manager told us that they anticipated having draft service agreements for all services written by March 2016 and full implementation by the end of 2016.

OIG Update: Based on information provided to us in November 2016, we determined the system met its target date to develop and implement MH services agreements.

EWL Use

According to a system staff member, as of January 2016, “MH access was so good, there should be no one on the EWL.” The system provided EWL audit results for June to December 2015 that documented 95 percent compliance with correct consult use. To validate the system’s reported compliance with the correct use of the EWL, we independently reviewed EHRs for 50 veterans on the EWL prior to January 2016. Thirty-two of 50 veterans were identified as SC, and 31 of 32 were SC greater than 50 percent. Fifteen of the 31 veterans (48 percent), who were identified as SC greater than 50 percent had documentation of scheduled MH appointments. Our EHR review supported the system’s previous practice of tracking veterans with SC disabilities; however, because the system was no longer using the EWL, we were unable to determine if the system gave appointment scheduling priority to those veterans as required.²⁸

OIG Update: Based on information provided to us in November 2016, system staff were able to schedule appointments within required timelines and have not needed to use the EWL for veterans awaiting MH appointments. As of February 2017, the system was only using the EWL for veterans waiting for Compensated Work Therapy assignments.²⁹

Other Concern: MSA Scheduling Training

At the time of our site visit in January 2016, we found that 32 of 54 (59 percent) staff who scheduled MH appointments did not have current scheduling competencies on file. Additionally, competency forms were missing signatures, trainer names, dates, assessment timeframes, and scheduling competency elements.

OIG update: Based on the information provided to us in November 2016, we found that 6 of 42 MH schedulers (14 percent) did not have updated scheduling competencies and 9 of 42 competency files (21 percent) were missing elements such as dates of training, signatures of trainers, and date assigned to position. We determined that deficiencies continued to exist when documenting MSA annual scheduling training and competencies.

²⁸ VHA Directive 2010-027. Current VHA Directive 1230 states “...provide Veterans non-emergent outpatient health care service in accordance with the enrollment determination Priority Groups 1–8 defined in VHA Handbook 1601A.0...”

²⁹ The Compensated Work Therapy Program (CWT) is a Department of Veterans Affairs (VA) vocational rehabilitation program that attempts to match and support work ready veterans in competitive jobs and to consult with business and industry regarding their specific employment needs.

Conclusions

We found the system implemented and sustained corrective actions to improve consult package usage for patients referred for MH services and that consult review and closure processes were consistent with VHA policy. Additionally, as of November 2016, MH service agreements had been developed, signed, and implemented. The system was deficient in the area of ensuring that all MH schedulers had current competencies, and we could not be certain that MH schedulers consistently made direct contact with patients prior to scheduling appointments. We made two recommendations.

Recommendations

1. We recommended the System Director ensure Mental Health schedulers consistently make direct contact with patients prior to scheduling appointments and that compliance is monitored for a minimum of three months.
2. We recommended the System Director ensure training and competencies are documented, complete, and up to date for all staff responsible for scheduling Mental Health appointments.

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: March 13, 2017

From: Director, VA New England Healthcare System (10N1)

Subj: Healthcare Inspection—Follow-up of Mismanagement of Mental Health Consults and Other Access to Care Concerns, VA Maine Healthcare System Augusta, Maine

To: Director, Seattle Office of Healthcare Inspections (54SE)
Director, Management Review Service (VHA 10E1D MRS Action)

1. Thank you for the opportunity to review and respond to the report, Mismanagement of Mental Health Consults and Other Access to Care Concerns, VA Maine Healthcare System, Augusta Maine.
2. I have reviewed and concur with the recommendations in the report. If you have any questions or require further information, please contact Janice Bernzott, Chief, Quality Management at 781-687-4979.



Michael F Mayo-Smith, MD, MPH
Network Director, New England Healthcare System

System Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: March 6, 2017

From: Director, VA Maine Healthcare System (402/00)

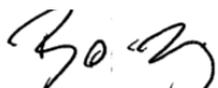
Subj: Healthcare Inspection—Follow-up of Mismanagement of Mental Health Consults and Other Access to Care Concerns, VA Maine Healthcare System, Augusta, Maine

To: Director, VA New England Healthcare System (10N1)

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

1. Facility Access Committee will develop and implement ongoing audits to confirm that appointments are indeed negotiated and direct contact is being made with the Veterans prior to scheduling appointments. The committee will standardize these audits across the system. Audits will begin April 1, 2017, and will continue until we can demonstrate 3 months of 85% compliance.
2. The Facility Access Committee will review the current competency process for all schedulers and make concise recommendations for consistency across the VA Maine HCS. A standardized competency form for schedulers will be developed and utilized annually for all staff who schedule. This competency form will be developed by March 31, 2017. Competencies for all staff who schedule mental health appointments will be evaluated with a targeted completion date of April 30, 2017.

VA Maine HCS will monitor compliance of this process and ensure accurate completion of the forms with feedback to the departments as necessary. A follow-up report will be provided to the OIG by May 15, 2017, or other date as designated by the OIG.



Ryan S. Lilly
Center Director

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended the System Director ensure Mental Health schedulers consistently make direct contact with patients prior to scheduling appointments and that compliance is monitored for a minimum of three months.

Concur

Target date for completion: June 2017

System response: VA Maine schedulers are required to negotiate appointments with the Veteran. Documentation of this conversation is contained within the scheduling package. The Facility Access Committee will develop and implement ongoing audits to confirm that appointments are indeed negotiated and direct contact is being made with the Veterans prior to scheduling appointments. The committee will standardize these audits across the system. Audits will begin April 1, 2017, and will continue until we can demonstrate 3 months of 85% compliance.

Recommendation 2. We recommended the System Director ensure training and competencies are documented, complete, and up to date for all staff responsible for scheduling Mental Health appointments.

Concur

Target date for completion: April 30, 2017

System response: VA Maine schedulers are required to have annual competencies that comply with the Scheduling Directive. The Facility Access Committee will review the current competency process for all schedulers and make concise recommendations for consistency across the VA Maine HCS. A standardized competency form for schedulers will be developed and utilized annually for all staff who schedule. This competency form will be developed by March 31, 2017. Competencies for all staff who schedule mental health appointments will be evaluated with a targeted completion date of April 30, 2017.

VA Maine HCS will monitor compliance of this process and ensure accurate completion of the forms with feedback to the departments as necessary. A follow-up report will be provided to the OIG by May 15, 2017, or other date as designated by the OIG.

OIG Contact and Staff Acknowledgments

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