Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Post-Traumatic Stress Disorder Program Issues
VA San Diego Healthcare System
San Diego, California

Report No. 08-01297-187 **August 26, 2008**

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
Call the OIG Hotline – (800) 488-8244

Executive Summary

The purpose of this inspection was to review allegations regarding the Post-Traumatic Stress Disorder (PTSD) Program at the VA San Diego Healthcare System (VASDHS):

We substantiated that the designated Medical Director of the PTSD clinical team (PCT) and the PTSD Program does not function as a full-time director. At the time of our review, the Medical Director was only available for program management and clinical care 0.5 days per week and spent the remainder of his time on research studies. In light of the salient role of PTSD treatment in veteran mental health care and the increasing number of recently discharged veterans and Vietnam era veterans seeking VA mental health services, the substantial presence of a clinician-administrator appears to be reasonable and warranted.

In the absence of valid workload and productivity data, it appeared that generally, the PTSD Program is able to meet requests for group or individual evidence-based therapy. However, during times of higher volume, the demand exceeds the ability to provide individual therapy slots.

Veterans do not always report for scheduled appointments (termed "no shows") and internal audits showed that staff did not adhere to the expected process for follow-up contacts. The no show rate for the PTSD Program may in part reflect the need for younger veterans to be present at work or school during the day. Offering evening hours could potentially expand access to individual evidence-based therapy for these patients and help to meet their needs.

We substantiated that some staff members who are in clinical leadership positions in the PTSD programs spend a majority of their time doing research. In addition, we validated the assertion that some staff members, who were initially assigned substantial clinical work subsequently had changes in their responsibilities, and newly hired staff members or trainees had been assigned to take over or fill in for some of their clinical duties.

We recommended that a clinician-administrator be designated to provide overall PCT and PTSD program direction and leadership; relevant data sources be identified, updated, and coordinated to ensure that appropriate PTSD treatment conclusions can be made; follow-up patient contact procedures be consistently performed; and action is taken to enhance accessibility of PTSD therapies to OIF/OEF patients.

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

TO: Veterans Integrated Service Network 22 Director

SUBJECT: Healthcare Inspection – Post-Traumatic Stress Disorder Program Issues, VA San Diego Healthcare System, San Diego, California

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections reviewed allegations regarding Post-Traumatic Stress Disorder (PTSD) Program issues at the VA San Diego Healthcare System (VASDHS). The purpose of this inspection was to determine the validity of the following allegations:

- There is no full-time Medical Director of the PTSD clinical team (PCT). The program directors for the PCT and the Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF) PTSD Program are competent and concerned but serve multiple roles as clinicians, researchers, and program directors. Their research responsibilities detract from the time available for direction of the clinical program.
- The Psychology Service disregards the merit promotion system, and mental health leadership jobs are not posted by Human Resources, in violation of VA directives.
- As a result of the absence of full-time clinic direction and staff fragmentation, there is no consistent treatment plan or program for OIF/OEF veterans with PTSD. They are seen within the prescribed period of time by a psychiatrist somewhere in the system, but there is inadequate staffing to provide treatment programs, except for some formulaic, time-limited groups run by interns, and inexperienced people without time to do real individual therapy.
- Therapists in the PCT are overwhelmed by sheer numbers due to increasing mental health needs of Vietnam and Korean War era veterans.
- Research has been given inappropriate priority over clinical PTSD care.
- Office space is preferentially allocated in both the Mission Valley community based outpatient clinic (MVCBOC) and the medical center in La Jolla to researchers over clinicians.

Background

The complainant wrote to Congressman Bob Filner, Chairman of the House Committee on Veterans' Affairs, who requested an inspection.

The VASDHS is a tertiary medical center with 242 beds and 2,820 employees. The VASDHS consists of the medical center located in La Jolla and five community based outpatient clinics (CBOCs) in San Diego (Mission Valley), Escondido, Chula Vista, Vista, and Brawley, CA. It is affiliated with the University of California, San Diego's School of Medicine, and more than 780 residents, interns, and students are trained at the VASDHS each year. The VASDHS has one of the largest research programs in the VA, with studies in such areas as AIDS, diabetes, PTSD, and stress related mental health issues. It is part of Veterans Integrated Service Network (VISN) 22.

The VASDHS offers a variety of mental health programs. Some programs focus on provision of a specific type of therapy, such as cognitive therapy for depression or a "Seeking Safety" evidence-based coping skills group for OIF/OEF combat veterans with significant problems associated with substance use as it relates to PTSD. Some target specific patient populations, for example, the Women and Depression Clinic focused on female veterans with mood disorders such as post-partum depression. Some programs also see patients who would like or have been recruited to participate in research protocols. Appendix A lists mental health services and programs offered at the VASDHS.

A patient may be referred for PTSD treatment via several avenues, including screening by a social worker upon enrollment, direct self-initiated referral, or referral from an active duty branch, the emergency room, primary care clinics, or medical specialty/treatment clinics. Although most OIF/OEF patients with PTSD symptoms at the VASDHS are referred to specialty mental health for treatment, some are treated in primary care settings. Some of these patients decline referral, while others may choose not to pursue mental health intake/consultation. Some referred patients may have moved out of the area.

While PTSD treatment is available at other sites, a majority of VASDHS outpatients treated for PTSD are seen at the MVCBOC. Patients who have had an intake evaluation through another mental health program may not need to repeat an intake at the MVCBOC. For example, a patient who has completed the "Seeking Safety" program at the La Jolla site could be directly referred for individual therapy at the MVCBOC.

The choice of treatment options and venues is dependent on several factors, including service era, preference, clinical factors, and the immediate availability of the treatment options. This determination may be made at the time of the intake evaluation or after referral. Although an OIF/OEF patient may have PTSD symptoms, the PTSD Program

may not be where a patient receives mental health care. The following examples illustrate the array of available treatment options.

- Patients with PTSD and substance issues might be referred to the "Seeking Safety/Seeking Strength" program at the La Jolla site.
- Patients with primary substance use issues and an anxiety component might be referred to the Substance Abuse Mental Illness Program at the La Jolla site.
- Patients in need of detoxification might first receive treatment at the Alcohol and Drug Treatment Program at the La Jolla site.
- Patients with mild non-combat related PTSD symptoms and obsessive-compulsive or panic disorder might be seen at the MVCBOC's anxiety disorders clinic.
- Patients with mild PTSD symptoms and prominent symptoms of major depression might be served in the mental health clinic at the MVCBOC or might be referred to the Cognitive and Behavioral Interventions Program at the La Jolla site.
- Patients with prominent symptoms related to military sexual trauma (MST) might receive treatment with MST-focused providers at the MVCBOC.

At the MVCBOC, there are two specialized mental health treatment programs for veterans with symptoms primarily related to military PTSD. The PCT generally services veterans suffering from non-sexual, combat- or military-related PTSD who served prior to 1998, including veterans of World War II and the Korean and Vietnam eras. The PCT has been in place since 1999 and is a well-established program. The PTSD Program is newer and is primarily targeted toward OIF/OEF combat veterans. Although the PCT typically treats veterans whose service predates 1998, there are circumstances under which some OIF/OEF veterans may be treated in the PCT clinic (for example, a 55-year-old National Guard member who expresses a preference for treatment in the PCT clinic).

Upon referral to the PCT, the patient is invited to attend a screening group during which he/she receives an orientation and some information about PTSD. If the PCT appears to be an appropriate treatment venue, an intake evaluation is arranged. The provider who performs the intake evaluation becomes the patient's case manager. The patient then attends a weekly group titled "PTSD 101" during which he/she receives education regarding PTSD and learns breathing exercises and stress management skills. During this time period, the patient meets periodically with a case manager. At the end of "PTSD 101," the patient might pursue various group therapy options, such as an anger management group, a cognitive behavioral therapy (CBT) group, or the "Seeking Safety/Seeking Strength" program. The patient continues to meet with a therapist for supportive/interpersonal treatment. Although a patient might receive individual cognitive processing therapy (CPT) or prolonged exposure (PE) therapy, only a few patients actually receive these therapies. These therapy modalities are explained on the next page.

Treatment modalities offered in the PTSD Program include medication management, group or individual CPT, individual PE therapy, and a life skills based CBT group (including interpersonal skills and anger management). Patients who may benefit from and desire medication management are evaluated and followed by psychiatrists. The life skills group is offered to all patients. The CPT group is structured to run for a certain length of time without adding any new members. Some patients opting for this form of treatment might attend the life skills group until a new CPT group begins. Most patients who desire individual CPT or PE therapy are typically to be seen weekly by a therapist. If a time slot for individual therapy is not presently available, a patient may be asked to attend group CPT or the life skills group until an individual therapy slot becomes available. Patients living far away, or for whom interim group treatment is not practical, may be referred for fee-basis treatment in the community. Alternatively, individual PE therapy by a trained mental health provider is offered during evening hours at the San Diego Veterans Readjustment Counseling Center (Vet Center).

CBT combines cognitive and behavioral approaches and is focused on helping patients change patterns of assumptions and/or beliefs and on modifying harmful or self-defeating behavior. CBT is the treatment approach with the most research supporting its effectiveness. CBT therapies are usually structured with an agenda, topic, or goal for each session and are limited to a specified number of sessions (for example, 10–15). Forms of CBT are used in the treatment of depression, PTSD, and other mental health conditions.[1]

Several kinds of CBT-related therapies are available for PTSD. During PE therapy, the patient confronts the feared situation, object, thought, or memory. The exposure is continued until the anxiety is reduced. CPT incorporates cognitive therapy and exposure therapy and systematically builds the patient's skills to deal first with the traumatic event and then with its effect on other areas of the patient's life.[2]

Several meta-analyses have been published comparing the effectiveness of specific treatments for PTSD. Some of the studies involved patients with PTSD from non-military related etiologies, while some studies involved patients with military-related PTSD. One analysis found that psychological therapies had significantly lower dropout rates than drug therapies and were also more effective than drug therapies in reducing symptoms. A recent RAND Institute report, *Invisible Wounds of War*, notes that the scientific literature is consistent with the VA/Department of Defense guidelines for treatment, which include various forms of CBT.[3] The Institute of Medicine's PTSD report found that the evidence is sufficient to conclude that exposure therapies are efficacious in the treatment of PTSD. The report noted that this endorsement is not

[1] Terri Tanielian and Lisa Jaycox, Editors, *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery*, RAND Center for Military Health Policy Research, Rand Corporation, 2008, p. 340.
[2] Tanielian and Jaycox, p. 340–341.
[3] Tanielian and Jaycox, p. 348.

intended to imply that exposure therapy is the only treatment that should be used in treating patients with PTSD.[4,5]

The VA has undertaken efforts to train clinical providers in PE therapy and CPT. Dissemination of new therapeutic techniques requires not only education and training but also involves culture change for clinicians and staff accustomed to longer-standing interventions and programs. On the one hand, this paradigm shift entails acceptance of change. On the other hand, it does not imply that PE and CPT will be the right fit for the needs of all PTSD patients or that there are not appropriate circumstances for use of more familiar interventions.

In the RAND report, the authors discussed two kinds of service gaps from the health services research literature—gaps in access to care and gaps in quality of care. A gap in access exists when individuals who need services are not using them. This gap can arise from multiple contributing factors, including structural, geographic, personal, and social. A gap in quality exists when the services that individuals typically receive are not consistent with high-quality care. Based on the Institute of Medicine's Quality Chasm report, the RAND authors define high-quality care as care that is safe, based on the best available evidence and expert consensus about what is most effective, timely, efficient, equitable, and patient centered (values and preferences of individuals are respected in clinical decision making and patients are informed participants in their treatment).[6,7]

All veterans with combat service after November 11, 1998, who were discharged under other-than-dishonorable conditions are eligible to receive cost-free health care through the VA for 5 years after separation from active military service. Recent estimates indicate that approximately 18 percent of OIF/OEF veterans seeking care through the VA are receiving care for PTSD. In one study, approximately 29,000/184,500 (16 percent) OIF/OEF veterans who sought care at VA medical facilities between October 2001 and May 2006 had a "probable diagnosis of PTSD." A 2006 report by the Democratic staff of the House Committee on Veterans' Affairs noted that 5,339 OIF/OEF veterans who had been diagnosed with PTSD had been treated exclusively through Vet Centers, and an additional 3,764 OIF/OEF veterans with a diagnostic code for PTSD were seen at both a VA medical facility and a Vet Center.[8]

The increased demand for mental health and PTSD services is not limited to OIF/OEF veterans but also reflects growing or changing needs of veterans of previous war eras.

[4] Institute of Medicine of the National Academies, Report Brief, *Treatment of PTSD: An Assessment of the Evidence*, October 2007, p.1.
[5] Rabekah Bradley, et al., "A Multidimensional Meta-Analysis of Psychotherapy for PTSD," *American Journal of Psychiatry*, 162 (February 2005) p. 214–227.
[6] Tanielian and Jaycox, p. 245–247.
[7] . Institute of Medicine of the National Academies, *To Err is Human: Building a Safer Health System,* November 1999 and *Crossing the Quality Chasm: A New Health System for the 21st Century*, March 2001.
[8] Tanielian and Jaycox, p. 264–65, p. 269.

Rosenheck and Fontana reported that the recent increase in use of VA mental health services by earlier era veterans has been five times greater than that observed for Gulf era veterans. Despite an increase in utilization of VA mental health services, Rosenheck and Fontana also noted a decrease in the number of clinic visits per veteran from 1997 to 2005.[9] The RAND authors assert that because evidence-based psychotherapies require a certain frequency and number of visits, a trend toward fewer visits per patient could potentially impact the ability to deliver evidence-based psychotherapies.[10]

Scope and Methodology

We interviewed the complainant by phone on several occasions from March 13–18, 2008, and in person on June 9, 2008. We conducted site visits at VASDHS March 18–20 and June 9–11 and interviewed clinical providers and program managers from the PCT and OIF/OEF PTSD Program and VASDHS mental health service chiefs. In addition, we interviewed a psychologist from the San Diego Vet Center and met with a representative of a Combat Veterans Service Organization, known as ACTVOW. We reviewed documents, including directives, medical records, policies, and reports. The scope of our review was limited to the allegations made by the complainant.

We conducted the inspection in accordance with *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

Inspection Results

Issue 1: PCT and PTSD Treatment Program Leadership

The complainant alleged that there is no full-time Medical Director of the PCT and that the program directors for the PCT and the PTSD Program are competent and concerned, but serve multiple roles as clinicians, researchers, and program directors. It was also alleged that their research responsibilities detracted from the time available for direction of the clinical program.

We substantiated that the designated Medical Director for the PCT and PTSD Program does not function as a full-time medical director. At the time of our review, the Medical Director, a psychiatrist, was only available for program management and clinical care 0.5 days per week and did not substantively participate in the operations of the PCT or the PTSD Program. In addition to previous research responsibilities, the Medical Director had recently joined a research team directing a $60 million multi-site VA/Department of Defense collaborative study focused on treatment of PTSD symptoms.

[9] R.A. Rosenheck, and A.F. Fontana, "Recent Trends in VA Treatment of Post-Traumatic Stress Disorder and other Mental Disorders," *Health Affairs*, 26, 2007, p. 1720–1727.
[10] Tanielian and Jaycox, p. 268.

Clinicians we interviewed described the psychologist program directors of the PCT and the PTSD Program as talented, energetic, and caring clinician-researchers. The PCT Program Director has a Career Development Award for research that expects full-time participation and precludes any clinical care duties for about 5 more years. This individual has been expected to provide, and has been voluntarily providing, 0.25 full-time equivalent (FTE) program leadership over and above his 1.0 FTE research obligation. The PTSD Program Director also has a Career Development Award that expects 75 percent participation in research and precludes clinical care duties for about 2 more years. This individual has been providing approximately 37.5 hours of program management and trainee supervision per week by working 60-hour workweeks.

As mentioned earlier, the VASDHS provides a broad range of mental health service options, and the PCT and the PTSD Program are two of the larger programs. Although VASDHS policy indicates that the PCT should have a program director who is 1.0 FTE and manages the program, we could not find a VHA or VASDHS directive specifying a minimum amount of administrative time or administrative FTE required for program or medical directorship of the PCT or the PTSD Program.

It is unclear whether both the PCT and the PTSD Program individually require full-time clinician-administrator program direction. However, in light of the salient role of PTSD treatment in veteran mental health care and the increasing number of OIF/OEF and Vietnam era veterans who are accessing VA mental health services, the substantial presence of a clinician-administrator with overall responsible for both the PCT and PTSD Programs, appears to be reasonable and warranted.

Recommendation 1. We recommend that the VISN Director require the VASDHS Director to designate a clinician-administrator fully committed and substantially present to provide overall program direction and leadership for both the PCT and PTSD Program.

The complainant also alleged that the Psychology Service disregarded the merit promotion system and that mental health management jobs were not posted properly, in accordance with VA directives. The directives provide the procedures necessary to fill leadership positions in mental health. The directives state that to support the provision of high-quality, inter-disciplinary mental health services, it is important that the most qualified individuals be selected for management positions, regardless of their professional discipline. However, appointment of an already employed clinician to a management role at the same grade usually does not require the formal posting of a position announcement.

We found that the actual position in question was selected according to regulations. However, a service chief had given another staff member a title that implied a leadership role but was not an actual leadership position with leadership responsibilities. This unilateral decision resulted in role confusion among the multidisciplinary team members

as well as other staff and patients. We were told that this situation had been corrected. Therefore, we did not make a recommendation.

Issue 2: Clinical Staffing and Access to Treatment

The complainant alleged that as a result of the absence of full-time clinic direction and staff fragmentation, there was no consistent treatment plan or program for OIF/OEF veterans with PTSD. He stated that patients are seen within the prescribed period of time by a psychiatrist somewhere in the system but that there is inadequate staffing to provide treatment programs, except for some formulaic, time-limited groups run by interns, and to provide real individual therapy.

Staffing. At the time of our visit, the PCT was staffed as follows:

- Psychiatrists – four psychiatrists performed intakes and medication evaluations and management. Two of the physicians were 0.5 FTE, and one was 0.25 FTE. Another psychiatrist was 0.9 FTE, and we were told that he would begin splitting his time between the PCT and the PTSD Program.
- Nurse practitioner – 1.0 FTE provided therapy and case management.
- Licensed clinical social worker – 1.0 FTE provided therapy and case management.
- Chaplain – 1.0 FTE provided counseling.
- Post-doctoral psychology fellow – 1.0 FTE provided therapy.

At the time of our visit, the PTSD Program was staffed as follows:

- Psychiatrists – three psychiatrists performed intakes and medication evaluations and management. Two of the physicians were 0.2 FTE, and one was 0.25 FTE. The Chief of Psychiatry Service reported expected hiring of additional psychiatrists, including two 0.25 FTE psychiatrists and a 0.875 FTE psychiatrist.
- Psychologists – 1.0 FTE and 0.625 FTE post-doctoral psychology fellows, another psychologist who works intermittently, a psychology intern, and the full-time psychologist filling in for the PTSD Program Director, who was on maternity leave.

Treatment Programming.

As described in the background section, the treatment model differs between the PCT and the PTSD Program. The services and therapy in the PCT flow in series, with a greater emphasis on care coordination and treatment planning than in the PTSD Program. In addition, PCT providers are relatively familiar with each other's patients because they treat each other's patients in various groups. Therapy in the PTSD Program flows in parallel, with patients choosing individual or group therapies. The evidence-based therapies (CPT and PE), by design, are structured, thematically sequenced, and formulaic

by design. We found that there was not an absence of a program, but rather, structured therapy inherently is the program.

In general, the PTSD Program is staffed with less experienced clinicians. While clinical experience is an asset, newer clinicians, such as those who recently finished their doctorates, may be more familiar with, or more likely to have been trained in, the evidence-based therapies. An important consideration is the level or availability of supervision for new staff. A post-doctoral psychologist told us that the PTSD Program Director was easily accessible for guidance and readily approached. The PTSD Program Director told us that she met with the psychology intern and reviewed select tapes from the intern's therapy sessions. One psychiatrist observed that the PCT is staffed with a coherent group that has been working together for years, "good clinicians and dedicated." Treatment in the PCT is more coordinated than in the PTSD Program. The PTSD Program has "younger looking staff but qualified, dedicated, and still in the process of becoming a team."

Providers who have worked with both groups told us that the PCT and the PTSD Program face some distinctive challenges that differentially impact program structure, the perception of clinic stability, and team building. For example, the PCT patient population is more likely to seek out evaluation/treatment and return for follow-up treatment. A primary challenge with the OIF/OEF population is getting new veterans to present for treatment, to accept treatment, and to continue for the duration of treatment.

While the therapies of choice in the PTSD Program are CPT and PE, this does not preclude a role for adjunctive supportive therapy, interpersonal therapy, spiritual counseling with a member of Chaplaincy service or other interventions. In turn, CPT and PE can benefit and are appropriate evidence-based therapies for other service era veterans.

Access to Evidence-Based Therapy.

Essential to the complainant's allegation is whether there is adequate staffing to provide treatment programming and/or therapy for those OIF/OEF veterans who desire to pursue individual evidence-based therapy. We attempted to address this question from quantitative and qualitative perspectives.

From a quantitative standpoint, we were unable to thoroughly assess the adequacy of staff time for clinical care because of inadequate data. Several reports were supplied to us by the Psychology, Psychiatry, and Social Work Services. We identified multiple problems with the reports, including duplicate patient names and names of patients who had moved out of the area. For example, we were given data on the number of unique patient visits and total encounters for the PCT and the PTSD Program, but the data combined individual psychotherapy and pharmacology visits and did not distinguish between the PCT and the PTSD Program.

Another data query compiled a list of OIF/OEF veterans enrolled in care who have been diagnosed with PTSD. The original query listed 1,186 patients newly diagnosed between March 2003 and March 2008. When those who had moved out of the area were removed, the number decreased to 1,010 patients. An initial query indicated that 68 percent (689/1,010) had received treatment for PTSD. However, when the data was analyzed with other mental health clinics included (for example, anxiety disorders), the percent increased to 82 percent (833/1,010). It was later determined that the 1,010 patients included those diagnosed with PTSD in primary care, which could include for example, patients with mild symptoms who were being treated in the primary care setting or who had declined mental health referral. In addition, the data system does not distinguish Gulf War I veterans from OIF/OEF veterans and combines both under one category. Furthermore, the current data system treats each provider (several of whom provide care at multiple sites) as a separate clinic which further complicates tracking of patients seen by the PTSD Program. Finally, the data could not account for patient preference. For example, if a patient on the list had two group therapy visits to the PTSD Program, one could not know whether the patient preferred individual therapy but did not receive it because it was not available or if the patient preferred group therapy.

It would be inappropriate to make conclusions about staff resource needs based on such inaccurate information. Data gathered by managers from non-patient record systems appeared capable of providing VASDHS mental health leaders with information relevant to performance measures but without sufficient patient tracking capability. In line with the recommendations from the Task Force on Returning Global War on Terror Heroes, VA is reportedly planning enhancements to the computerized patient record system (CPRS). Two planned initiatives are the development of a veteran tracking application and a specific OEF/OIF combat-veteran identifier.[11] In the meantime, the VASDHS should assign clear responsibility for centralized mental health data management. Mental health service chiefs should consider mechanisms by which to gather, organize, and analyze data to more meaningfully track utilization of PTSD treatment services in the PCT and the PTSD Program as the present methodology employed by VASDHS mental health appears insufficient.

Qualitatively, PCT therapists reported feeling overwhelmed due to increasing numbers and mental health needs of Vietnam and Korean War era veterans and reported that it was hard to see patients as often as they consider necessary. In the PTSD Program, one provider told us that sometimes some patients may be asked to attend the life skills group while waiting 2–4 weeks for an opening for individual therapy. Another provider reported that sometimes patients wait 1–2 weeks for individual therapy. A third provider reported that the program receives approximately 10 consults per week, has a high no show rate, and provides approximately 80 group and/or individual therapy patient visits per month. This provider reported that generally, the service is able to meet requests for

[11] Terri Tanielian, p.289–290.

individual therapy, but during some heavier consult periods, there is a need to offer fee basis or refer patients to the two area Vet Centers. We met with the San Diego Vet Center Director, a psychologist, who verified that the Vet Center has two therapists who provide prolonged exposure therapy. She reported that she has received seven referrals from the VASDHS since March 2008. Finally, a relatively new provider reported being pleasantly surprised by the lack of patients needing to wait for therapy.

Overall, in the absence of valid workload and productivity data, it appeared that generally, the PTSD Program is able to meet requests for group or individual evidence-based therapy. However, during times of higher volume, the demand exceeds the ability to provide individual therapy slots.

Recommendation 2. We recommend that the VISN Director require the VASDHS Director to ensure that all relevant data sources are identified, updated, and centrally coordinated to ensure that appropriate conclusions can be made about PTSD treatment effectiveness, efficiency, and resource requirements.

No Show Policy.

Veterans do not always report for scheduled care appointments (termed "no shows"). From June 2007 through January 2008, the VASDHS's OEF/OIF veterans' no show rate for PTSD services ranged from 18 to 50 percent. VASDHS policy defines a process for staff to contact these veterans and offer to reschedule the appointments. Internal audits showed that staff did not adhere to the expected process for follow-up contacts. Only 46 percent of no shows received any phone calls, and only 17 percent received the full series of contacts that the policy requires. In the absence of follow-up contacts, no one knows if these veterans have continuing needs for care or services. The follow-up contact policy should be enforced.

A provider raised the concern that the no show rate from the OIF/OEF PTSD Program may in part reflect the need for OIF/OEF veterans to be present at work or school during the day. Offering evening hours could potentially expand access to individual evidence-based therapy for these patients and help to meet their needs. Given the size of the VASDHS and the active duty and veteran population in the San Diego area, and the no show rate in the OIF/OEF PTSD Program, this idea warrants serious consideration by VASDHS leadership. The VASDHS should also consider using alternative treatment sites, such as local universities, to increase outreach and access for returning veterans who are attending college.

Recommendation 3. We recommend that the VISN Director require the VASDHS Director to ensure that follow-up patient contact procedures are consistently performed.

Recommendation 4. We recommend that the VASDHS Director ensures that VASDHS Mental Health Leadership takes action to enhance accessibility of evidence-based PTSD therapies to OIF/OEF patients.

Issue 3: OEF/OIF Case Management

VHA requires that each returning combat veteran seeking treatment at a VA facility be assigned a case manager and that an adequate number of case managers be designated based on the workload. A VHA handbook states that the standard caseload should be 25–30 patients per case manager.[12] At the time of our review, 260 OEF/OIF veterans were identified as needing case management, and the OEF/OIF Care Management Program had only three case managers. The Chief of Social Work Service had submitted a plan to increase case managers. During our first site visit, we suggested that this plan receive immediate consideration. Subsequently, the VASDHS has begun recruiting for seven additional case manager positions. Therefore, we are not making a recommendation in this area.

Issue 4: Prioritization of Clinical Care Versus Research

The complainant alleged that research has been given inappropriate priority over clinical PTSD care. VHA's mission includes clinical care, teaching, and research, and there is an expectation that all three may be achieved concurrently. It is also expected that neither teaching nor research should be allowed to detract from clinical care, which is the foremost priority. The VASDHS is a large system with a historically strong university affiliation and a tradition of joint clinical faculty appointment and collaborative research, which along with the opportunity to serve veterans, helps attract clinical talent to careers at the VASDHS. The presence of an academic and research relationship may also facilitate the opportunity for some veterans to avail themselves of innovative treatments (for example, virtual reality therapy for PTSD) that may prove beneficial to the individual veteran and ultimately to other veterans.

We substantiated that some staff members who are in clinical leadership positions in the PCT and PTSD Program spend a majority of their time doing research. In addition, we validated the assertion that some staff members initially assigned substantial clinical work subsequently had changes in their responsibilities, and newly hired staff members or trainees had subsequently been assigned to take over or fill in for some of their clinical duties.

The appropriate mix of clinical, research, and/or administrative responsibilities depends on multiple factors, including trends in access and utilization, adjustment to the patients' clinical needs, patients' preferences, the number of available providers, and the mix of

[12] VHA Handbook 1010.01, *Transition Assistance and Case Management of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) Veterans*, May 31, 2007, p. 5.

provider abilities. Although the VASDHS is clearly a major participant in research, we were unable to make a conclusion as to the presence or absence of a hierarchical preference toward research in the PCT and OIF/OEF PTSD Program. Due to unreliable, inadequate, incomplete, or conflicting patient tracking and utilization data (as discussed in Issue 2), we did not find objective data to suggest that patients were being denied access to evidence-based therapies for PTSD as a result of competing priorities.

Office Space.

The complainant alleged that office space is preferentially allocated in both the MVCBOC and the La Jolla site to researchers over clinicians. Managers at the MVBOC told us that available office space is at a premium. Allocation of office space is an internal management issue for which we make no recommendation.

Conclusions

The substantial presence of a clinician-administrator at the MVCBOC is needed to provide overall coordination and leadership for PTSD treatment at all VASDHS sites. Considerable efforts are needed to improve database management used to track patients with PTSD so that data-driven decisions can be made regarding treatment options and resource requirements. VASDHS Mental Health Leadership should take action to enhance accessibility of evidence-based PTSD therapy to OIF/OEF patients.

Recommendations

Recommendation 1. We recommend that the VISN Director require the VASDHS Director to designate a clinician-administrator fully committed and substantially present to provide overall program direction and leadership for both the PCT and PTSD Program.

Recommendation 2. We recommend that the VISN Director require the VASDHS Director to ensure that all relevant data sources are identified, updated, and centrally coordinated to ensure that appropriate conclusions can be made about PTSD treatment effectiveness, efficiency, and resource requirements.

Recommendation 3. We recommend that the VISN Director require the VASDHS Director to ensure that follow-up patient contact procedures are consistently performed.

Recommendation 4. We recommend that the VASDHS Director ensures that VASDHS Mental Health Leadership takes action to enhance accessibility of evidence-based PTSD therapies to OIF/OEF patients.

Comments

The VISN 22 Director concurred with the findings and recommendations and submitted acceptable action plans, which include designating a full-time Medical Director as the lead clinician-administrator for PTSD services, establishing a PTSD Coordinating Committee responsible for tracking data, strengthening the no show follow-up process, and increasing access by ensuring same day clinical care availability and by hiring additional staff. We find the action plans acceptable and will follow up until the plans have been implemented.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Appendix A

List of Mental Health Services and Programs

Medical Center at La Jolla

OIF/OEF Care Management	Primary Care Post-Deployment Clinic
"Seeking Safety" Program	Spinal Cord Injury Psychology Service
Anxiety Disorders Clinic	General Mental Health Clinic
Traumatic Brain Injury Assessment	Alcohol and Drug Treatment Program
Acute General Psychiatry Inpatient Unit	Geriatric Psychiatry Program
Behavioral Medicine Service	Cognitive Disorders Clinic
Cognitive and Behavioral Interventions Program	Chaplaincy Program-Acute Inpatient Unit
Family Mental Health Program	Psychiatric Primary Care Program
Mental Health Intensive Case Management	Mental Health Services Tobacco Use Cessation
Mood Disorders Clinic	Neuropsychological Assessment
Schizophrenic Psychosocial Rehabilitation Program	Special Assessment Intervention and Liaison Program
Sleep Disorders Clinic	Women and Depression Clinic
Substance Abuse/Mental Illness Program	Special Treatment and Evaluation Program-Mood
Psychiatric Emergency Clinic	Suicide Prevention Program

Mission Valley CBOC

PCT	OIF/OEF Care Management
PTSD Program	OIF/OEF General Mental Health Clinic
Anxiety Disorders Clinic	Military Sexual Trauma
Chaplaincy Program–Post-Traumatic Stress Disorder	Wellness and Vocational Enrichment Clinic
Mental Health Clinic	Health Care for Homeless Veterans
Behavioral Medicine Service	

Chula Vista CBOC

PCT	Alcohol and Drug Treatment Program
PTSD Program	OIF/OEF General Mental Health
Telemental Health	Mental Health Clinic

North County CBOCs (Vista and Escondido)

PCT	Alcohol and Drug Treatment Program
PTSD Program	OIF/OEF General Mental Health
Military Sexual Trauma	Mental Health Clinic

Brawley CBOC

Telemental Health	

Appendix B

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 1, 2008

From: VISN 22 Director (10N22)

Subject: **Healthcare Inspection – Post-Traumatic Stress Disorder Program Issues, VA San Diego Healthcare System, San Diego, California**

To: Director, OHI Los Angeles Regional Office (54LA)

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

OVERVIEW

VA San Diego is pleased to respond to the review and recommendations of the Office of Inspector General following their recent Healthcare Inspection of programs for treatment of post-traumatic stress disorder (PTSD), conducted March 13–18, 2008 and June 9–11, 2008. Strengths of the programs offered by VA San Diego Healthcare System (VASDHS) included a broad variety of specialty care; an emphasis on empirically-based therapies, along with access to traditional adjunctive therapies, including spiritual care; delivery of therapy by highly qualified professionals; close coordination with the Vet Center; and a historically strong affiliation which helps attract clinical talent to careers at VA San Diego. Nevertheless, the inspection also revealed limitations, and made specific recommendations to improve our programs. We concur with these recommendations, as described in the responses below.

OIG RECOMMENDATIONS

Recommendation 1. *We recommend that the VISN Director require the VASDHS Director to designate a clinician-administrator fully committed and substantially present to provide overall program direction and leadership for both the PCT and PTSD Program.*

Response: We concur. Staffing shortfalls have prevented our establishing the fully-committed, on-site leadership team essential to successful programs. With recent hires we now can deploy such clinician-administrators. We have had success with multidisciplinary programs (of the type employed in PTSD) by using a joint program leadership system consisting of a Medical Director (a psychiatrist) and a Program Director (a psychologist) with specialty competence. We intend to use this system to staff the leadership of PTSD services. The leadership team will consist of an essentially full-time Medical Director (psychiatrist) as the lead medical clinician administrator for PTSD services (OIF/OEF and PCT) for day-to-day operations who is joined by a full time Program Director psychologist. This psychiatrist will also be the psychiatrist team member for the PCT unit; another essentially full time psychiatrist will be the psychiatrist for the OIF/OEF PTSD team. Thus, both PCT and OIF/OEF teams will be separately staffed by full time or nearly full time nurses, social workers, psychiatrists, and psychologists.

Recommendation 2. *We recommend that the VISN Director require the VASDHS Director to ensure that all relevant data sources are identified, updated, and centrally coordinated to ensure that appropriate conclusions can be made about PTSD treatment effectiveness, efficiency, and resource requirements.*

Response: We concur. To address this recommendation, the MH service chiefs propose establishing a PTSD Coordinating Committee composed of the overall medical director for PTSD services, the clinical directors for the PCT and OEF/OIF clinics, and the Program Coordinator for the Mission Valley Mental Health Clinical Services. Using the expert resources identified below, this Committee will be responsible for establishing a system for tracking the requested data for each clinic in a standardized format, and reporting on a monthly basis the following data to the VA San Diego Mental Health and Behavioral Sciences Executive Committee (MHBS).

1) Number of requests for services received

2) Disposition of treatment requests

Number and percentage seen in clinic
Number and percentage referred to other services
Number and percentage who no-showed services
Number and percentage that refused services
Number and percentage not receiving services for other reasons

3) For those veterans seen in the clinics

Time to initial intake
Time to initial treatment
Number and percentage of new veterans receiving evidence-based psychotherapy
Number and percentage completing evidence-based psychotherapy
Number and percentage discontinuing treatment
Disposition of those who discontinued treatment

An example of the data (specifically from the OIF/OEF PTSD clinic) is provided below.

Example: Data tracking of patients referred to OIF/OEF clinic 10/07–6/08 (current fiscal year to date): 321
Number enrolled in therapy in OIF/OEF Program: 148 (46%)

Of those enrolled in therapy in OIF/OEF Program (all individual and group treatments are evidence-based, recovery oriented):

	Completed therapy (planned termination or ≥70% group sessions attended)	**Current**	**Did not complete** (voluntary discontinuation, moved, receiving other VA services,)	**Total**
Individual	29	20	24	66 (45%)
Groups[a]	21	26	35	82 (55%)
Totals	**50 (34%)**	**39 (26%)**	**59 (40%)**	**148**

[a]Groups include CBT skills group (since 10/2007), Wednesday evening Seeking Strength group (began 10/2007), and Cognitive Processing Therapy group (began 02/2008).

Dispositions of the 173 who were not enrolled in therapy in the OIF/OEF clinic were:

1) Completed intake, scheduled for treatment; no showed and did not respond to follow-up calls (42; 24.3%)
2) Other VA clinical services (Military Sexual Trauma program, family therapy, Vista CBOC, La Jolla Mood program, etc.; 38; 22%)
3) Vet Center (35; 20.2%)
4) Did not respond to calls to schedule intake; never seen (22; 12.7%)
5) Referred but later refused treatment (25; 14.5%)
6) Moved to new city (5; 2.9%)

7) Fee basis (4; 2.3%)
8) Referred to free community services (1; .6%)
9) In jail (1; .6%)

On a quarterly basis, the PTSD Coordinating Committee will report to the MHBS on program functioning, and any changes occasioned by these or other relevant data and experience. The MHBS, which is composed of the Chiefs of Chaplains, Nursing, Psychiatry, Psychology, and Social Work Services, will review these data, and programmatic recommendations, as part of its oversight function. The MHBS will take these reports into consideration in proposing requests for clinical staffing or space resources to the VA San Diego Executive Leadership Team.

To ensure that data capture is efficient and accurate, the PTSD Coordinating Committee members will meet with appropriate VISN 22 and VA San Diego administrative staff to establish a standardized procedure for data tracking. Resources to be used in establishing a systemic approach to data collection and analysis will be the VISN 22 Data Warehouse, VA San Diego Patient Care Services analysts, and the VA San Diego Clinical Applications Unit. Furthermore the Coordinating Committee will consult with the VA Greater Los Angeles (GLA) and VA San Diego Mental Illness Research and Clinical Care Centers (MIRECCs), which have expertise in establishing data management systems, analyzing, and interpreting these kinds of data for clinical program development. Given the unique, interactive nature of this approach, we expect the results to be of general interest to VISN 22 leadership in planning for access, staffing, and delivery of PTSD services.

Recommendation 3. *We recommend that the VISN Director require the VASDHS Director to ensure that follow-up patient contact procedures are consistently performed.*

Response: We concur that more rigorous and systematic adherence to the policy guiding follow-up patient contact is essential to effective and efficient care. The Psychiatric Service Administrative Officer will assume overall responsibility for educating clinician and administrative staff on patient contact procedures, monitoring performance, and providing feedback to individual clinicians and staff on performance. The action plan will utilize an iterative process of training, or re-training as needed on the importance and rationale of follow-up contacts; establishment of individual and service-specific goals (> 92% contacts attempted); and quarterly individual feedback. Results will be submitted to the PTSD program leadership, the Mental Health and Behavioral Sciences Executive Committee, and the Service Chief of the individual staff and clinician.

Recommendation 4. *We recommend that the VASDHS Director ensures that VASDHS Mental Health Leadership takes action to enhance accessibility of evidence-based PTSD therapies to OIF/OEF patients.*

Response: We concur with the recommendation that we enhance access to PTSD services. We intend to do so using three approaches. First, we will implement a structural change in service delivery to ensure 'same day' access to mental health services for all patients seeking such care. This structural change is based upon principles enunciated in the first VA Mental Health Collaborative Care Systems Redesign Conference, held in Dallas, Texas, May 19–22, 2008. VA San Diego Chief of Staff, and Chiefs of Psychiatry and Psychology attended this meeting. We set the goals of providing same day access to 75% of all patients seeking such care by January 1, 2009, and to 100% of patients by July 1, 2009. Two VA San Diego Teams have been established to implement an action plan, one at the Medical Center and one at Mission Valley CBOC. The Chief of Psychiatry, supported by the Chiefs of Psychology and Social Work, leads the Medical Center Team; the Mission Valley Team is led by the Chief of Psychology, supported by the Chiefs of Psychiatry and Social Work. Key clinical and administrative personnel have been appointed to these teams; an analysis of patient demand and clinician supply is underway, utilizing Advanced Access to Care and Mental Health Collaborative principles. To gain experience in implementation of same day access, a pilot program has been launched at the Medical Center, where approximately 10-15 patients with same day requests have been seen weekly. The promised results of same day access are improved access, enhanced efficiency, lower no-show rates.

Secondly, as noted by the inspection, we concur with the need to expand services on weekends and evenings. We now offer individual and group treatment one evening per week at the Medical Center, and one evening per week at one CBOC (Chula Vista). We anticipate expanding this in the near future (by September 30, 2008) by adding an additional 12 hours of psychiatrist time (4 hours for evenings, and 8 hours for weekends). This latter staffing should improve general access to care. As suggested, we will seriously consider expanding access specifically to empirically based care on weekends and evenings, as indicated, based on our forthcoming demand and supply analyses.

Thirdly, in response to this recommendation, we already are continuing to hire new staff to fill both vacant positions as well as newly funded positions in several disciplines. In regards to Psychology staffing, VA Central Office has recently allocated one (1) FTE position for a psychologist to provide

dual diagnosis PTSD and substance abuse treatment, and this position will be assigned to the OIF/OEF PTSD clinic. With the support of VASDHS leadership, in the last year we have hired additional psychologists to provide psychotherapy services in North County San Diego and Mission Valley CBOC, Family Mental Health Services, and Traumatic Brain Injury services. While these services are not all directly PTSD related, they are all in support of OIF/OEF veterans, relieving the burden on the OIF/OEF PTSD clinic to meet multiple needs. All staff are trained in and providing evidence-based assessment and treatment for veterans. In fact the OIF/OEF repertoire of behavioral interventions includes only evidence-based psychotherapy services. The presence of additional psychiatry staff described below also reduces the need for psychology and social work to complete intakes, and should mean more availability of evidence-based psychotherapy in the upcoming year.

Psychiatry staffing is also enhanced. In calendar year 2008, we have hired two essentially full-time psychiatrists recently discharged from military service, both of whom have extensive experience with PTSD in general and OIF/OEF in particular. One of these psychiatrists will staff the PCT team; the other will staff the OIF/OEF PTSD team. Additionally we have hired two 50% time psychiatrists with extensive PTSD experience, and have in process the hiring by September 30, 2008, of another 2.6 FTE psychiatrists, all of whom will be assigned to Mission Valley CBOC. Recruiting for other positions is ongoing.

As noted in the Healthcare Inspection, Social Work Service staffing is being increased by seven full-time case managers. It is agreed that all will be trained in Motivational Interviewing techniques and that three will be trained in other empirically supported interventions (CBT, CPT, Seeking Safety/Strength, etc.) and allocate a portion of their time to therapy services in conjunction with their case management responsibilities.

Finally, please note that the San Diego Center of Excellence for Stress and Mental Health has developed specific training programs and opportunities for empirically supported behavioral interventions. Current and planned training sessions include Cognitive Processing Therapy, Seeking Strength, and Cognitive Behavior Therapy. The Mental Health and Behavioral Sciences Executive Committee will be responsible for ensuring that all psychotherapy providers are trained in these forms of treatment.

2. If you have any questions or need further information, please contact John Tryboski, Quality Management Officer, at (562) 826-5963.

(original signed by:)
Ronald B. Norby

cc: Director, Management Review Service (10B5)
Office of Management and Administration, Operational Support Division (53B)
Director, VA San Diego Healthcare System (664/00)

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Michael Shepherd, MD (202) 461-4660
Acknowledgment	Julie Watrous, Healthcare Inspector

Appendix D

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, Veterans Integrated Service Network (10N22)
Director, VA San Diego Healthcare System (664/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. House of Representatives: Bob Filner

This report is available at http://www.va.gov/oig/publications/reports-list.asp.