



Department of Veterans Affairs Office of Inspector General

Healthcare Inspection

Allegations of Mental Health Diagnosis Irregularities at the Olin E. Teague VA Medical Center Temple, Texas

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Executive Summary

Introduction

VA's Office of Inspector General (OIG) reviewed allegations regarding a March 20, 2008, e-mail written by a staff psychologist of the Central Texas VA Healthcare System (CTVAHCS). This e-mail to colleagues was obtained by local and national media and widely disseminated. The e-mail was broadly interpreted as advocating that for veterans being seen at CTVAHCS by its post-traumatic stress disorder (PTSD) Clinical Team (PCT), a diagnosis of "adjustment disorder" be made over other psychiatric diagnoses, particularly PTSD.

On June 4, 2008, the Senate Veterans' Affairs Committee (SVAC) addressed these issues in an open hearing. At this hearing, numerous concerns were raised, including many about the controversial e-mail itself, as well as the diagnosis, treatment, and compensation of veterans with PTSD. Concerns were expressed about veterans' mental health care in general and particularly as it pertained to veterans returning from the hostilities in Iraq and Afghanistan. The SVAC further focused on the e-mail itself as it applied to CTVAHCS and whether there was a VA-wide policy that encouraged the diagnosis of "adjustment disorder" when the more appropriate and compensable clinical diagnosis should have been PTSD.

Additionally, in conjunction with the controversial e-mail cited above, OIG received written allegations via its hotline that the Olin E. Teague VA Medical Center (VAMC) in Temple, Texas (OETVAMC, usually referred to in this report as Temple VAMC) was no longer offering PTSD support groups. The Secretary of Veterans Affairs and Members of Congress also requested that the OIG address issues raised by the e-mail and questions relating to PTSD support groups.

Results

We found that the e-mail in question was written by the clinical psychologist who headed the Temple VAMC PCT clinic; the psychologist authored the message without input or direction from supervisors. The e-mail was an interoffice communication written to PCT staff only; it employed professional jargon, and it was not intended for general distribution. Our interviews of all e-mail recipients revealed no consistent perception that the e-mail suggested to them that inappropriate diagnoses should be rendered.

Allegations surrounding the e-mail message suggested the diagnosis of adjustment disorder would be more frequently applied after the message was sent. We found that patient encounters were coded as adjustment disorder at a similar rate both before and after the e-mail message. We also found that the number of PCT encounters with a code

of adjustment disorder was consistently small compared with the total number of PCT encounters.

We reviewed electronic medical records of all patients seen in the PCT clinic for whom encounters were coded as an adjustment disorder during the period February 20, 2008, through April 19, 2008 (a total of 68 patients). It was apparent from our review that both prior to and following the March 20 e-mail, a diagnosis of adjustment disorder on any given day did not preclude other diagnoses, including PTSD on the occasion of another PCT visit with another PCT clinician. Not only could different clinicians give different diagnoses, but the same clinician might give different diagnoses on different visits. Moreover, we found that a patient diagnosed with adjustment disorder could well be receiving benefits for PTSD or in some cases for chronic adjustment disorder. In our review of these patients' records, we found no discernible change in the appropriateness of diagnoses occurring before and after the e-mail.

Of the 68 patients whose medical records were reviewed, 29 underwent compensation and pension (C&P) examination for mental health related conditions. Twenty-six had their C&P examination at CTVAHCS and 3 had examinations elsewhere. Five of the 26 CTVAHCS examinations were performed by 2 clinicians who were recipients of the e-mail, while the rest were performed by clinicians who do not work in PCT clinic and did not receive the e-mail. Only 1 of the examinations by an e-mail recipient took place after March 20. Nineteen of the 26 (73 percent) patients who underwent C&P examination at the CTVAHCS received a service-connected disability rating for a mental health diagnosis. Thirteen of these 19 veterans were service-connected for PTSD, 4 for chronic adjustment disorder, one for "neurosis," and one for generalized anxiety disorder and neurosis. The 3 patients who underwent C&P examinations outside of CTVAHCS all received service-connected disability ratings: one for major depressive disorder, one for PTSD, and one for chronic adjustment disorder. For both PCT clinic and C&P examination diagnoses, we observed no pattern in temporal relation to the e-mail.

With regard to the aftercare groups, we substantiated that they were either disbanded or moved to the Harker Heights Vet Center.

Conclusions

The e-mail message which prompted this review was an interoffice communication from one individual to one clinic team. It was not intended for general distribution. Our interviews with all recipients of the message revealed no consistent perception that inappropriate diagnoses should be rendered. The e-mail was written on the author's initiative, without direct or indirect instruction from local, regional, or national VA leadership.

PCT clinic patient encounters were coded as adjustment disorders at similar rates both before and after the e-mail message.

There was no discernible change in the appropriateness of diagnoses occurring before and after the e-mail.

Comments

We made no recommendations. The Director of Veterans Integrated Service Network (VISN) 17 and the Acting Director of the Olin E. Teague VA Medical Center in Temple, Texas, concurred with the findings of the report.

(original signed by:)

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

Part I. Introduction

Purpose

VA's Office of Inspector General (OIG) Office of Healthcare Inspections (OHI) reviewed allegations regarding a March 20, 2008, e-mail written by a staff psychologist of the Central Texas VA Healthcare System (CTVAHCS). This e-mail to colleagues was obtained by local and national media and widely disseminated. The e-mail was broadly interpreted as advocating that for veterans being seen at CTVAHCS by its post-traumatic stress disorder (PTSD) Clinical Team (PCT), a diagnosis of "adjustment disorder" be made over other psychiatric diagnoses, particularly PTSD. The e-mail also raised numerous related issues regarding VA's diagnosis, treatment, and compensation of veterans with mental health conditions such as PTSD.

On June 4, 2008, the Senate Veterans' Affairs Committee (SVAC) addressed these issues in an open hearing. At this hearing, numerous concerns were raised, including many about the controversial e-mail itself, as well as the diagnosis, treatment, and compensation of veterans with PTSD. Concerns were expressed about veterans' mental health care in general and particularly as it pertained to veterans returning from the hostilities in Iraq and Afghanistan. The SVAC further focused on the e-mail itself as it applied to CTVAHCS and whether there was a VA-wide policy that encouraged the diagnosis of "adjustment disorder" when the more appropriate and compensable clinical diagnosis should have been PTSD.

Additionally, in conjunction with the controversial e-mail cited above, OIG received written allegations via its hotline that the Olin E. Teague VA Medical Center VAMC in Temple, Texas (OETVAMC, usually referred to in this report as Temple VAMC or Temple, for ease of reading) was no longer offering PTSD support groups. The Secretary of Veterans Affairs and Members of Congress also requested that the OIG address issues raised by the e-mail and questions relating to PTSD support groups.

Background

A. The E-Mail

On March 20, 2008, a psychologist at the Temple branch of the CTVAHCS sent an e-mail at 11:08 in the morning to eight colleagues. The psychologist, who had been designated team leader of the PCT clinic for administrative purposes but had no direct supervisory authority over any of the e-mail's recipients, had completed all appropriate

training, and was unlicensed¹ pending successful completion of a licensure examination. The e-mail was entitled “Suggestion” and read in full:

Given that we are having more and more compensation seeking veterans, I’d like to suggest that you refrain from giving a diagnosis of PTSD straight out. Consider a diagnosis of Adjustment Disorder, R/O [rule out] PTSD.

Additionally, we really don’t or have time [sic] to do the extensive testing that should be done to determine PTSD.

Also, there have been some incidence [sic] where the veteran has a C&P [compensation and pension exam], is not given a diagnosis of PTSD, then the veterans [sic] comes here and we give the diagnosis, and the veteran appeals his case based on our assessment.

This is just a suggestion for the reasons listed above.

In May 2008 this e-mail was widely circulated in the media. Congressional concerns were forwarded to VA’s OIG requesting an immediate review of the following:

- The suggestion that diagnoses of PTSD should be avoided due to cost and time considerations.
- Diagnosis patterns of PTSD at the CTVAHCS.
- CTVAHCS guidelines for the diagnosis and treatment of PTSD.
- Benefit decisions based on the C&P exams performed at the CTVAHCS for any irregularities.

B. CTVAHCS

The CTVAHCS is part of Veterans Integrated Service Network (VISN) 17, serving 39 counties in Texas in five congressional districts. It consists of two VA medical centers (VAMCs): OETVAMC located in Temple and the Waco VAMC. Additionally, CTVAHCS provides health care and social services to veterans at the Austin Outpatient Clinic (OPC), and the Brownwood, College Station, Palestine, and Cedar Park

¹ To license a psychologist for independent practice, the State of Texas requires a doctorate degree in psychology, passage of an oral examination, and 2 years of supervised experience. Many states require 2 years of supervised experience for independent licensure; VA standards are therefore designed to permit this. Specifically, VHA qualification standards require a doctoral degree in psychology from a graduate program in psychology accredited by the American Psychological Association (APA) and the successful completion of a psychology internship program which has also been accredited by APA. In addition, a psychologist must hold “a full, current, and unrestricted license to practice at the doctoral level in a State...of the United States.... The Secretary may waive the requirement...for a period not to exceed 2 years...on the condition that such a psychologist provide care only under the supervision of a psychologist who is so licensed.” Recent increases in staffing in mental health means that many young professionals have been hired in VHA; frequently they have had extensive training in evidence-based treatment methods, although they have not yet completed 2 years of supervised experience.

Community Based Outpatient Clinics (CBOCs). CTVAHCS, along with the VA North Texas Health Care System and the South Texas Veterans Health Care System, combine to comprise VISN 17, the VA Heart of Texas Healthcare Network.

According to its Fiscal Year 2007 (FY2007) Annual Report, the CTVAHCS serves 238,349 veterans, with 757 inpatient beds and the five outpatient facilities noted above. In FY2007, CTVAHCS had 829,011 outpatient visits and 7,847 inpatients were treated. The CTVAHCS has 2,646 full-time employees.

The Temple VAMC is a tertiary care facility. It provides primary care, specialty care, and long-term care in key medical specialties including internal medicine and its subspecialties, neurology, surgery, psychiatry, rehabilitative medicine, dentistry, geriatrics, and extended care. The Waco VAMC is a mental health hospital that provides acute inpatient psychiatric care and long term psychogeriatric care, as well as outpatient mental health care.

The CTVAHCS's primary academic affiliation is with Texas A&M University's College of Medicine. A second medical school affiliation exists with the University of Texas Medical Branch in Galveston.

C. CTVAHCS Mental Health Services

Mental health services at the Temple VAMC include:

- PCT clinic.
- Outpatient substance abuse treatment program.
- General mental health clinic.
- Consult-liaison service to the medical and surgical services.
- Domiciliary program (including an 8-bed Women's Trauma Recovery Center and the Health Maintenance Program).
- Compensated work therapy transitional residence for patients with serious mental illness, dual diagnoses, and/or in the process of transitioning from the domiciliary program.

At the Waco campus, mental health services include:

- PCT clinic.
- Outpatient substance abuse treatment program.
- General mental health clinic.
- Outpatient Psychosocial Rehabilitation recovery center for patients with serious mental illness.
- Sixty-six inpatient beds on locked units.
- A 40-bed PTSD residential program.

- A 44-bed residential program for patients with serious mental illness.

The Austin campus is a stand-alone clinic. Mental health services available at the Austin OPC include a general mental health clinic, a PCT clinic, substance abuse treatment, and the Mental Health Intensive Case Management program.

Mental health services are also available at CBOCs in Brownwood, Cedar Park, Bryan-College Station, and Palestine.

D. Compensation and Pension

Veterans Benefits Administration's (VBA's) Compensation and Pension (C&P) process is distinctly different from the clinical process of diagnosis, treatment, and long-term management of a mental health disorder. Nevertheless, there are potential areas of overlap between the clinical care provided by Veterans Health Administration (VHA) and VBA's C&P process. For example, since VA records are electronic, VBA staff performing C&P examinations are able to review VHA clinician notes. In turn, VHA caregivers are able to review the often detailed C&P examinations.

When a veteran submits a C&P request to the VA Regional Office (VARO), a VBA case manager in Waco assembles a claim file. The veteran is asked what conditions he or she thinks might be service-connected. The C&P Office at the Temple VAMC is then contacted by the VBA case manager who requests performance of a C&P examination. Multiple examinations may be requested for one patient, and the VARO will indicate what examinations are needed for a patient and in what time frame. For mental health related issues, the C&P office then schedules the patient into a specific C&P time slot with a clinician who will perform the evaluation; provider assignment is largely carried out on a rotating basis.

After completing the evaluation, the examiner writes a report which is sent to the C&P office at Temple and then to the VARO. A rating, expressed as a percentage of service-connected disability, is determined at and by the VARO in Waco. A determination letter is subsequently sent from VBA to the veteran. Disability ratings of a given percentage result in identical disability payments regardless of the condition for which the rating is made. At the present time VBA uses a single set of evaluation criteria for all mental disorders, whatever their category, for example, whether schizophrenia, PTSD, depression, or adjustment disorder. One hundred percent service-connected ratings are possible for individuals considered to have either PTSD or adjustment disorder (see following section).

In an evaluation for PTSD, the clinician is required to comment on the presence or absence of the condition, the presence of a stressor(s), and whether and to what extent a connection exists between the stressor(s) and the condition.

The volume of C&P examinations relative to the number of providers available in the appropriate specialty can require clinicians to act both as a clinical provider and a C&P examiner. It is important to note that the relationship between an examining clinician and a patient differs greatly depending upon the purpose of the exam. A C&P exam is done to determine the presence or absence of diagnostic criteria specified by the VBA claims examining process; it has no therapeutic purpose. In contrast, for a treating clinician diagnostic assessments are intrinsically linked to treatment, and treatment is potentially compromised if a veteran questions the clinician's motivation. Therefore a mental health clinician who performs a patient's C&P examination ideally should not be the same clinician from whom this patient is receiving treatment. When a patient is scheduled for a C&P examination at Temple, staff reportedly checks the Compensation and Pension Record Interchange (CAPRI) system to make sure that the assigned clinician is not a patient's treating clinician, and if so, the patient with rare exceptions is usually scheduled with a different clinician.

The Temple Associate Chief of Staff for Mental Health initiated a review of 10 C&P examinations performed by the author of the subject e-mail during June 29, 2007–September 25, 2007, period. Separate assessments by a psychiatrist and a psychologist found the exams to be generally competent. It was noted, however, that documentation of the exams “failed to have a supervisor's co-signature as required for unlicensed staff.” The supervisor responsible for co-signing the exams received counseling for failure to co-sign these exams.

E. PTSD, Adjustment Disorders, and “R/O”

Reliable diagnosis is an integral step in formulating a mental health treatment plan. Performing a thorough history and mental status exam is the cornerstone of patient assessment. Collateral data sources may be needed to inform the diagnostic process. Information may come from family members, review of the electronic medical record including laboratory results, review of treatment records from non-VA facilities, neuroimaging tests, neuropsychiatric assessment, and further assessment of the patient on a subsequent visit.

Clinicians typically make a mental health diagnosis based upon a patient's clinical presentation, including history, symptoms, and signs. Diagnosis generally cannot be determined from laboratory or radiologic tests. *The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV) is a categorical approach to classification of mental disorders developed for use in clinical, educational, and research settings. DSM-IV is the most widely accepted system for classification of mental disorders. In DSM-IV, each mental disorder is “conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more areas of functioning) or with a significantly increased risk of suffering death, pain,

disability, or an important loss of freedom.”² In addition, this symptom pattern must not be merely a culturally sanctioned response to a particular event nor represent deviant behavior in an individual without a mental condition.

DSM-IV delineates specific clinical features that must be present or absent for a given diagnosis to be made. Limitations to a categorical approach to diagnosis include the reality that patients satisfying criteria for a given diagnosis may be heterogeneous (patients sharing a diagnosis are not identical in symptom presentation); diagnoses are not mutually exclusive, and symptoms may satisfy some of the criteria present in more than one diagnosis; each category of mental disorders is not “a discrete entity with absolute boundaries dividing it from other mental disorders or from no mental disorder...and boundary cases will be difficult to diagnose in any but a probabilistic fashion.”³

In DSM-IV, PTSD is classified as an anxiety disorder. When considering the diagnosis of PTSD, mental health clinicians must also evaluate the likelihood of other conditions, including adjustment disorder, other anxiety disorders, depression, and substance abuse related conditions.

DSM-IV criteria for diagnosis of PTSD require exposure to a traumatic event in which the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others and the person’s response involved intense fear, helplessness, or horror. In addition, the traumatic event must be persistently re-experienced in 1 or more of 5 ways delineated in the criteria. There must be persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by 3 (or more) of 7 symptoms listed in the criteria. Furthermore, there must be persistent symptoms of increased arousal (not present before the trauma) as indicated by 2 (or more) of 5 symptoms listed in the criteria. The duration of the symptoms must be more than 1 month and the disturbance must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. PTSD when present is specified as acute if the duration of symptoms is less than 3 months, chronic if present more than 3 months and with delayed onset if the symptoms began at least 6 months after exposure to the stressor.

In PTSD the stressor must be of an extreme nature. In contrast, an adjustment disorder can develop in response to a stressor of any severity. DSM-IV notes “the diagnosis of adjustment disorder is appropriate both for situations in which the response to an extreme stressor does not meet criteria for Post Traumatic Stress Disorder (or another specific mental disorder) and for situations in which the symptom pattern of Post Traumatic

² *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*. American Psychiatric Association. Washington, D.C. 1994. p. xxi.

³ *Ibid.* p. xxii.

Stress Disorder occurs in response to a stressor that is not extreme (e.g., spouse leaving, being fired).”⁴

Diagnostic criteria for adjustment disorder require the development of emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor(s). The symptoms or behaviors are clinically significant as evidenced by marked distress that is in excess of what would be expected from exposure to the stressor and/or significant impairment in social or occupational functioning. In addition, the stress-related disturbance must not meet criteria for another specific disorder or is not merely an exacerbation of a preexisting disorder. The symptoms should not represent bereavement. Once the stressor or its consequences have terminated, the symptoms should not persist for more than an additional 6 months.

An adjustment disorder is specified as acute if symptoms last less than 6 months and chronic if symptoms last 6 months or longer. DSM-IV states “by definition, symptoms cannot persist for more than 6 months after the termination of the stressor or its consequences. The chronic specifier therefore applies when the duration of the disturbance is longer than 6 months in response to a chronic stressor or to a stressor that has enduring consequences.”⁵

When information is not sufficient to formulate an initial or definitive diagnosis, a clinician may defer diagnosis or specify a diagnosis as provisional. In some situations when presenting symptoms meet several but not full criteria for a DSM-IV diagnosis within a category (e.g., anxiety disorders) and/or diagnosis is uncertain, a not otherwise specified (NOS) diagnosis may be used by a clinician (e.g., anxiety disorder NOS).

At times, clinicians as a documentation convention will use the nomenclature “rule out” (or the acronym R/O) to document diagnostic uncertainty or a hierarchical flow of their diagnostic thought process. For example, when a patient presents to the emergency room with abdominal discomfort and vomiting, a physician might record “gastroenteritis, R/O appendicitis” when he or she is considering several diagnoses. The physician believes viral gastroenteritis to be the most likely but is also concerned about the worrisome possibility of appendicitis. In this case, the physician may undertake specific diagnostic tests and/or admit the patient for a period of observation to diagnose or to reasonably exclude the possibility of appendicitis. Ultimately, as diagnoses become clearer, the clinician moves from a “rule out” diagnosis to a definitive diagnosis.

F. Temple VAMC PTSD Clinical Team

At the Temple VAMC, a patient with PTSD symptoms may be referred for a mental health intake through various routes including referral from the emergency room, from a

⁴ *Ibid.* p. 427.

⁵ *Ibid.* p. 624.

primary care provider after evaluation or because of a positive PTSD screen, from a mental health provider integrated in a primary care clinic, or from a clinician in another mental health clinic at the VAMC. Patients referred from primary care or the emergency room would typically be scheduled for an evaluation by a provider in the general mental health outpatient clinic. Patients referred from a mental health provider integrated in primary care or from another mental health clinic would generally bypass this step and would be scheduled for an intake at the PCT clinic.

After the mental health service intake, patients diagnosed with a stress related disorder would then be scheduled for a focused intake evaluation at PCT clinic. After PCT intake, some patients would be clinically diagnosed with PTSD. Others may receive a provisional diagnosis, a rule out diagnosis, or an anxiety disorder not otherwise specified diagnosis indicating diagnostic uncertainty at that point in the treatment process. Some patients may have a non-PTSD stress related condition such as adjustment disorder with anxious and depressed mood. Still other patients may be diagnosed with a non-stress related condition, like panic disorder or bipolar disorder, and may be scheduled for further follow-up at an appropriate non-PCT clinic.

Patients with a stress related condition are offered group or individual therapy and appointments for medication management. Initially, many patients are referred to the Coping Skills Group at Temple. Following Coping Skills Group, some patients may be referred for and/or opt to pursue Cognitive Processing Therapy (CPT) in a group format depending on clinical presentation and circumstance. Some patients for whom the group setting would be a poor fit are placed on a waiting list to be seen for individual therapy, which can be for individual CPT or another form of individual cognitive-behavioral therapy. Patients in crisis with more immediate need for treatment are reportedly not placed on the waiting list but are worked in as soon as possible.

Some patients may be referred for and/or opt to pursue individual Prolonged Exposure Therapy (PE). At present only one clinician at the Temple VAMC is trained in PE. Patients for whom PE would be appropriate and who can tolerate intensive exposure therapy are placed on a waiting list. Most patients seen at the Temple PCT clinic receive some form of group therapy although individual therapy is available within the constraints noted above.

Patients who desire supportive therapy at any point in treatment at the PCT clinic would be referred for counseling at the Veterans Readjustment Counseling Center (Vet Center).

Scope and Methodology

In order to address the extensive issues raised by the case e-mail, OHI inspectors made multiple site visits both to Temple, as well as its sister VAMC in Waco. We also visited the Austin VAOPC, three of the CTVAHCS's CBOCs (Brownwood, Bryan/College

Station, and Palestine) and two of CTVAHCS's associated Vet Centers in Austin and Killeen Heights.

OHI interviewed CTVAHCS staff including the author of the e-mail as well as its eight recipients. We interviewed relevant management officials including the individual who was the supervisor of the e-mail's author on March 20 when the e-mail was written. We also interviewed the current PCT Team Leader; the current Chief, Psychology Service, who supervises the PCT Team Leader; and the CTVAHCS Associate Chief of Staff for the Mental Health Care Line.

In order to further examine whether one interpretation of the e-mail—that veterans with PTSD should not be given that diagnosis, with the diagnosis of adjustment disorder substituted—as well as to determine if such an interpretation was reflective of policy, we interviewed senior VHA management officials overseeing the CTVAHCS's Mental Health Care Line including the CTVAHCS Chief of Staff, the Medical Center Director, and the VISN Director.

Data were extracted from the National Patient Care Database and from Temple VISTA⁶ files. We identified all Temple VAMC PCT patient encounters coded with a diagnosis of adjustment disorder from August 20, 2007, through March 19, 2008 (the day prior to the e-mail); and from March 20 through September 20, 2008.⁷

Because one interpretation of the e-mail is that patients should be given a diagnosis of adjustment disorder more frequently than warranted, we measured the frequency of this diagnosis before and after March 20, 2008. We wanted to know if the e-mail was associated temporally with a change in PCT clinicians' diagnostic patterns.

We reviewed the electronic medical records of all patients seen in the Temple VAMC PCT clinic for whom one or more encounters were coded as an adjustment disorder during the period February 20, 2008, through April 19, 2008. We compared diagnostic patterns for the month before and the month following March 20. We reviewed medical record notes starting with each patient's first presentation to Temple. For the few patients who had been seen over many years, we reviewed chart notes from the previous 2 years. To accomplish this, we reviewed a total of 68 medical records in detail. For these patients, we also examined C&P results.

⁶ VISTA = Veterans Health Information Systems and Technology Architecture. See http://www.va.gov/VISTA_MONOGRAPH/.

⁷ ICD-9 codes: 309.0 Adjustment Disorder with Depression; 309.24 Adjustment Disorder with Anxiety, 309.28 Adjust Dis W Anxiety/Dep; 309.29 Adj React-Emotion Nec; 309.3 Adjust Disorder/Dis Conduct; 309.4 Adjustment Disorder-Emotion/Conduct; 309.82 Adjustment Reaction-Phys Sympt; 309.83 Adjust Reaction-Withdrawal; 309.89 Adjustment Reaction Nec; 309.9 Adjustment Reaction NOS.

We reviewed VHA directives, local policies, workload data, and other relevant administrative information. We reviewed CTVAHCS mental health patient flow, access to care, and workload.

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

Part II. Inspection Findings

Issue 1: Analysis of E-Mail Message

OHI found that the e-mail in question was written by the clinical psychologist who headed the Temple VAMC PCT clinic. The psychologist authored the message without input or direction from supervisors.

The eight recipients of the message were all members of the Temple PCT. The e-mail's author was the designated team leader but had no direct supervisory authority over any of the e-mail's recipients. Additionally, the Temple PCT functioned independently of the two other CTVAHCS PTSD clinical teams in Waco and Austin.

The details of the e-mail and how it came to be written were explained to OHI inspectors in two interviews with the clinical psychologist who authored the e-mail. OHI was told that on the morning of March 20 (the day the e-mail was written) the e-mail's author was approached by a psychiatrist in the PCT Clinic. We were told that the psychiatrist had been confronted by a patient who was distressed by conflicting diagnoses. Furthermore, we were told that this was the second such time that an event of this nature had occurred.

The psychiatrist shared concern over this situation with the clinical psychologist who headed the PCT Clinic. This interaction between the psychiatrist and the clinical psychologist was reportedly brief. It was spontaneous and essentially informal.

The PCT leader expressed the belief that ideally the diagnosis of PTSD would be made after both patient interview and formal psychological testing. Other clinicians whom we interviewed placed less emphasis on psychological testing and expressed the belief that a PTSD diagnosis may be established fairly rapidly on the basis of clinical history.

In light of the concern expressed by the psychiatrist to the clinical psychologist who headed the PCT Clinic, the latter wanted to express to PCT staff the need to be careful and deliberate in making a PTSD diagnosis. The PCT leader therefore wrote in paragraph 1:

*“Given that we are having more and more compensation seeking veterans,
I'd like to suggest that you refrain from giving a diagnosis of PTSD straight*

out. Consider a diagnosis of Adjustment Disorder, R/O PTSD.” [italics for emphasis added by OIG]

We concluded that the central idea the psychologist was attempting to communicate to PCT staff was carefulness in diagnosis.

Clinical treatment and C&P evaluations are separate processes. Patients receive diagnoses in each venue, and we found this has the potential to confuse patients. We found that the following prefatory phrase, “Given that we are having more and more compensation seeking veterans,” was written in this context.

In the e-mail, the psychologist then followed with a sentence which reflected the ideas of carefulness in diagnosis and the fact that comprehensive evaluation and psychological testing may be time consuming. Thus, the e-mail states:

“Additionally, we really don’t or have time [sic] to do the extensive testing that should be done to determine PTSD.”

The next sentence expressed concerns over possible consequences of not establishing a correct diagnosis:

“Also, there have been some incidence [sic] where the veteran has a C&P [examination], is not given a diagnosis of PTSD, then the veterans [sic] comes here and we give the diagnosis, and the veteran appeals his case based on our assessment.”

The juxtaposition of the compensation issue (C&P) with the diagnosis of PTSD created the potential for misunderstanding.

The e-mail was an interoffice communication written to PCT staff only; it employed professional jargon, and it was not intended for general distribution. Further, our interviews of all of the recipients of the e-mail revealed no consistent perception that the e-mail suggested that inappropriate diagnoses should be rendered.

Issue 2: Impact of E-Mail Message

Allegations surrounding the e-mail message suggested the diagnosis of adjustment disorder would be more frequently applied after the message was sent. We therefore examined the monthly distribution of Temple VAMC PCT clinical encounters coded with a diagnosis of adjustment disorder during the 6 months prior to and 6 months following the March 20 e-mail. Data were organized by month starting with the 20th of each month, to reflect periods before and after the e-mail. See Figure 1.

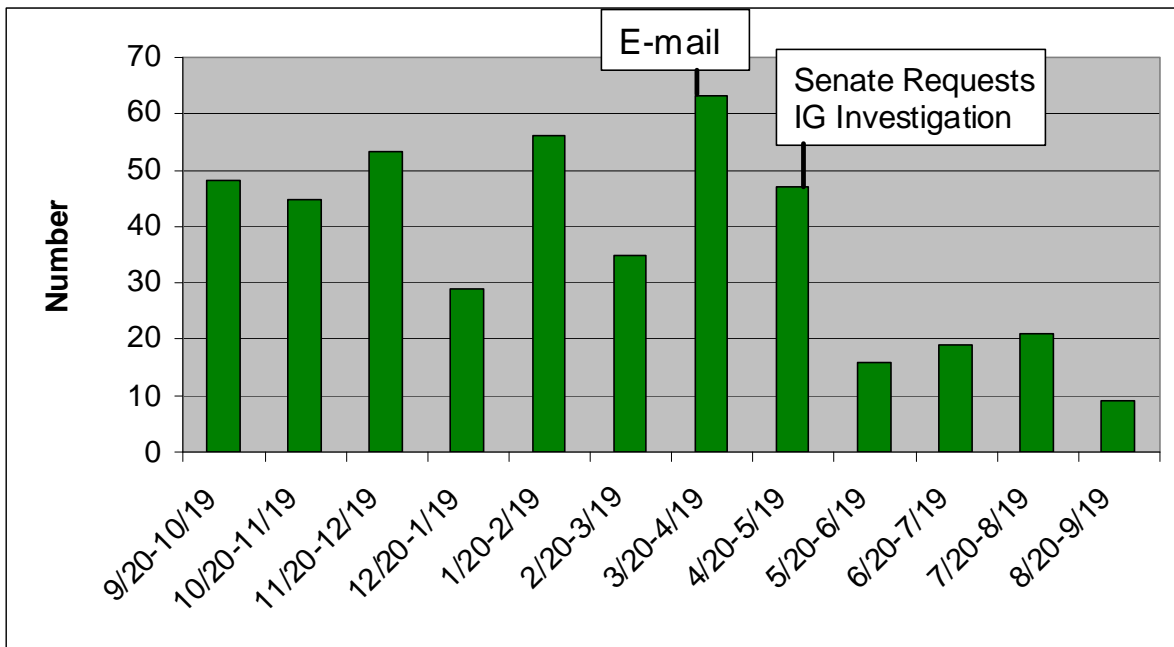


Figure 1. Monthly distribution of 441 PTSD Clinical Team patient encounters from 9/20/2007 through 9/19/2008 coded as adjustment disorder. Group therapy encounters are included.

We found that even prior to initial Congressional inquiry (May 16, 2008), patient encounters were coded as adjustment disorder at similar frequency before and after the e-mail message. There was no change in our findings after accounting for month to month variation in the number of Temple PCT encounters for all diagnoses, with or without inclusion of group encounters.

We also found that the number of PCT encounters with a code of adjustment disorder was consistently small compared with the total number of PCT encounters. See Figure 2 on the following page.

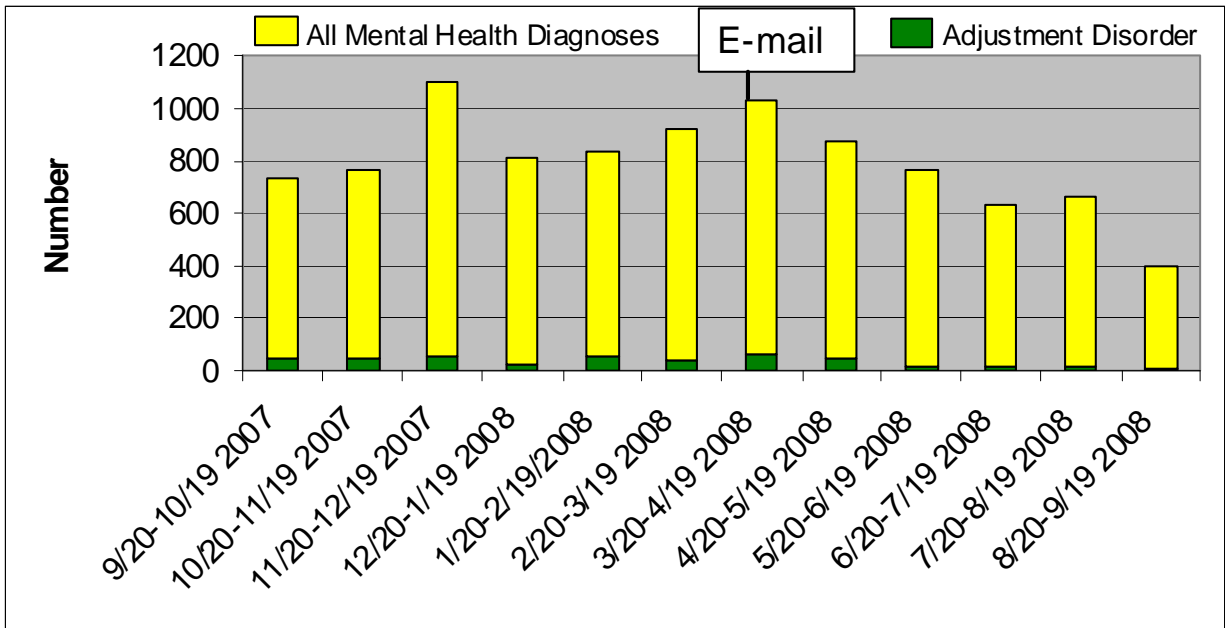


Figure 2. Monthly distribution of all 9,103 PTSD Clinical Team patient encounters from 9/20/2007 through 9/19/2008, including the 441 PTSD Clinical Team patient encounters coded as adjustment disorder. Group therapy encounters are included.

Issue 3: Clinical Chart Review

We reviewed the electronic medical records of all patients seen in Temple VAMC PCT clinic for whom encounters were coded as an adjustment disorder during the period February 20, 2008 through April 19, 2008. This was a total of 68 patients. For the month prior to March 20 (the date of the e-mail), 22 patients were identified, for March 20 and the month following, there were 41 patients; there were 5 patients who had encounters both before and after March 20. Forty-nine of these 68 patients (72 percent) were veterans of Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF).

Some of the encounters for these patients were for diagnostic evaluation, but many were specifically for individual or group therapy. We excluded 10 patients whose adjustment disorder encounters were exclusively for group therapy. The focus of these groups is therapy, and progress notes for these encounters invariably did not include any diagnosis. Individual therapy encounters were included, but serial individual therapy visits with the same therapist were counted only once. Because some patients were seen more than once by different providers during the periods, there were 61 encounters for these 58 patients (51 male, 7 female).

For each patient encounter, the clinician enters a progress note into the electronic medical record. A progress note may or may not include a diagnostic assessment. In addition, for each visit, an encounter code is assigned for administrative purposes. In our review, 8 of 61 (13 percent) encounters that were coded as adjustment disorder had an associated progress note indicating a different diagnosis. For 30 (49 percent) encounters, progress notes had documentation sufficient to support diagnoses. For 21 progress notes documentation did not permit an assessment as to the appropriateness of the assigned encounter code. For example, a visit focused on medication management may describe a patient's response to medications without noting underlying diagnostic criteria. Ten of these 21 patient visits were for individual therapy, at which time a new diagnostic assessment is not always relevant.

We identified two patients with encounters for which the progress note diagnosis of adjustment disorder was unsupported. One OIF veteran was given a diagnosis of "adjustment disorder, rule out PTSD" at a visit preceding the e-mail. The note stated that the patient reported significant symptoms related to combat trauma. Because the stressor terminated more than 6 months prior to the visit and there was no mention that its consequences were ongoing, the adjustment disorder diagnosis did not adhere to DSM-IV diagnostic criteria. However, by use of the "rule out PTSD" designation, the note for the 2008 encounter reflected some diagnostic uncertainty on the part of the provider and did indicate PTSD as a possible diagnosis for the patient to be considered at future visits. This patient was scheduled for treatment of PTSD symptoms and seen in skills group at Temple VAMC. As of the time of our review, this patient had not pursued a C&P examination for mental health at Temple.

The other patient for whom the progress note diagnosis of adjustment disorder was unsupported was also an OIF veteran. The patient was noted to have had a war related traumatic stressor and to be experiencing mild PTSD symptoms, but he did not meet diagnostic criteria for PTSD. Because he reported depressive symptoms, the patient was diagnosed with adjustment disorder with depressed mood. The use of adjustment disorder was unsupported because the stressor occurred more than 6 months earlier—in fact, more than 2 years earlier—and there was no mention that its consequences were ongoing. The patient was referred for group therapy and for evaluation by a psychiatrist, but the patient declined. In August the patient underwent a C&P examination and was found to have insufficient criteria for a PTSD diagnosis;⁸ the diagnosis of Depressive Disorder, Not Otherwise Specified, was rendered.

It was apparent from our review that both prior to and following the March 20 e-mail, a diagnosis of adjustment disorder on any given day did not preclude other diagnoses, including PTSD on the occasion of another PCT visit with another PCT clinician. Not only could different clinicians give different diagnoses, but the same clinician might give

⁸ The examining clinician documented that the patient did not endorse 2 of 3 required symptom clusters required by DSM-IV.

different diagnoses on different visits. Moreover, we found that a patient diagnosed with adjustment disorder could well be receiving benefits for PTSD or in some cases for chronic adjustment disorder.

Our review revealed that many diagnoses of adjustment disorder were correctly related to recent life events such as recent divorce, loss of a job, or illness of a family member. One patient reported stress related to the recent hospitalization of two family members. Another PCT patient had the diagnosis of adjustment disorder attributed to stress related to his ineligibility to rejoin the military because of development of a non-psychiatric medical condition.

In our review of these patients' records, we found no discernible change in the appropriateness of diagnoses occurring before and after the e-mail.

Issue 4: Compensation and Pension Examinations for Mental Health Service Connection of PCT Patients

Of the 68 patients whose medical records were reviewed as described in Issue 3, 29 underwent C&P examination for mental health related conditions. Twenty-six underwent C&P examination at CTVAHCS and 3 had examinations elsewhere. Eight examinations occurred during the period of the chart review (February 20–April 19) with 4 exams predating March 20 and 4 exams following March 20. An additional 12 occurred in 2008. The remaining exams were in 2005 (2), 2006 (1), and 2007 (3).

Five of the 26 CTVAHCS examinations were performed by 2 clinicians who were recipients of the e-mail, while the rest were performed by clinicians who do not work in PCT clinic and did not receive the e-mail. Only 1 of the examinations by an e-mail recipient took place after March 20.

Nineteen of the 26 patients (73 percent) who underwent C&P examination at the CTVAHCS received a service-connected disability rating for a mental health diagnosis. Thirteen of these 19 veterans were service-connected for PTSD, 4 for chronic adjustment disorder, one for “neurosis,” and one for generalized anxiety disorder and neurosis. See Figure 3 on the following page. The 3 patients who underwent C&P examinations outside of CTVAHCS all received service-connected disability ratings: one for major depressive disorder, one for PTSD, and one for chronic adjustment disorder.

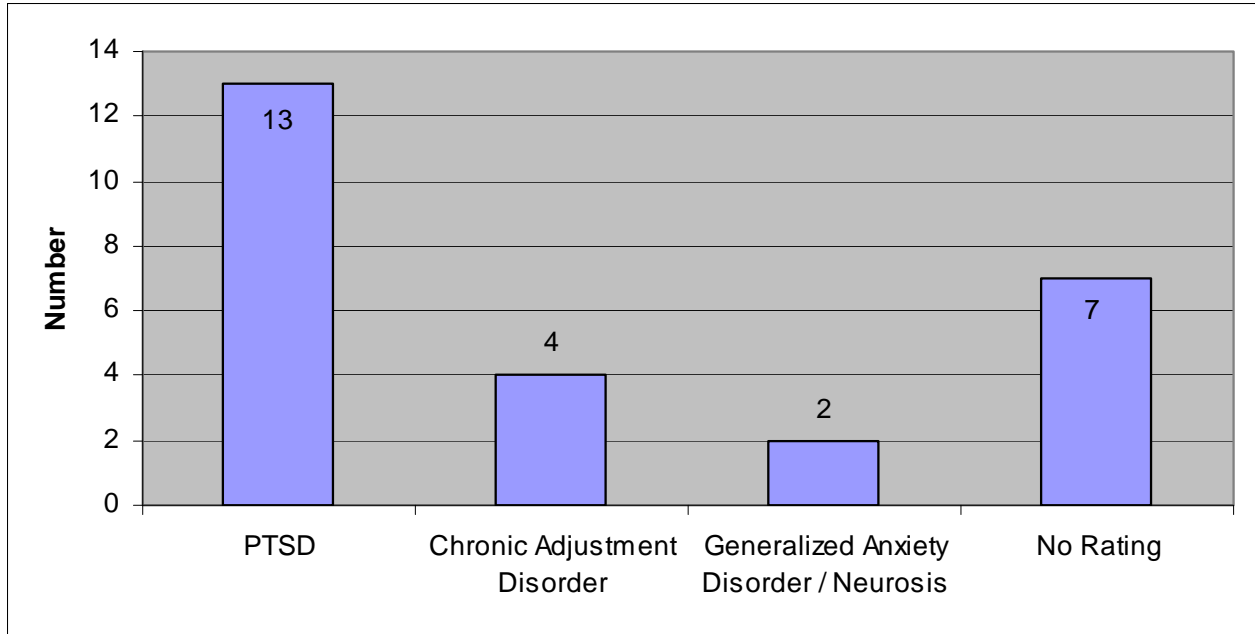


Figure 3: Conditions for which patients received service-connected disability ratings after CTVAHCS C&P examinations for mental health conditions. All of these patients had Temple VAMC PTSD Clinical Team patient encounters coded as adjustment disorder during February 20–April 19, 2008.

The 7 patients who received no mental health service-connected disability rating all had PCT encounters coded as adjustment disorder. Four of these encounters were for group or individual therapy, and no diagnosis was provided in the associated progress note. The other three had PCT clinic progress note diagnoses of adjustment disorder; two of these three notes also stated “R/O PTSD.” All three of these encounters preceded the March 20 e-mail. At C&P examination all 7 patients were given a mental health diagnosis, none of which was adjustment disorder. Although none of the 7 patients received mental health service-connected disability ratings, at the time of our review, 6 had service-connected ratings for non-mental health conditions. See the Table on the following page.

Our review of these 7 C&P examinations revealed thorough documentation and sound diagnostic reasoning. For both PCT clinic and C&P examination diagnoses, we observed no pattern in temporal relation to the e-mail.

	Date of PTSD Clinic Encounter	Temple VAMC PTSD Clinic Diagnosis	Date of CTVAHCS C&P	CTVAHCS C&P Diagnosis	Service-Connected Rating for Non-Mental Health Conditions
1	2/25/2008	None	2/28/2008	Major Depressive Disorder ⁹	40 percent
2	2/29/2008	Adjustment Disorder	4/26/2008	Generalized Anxiety Disorder	0 percent
3	3/14/2008	R/O Adjustment Disorder	8/23/2008	Depressive Disorder NOS	80 percent
4	3/18/2008	Adjustment Disorder R/O PTSD	9/24/2008	Anxiety Disorder NOS	80 percent
5	3/26/2008	None	7/26/2008	Generalized Anxiety Disorder	60 percent
6	3/31/2008	None	5/31/2008	Mood Disorder NOS	20 percent
7	4/3/2008	None	12/28/2005	PTSD ¹⁰	20 percent

Table. PCT Clinic and C&P diagnoses and non-mental health service-connected disability ratings for 7 patients with PCT clinic encounters coded as adjustment disorder during February 20–April 19, 2008, who did not receive a mental health service-connected disability rating.

Issue 5: PTSD Aftercare

We substantiated that aftercare groups at the Temple VAMC were disbanded or moved to the Harker Heights Vet Center.

Prior to the recent conflicts in Iraq and Afghanistan, PTSD patients from prior service eras attended long term supportive groups. At the Temple VAMC, these were referred to as aftercare groups. Some of the groups had been meeting at Temple for several years. Although providers would change, in general, over time the same groups of patients continued to attend. By 2006 there was increasing focus within VHA on evidence-based clinical practices for treatment of mental health conditions. This had also been the case with non-mental health problems like diabetes and congestive heart failure; that is to say, VHA focused on evidence-based treatments for a range of disorders.

⁹ The C&P examination noted the patient had meaningful employment until the time of a stroke several years after his military service.

¹⁰ The patient was denied service connection because VBA was unable to confirm a combat stressor.

VHA's emphasis on evidence-based clinical practice had ramifications for PTSD aftercare treatment at the Temple VAMC. Prior to the PCT team leader's employment at Temple, mental health clinical staff had questioned whether aftercare supportive groups were evidence-based, resulted in clinical improvement, and for some patients were potentially a detriment. The PCT team leader reportedly discussed what to do about the aftercare groups with a supervisor, a psychiatrist, and ultimately the Associate Chief of Staff for Mental Health. When the e-mail's author discussed moving from aftercare towards evidence-based groups, there was reportedly a generally but not universally favorable reaction among PCT clinical staff.

The initial transition plan was for the therapist working with a group to lead his or her group through the transition process. Since it was felt that the aftercare groups functioned somewhat autonomously, with the power coming from the group and the therapist in a peripheral role, it was suggested that group members could continue peer led groups at a non-VA venue. The e-mail's author, with input from other clinical staff, drafted a letter of explanation intended for participants in aftercare groups. The e-mail's author led one of the aftercare groups and handed out the letter at a meeting of that group. The Associate Chief of Staff for Mental Health reported that, although not the intent, the letter was perceived as "casual and garnered a negative reaction" from the group's members.

In response, the e-mail's author, the then-Chief of Psychology, the Associate Chief of Staff for Mental Health, an administrator, and a veteran-at-large spokesperson, among others, began having meetings with representatives from the aftercare groups. At one of the meetings a representative from the Vet Center attended and offered to provide for continuation of supportive groups at the Harker Heights Vet Center. By the time frame December 2007–January 2008, administrative leaders thought the transition had been agreeably worked out. However, we were told that one aftercare group did not agree and continued to express dissatisfaction over the changes. The Temple VAMC Chief of Staff met with that group and began co-leading the group, with a new focus on promoting general health and wellness. Two other groups reportedly elected to disband, and the remaining groups chose to continue group therapy at the Harker Heights Vet Center.

Conclusions

The e-mail message which prompted this review was an interoffice communication to clinic staff. It was not intended for general distribution. Our interviews with all recipients of the message revealed no consistent perception that inappropriate diagnoses should be rendered. The e-mail was written on the author's initiative, without direct or indirect instruction from local, regional, or national VA leadership.

PCT clinic patient encounters were coded as adjustment disorders at similar rates both before and after the e-mail message, as were CTVAHCS C&P examination diagnoses and service-connection determinations.

There was no discernible change in the appropriateness of diagnoses occurring before and after the e-mail.

Aftercare groups were disbanded or moved to the Harker Heights Vet Center.

Recommendations

We made no recommendations.

**Department of
Veterans Affairs**

Memorandum

Date: January 15, 2009

From: Network Director, VA Heart of Texas Health Care Network, (10N17)

Subject: **Healthcare Inspection – Allegations of Mental Health Diagnosis Irregularities at the Olin E. Teague VAMC, Temple, Texas**

To: Assistant Inspector General for Healthcare Inspections (54A)

1. I have reviewed and concur with the report. I see no changes or comments necessary.
2. For additional information, you may contact Ms. Antai-Otong at 817 385 3794.

(original signed by:)

Timothy P. Shea, FACHE

**Department of
Veterans Affairs**

Memorandum

Date: January 9, 2009

From: Director (00), Central Texas Veterans Health Care System, Temple, TX

Subject: **Healthcare Inspection – Allegations of Mental Health Diagnosis Irregularities at the Olin E. Teague VAMC, Temple, Texas**

To: Network Director, VA Heart of Texas Health Care Network, (10N17)

3. I concur with the report. I see no changes or comments necessary.

4. For additional information, you may contact me at 254-743-2306.



Thomas C. Smith, III, FACHE

OIG Contact and Staff Acknowledgments

OIG Contact	George B. Wesley, M.D. Director, Medical Consultation and Review (202) 461-4705
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