Department of Veterans Affairs

Office of Inspector General

Healthcare Inspection

Allegations Regarding the Homeless Women Veterans Program VA Medical Center Atlanta, Georgia

Report No. 08-02317-26

November 18, 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 the review was to evaluate allegations that a female patient committed suicide as a result of inadequate care by the Homeless Women Veterans Program (HWVP). The complainant also alleged that women veterans fear reprisal from HWVP staff and Mental Health Service Line (MHSL) managers are uninvolved in programs.

We did not substantiate that the female patient committed suicide as a result of inadequate care and compassion. We found that the patient received appropriate medication management, services, care, and follow-up. Further, the medical examiner's report ruled the cause of death as accidental.

We did not substantiate that that HWVP staff mistreated veterans, were uncompassionate, or reprised against veterans enrolled in the HWVP. We concluded that enforcement of program policies and consequences when rules were broken may have been perceived as mistreatment or reprisal.

We did not substantiate the allegation that MHSL leadership was not involved in programs. Overall, staff members described MHSL positively, and recent performance measures specific to the MHSL have consistently been met or exceeded for most indicators.

While not specifically an allegation, we identified deficiencies specific to the Southern Women Housing Alliance (SWHA) halfway house contract, inspections, and services.

We recommended that the SWHA contract be revised and upheld to assure that care and medical center resources are managed appropriately. Management agreed with our recommendation and provided an acceptable improvement plan.

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

TO: Director, VA Southeast Network (10N7)

SUBJECT: Healthcare Inspection – Allegations Regarding the Homeless Women Veterans Program, VA Medical Center, Atlanta, GA

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections received a complaint alleging that a female patient (subject patient) committed suicide as a result of inadequate care by the Homeless Women Veterans Program (HWVP) of the VA medical center (the medical center) in Atlanta, GA. The complainant also alleged that women veterans fear reprisal from HWVP staff and that Mental Health Service Line (MHSL) managers are uninvolved in programs. The purpose of the review was to determine whether the allegations had merit.

Background

The medical center is a teaching hospital that provides a full range of medical, surgical, mental health, and long term care services, and has 173 inpatient beds and 100 nursing home care beds. The medical center is part of Veterans Integrated Service Network (VISN) 7.

The MHSL, which is the subject of this complaint, offers multiple services including:

- The Homeless Program and the HWVP.
- Sexual Trauma and Recovery (STAR), a group therapy program for women who have experienced sexual trauma.
- Substance Abuse Treatment (SAT), a structured program designed to treat chemical and alcohol dependency.
- Compensated Work Therapy (CWT), a supported employment program.
- Contracts with halfway houses which provide supportive housing and services for residents.

On June 13, 2008, a confidential complainant contacted the OIG hotline and alleged that:

- The subject patient committed suicide because she did not receive adequate care, assistance, and compassion from the HWVP staff.
- Other homeless women veterans experienced similar treatment but did not initiate complaints for fear of reprisal, such as discharge.
- The MHSL leadership is not actively involved in programs and does not visit community facilities where veterans are placed.

As the inspection progressed, we also identified contracting and operational issues related to the Southern Women Housing Alliance (SWHA) halfway house which required additional review.

Scope and Methodology

Prior to our visit, we interviewed the complainant by telephone. We interviewed managers, employees, a female veteran previously enrolled in the HWVP, the SWHA halfway house owner, and a county criminal investigator knowledgeable about the topics discussed. We examined medical records from the medical center and documents from the SWHA halfway house. We reviewed the medical examiner's report related to the death of the subject patient. We also reviewed medical center and national policies; the VA contract and inspection records for the SWHA halfway house; the root cause analysis specific to the subject patient; and other quality management documents. We researched the medical center's MHSL-related performance measure results. We toured the SWHA halfway house and business office.

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

Case Summary

The subject patient was a woman in her mid-forties with a primary medical history of depression and substance (cocaine) abuse. Her first appointment with the medical center involved a visit to the Emergency Department (ED) in early July 2007, when she was diagnosed with anxiety, depression, and substance abuse. Although she was not considered to be suicidal at the time of the visit, the ED physician referred her for a same-day mental health evaluation.

The mental health notes state that the subject patient had attempted suicide by medication overdose in 2003, was separated from her husband, and did not have custody of her children. The HWVP social worker documented that the subject patient was living in a relative's residence, a place "not conducive to recovery efforts." Therefore, funding was arranged for the subject patient to stay at the SWHA halfway house.

Over the next several months, the subject patient complied with her treatment plan and participated in the SAT and STAR programs. In early October, she required emergency surgery and hospitalization for small bowel obstruction. Since she was unable to attend the treatment programs during her surgical recovery, she was discharged from the SAT and STAR programs in accordance with policy. In late November, the subject patient returned to the treatment groups and the SWHA halfway house. A week later, she told staff that she expected to regain custody of her children, was leaving the halfway house, and would be looking for work. As such, she did not expect to continue participation in the recovery programs.

Between December 2007 and March 2008, the subject patient occasionally attended group meetings. She did not regain custody of her children and reportedly returned to her uncle's house. In early April, the HWVP social worker discussed options with the subject patient to help her complete the STAR program, return to a halfway house, and resume SAT program aftercare. The treatment team met with her the following week and documented that she had rapid speech and other behaviors suspicious for drug relapse. The treatment team instructed the subject patient to get a drug urine screen but she did not comply. Two days later, the HWVP social worker left a voice mail for the subject patient regarding a job interview but she did not return the call. A week and a half later, in late April, another veteran reported to medical center staff that the subject patient had committed suicide.

The medical examiner's report of mid-July, stated that the subject patient died at her relative's home in late April from accidental multiple drug intoxication with prescribed and non-prescribed substances.

Inspection Results

Issue 1: Alleged Suicide

We did not substantiate the allegation that the subject patient committed suicide as a result of inadequate care and compassion. In general, we found that the patient received appropriate services and care. Efforts were made to contact and engage the subject patient when she missed appointments and group recovery meetings. The subject patient knew how to contact VA staff for help, as she had done so on several occasions over the past year and all contact numbers and names remained the same.

We also found that clinical management and prescribed medications were appropriate. Contrary to reports from the complainant, the medical examiner's report ruled the cause of death as accidental and the criminal investigator told us that there were no suicide notes at the scene.

We made no recommendations.

Issue 2: Alleged Mistreatment and Reprisal

We did not substantiate the allegation that HWVP staff mistreated veterans by not showing proper care and compassion, or that veterans were threatened with reprisal if they complained. One female veteran previously enrolled in the HWVP and SWHA told us that Homeless Program and SWHA staff did not show compassion when they "threw" other SWHA veterans out of the halfway house. However, we reviewed the medical records of the named veterans and found that they were discharged in accordance with program policy for issues such as fighting and non-compliant behavior.

While the former SWHA veteran did not provide additional examples of uncompassionate care or threat of reprisal, Homeless Program and SWHA staff reported that some women voiced their dissatisfaction with program structure and the strict adherence to rules. We also found documentation reflecting some of these concerns in the medical records of several HWVP veterans. Specifically, staff described the following scenarios:

- Many veterans obtain employment through the CWT program. In an effort to help gain budget skills and prepare for self sufficiency, CWT participants are required to work 40 hours weekly and assume payment for their halfway house room and board. Some veterans feel that the VA should continue to financially sponsor their living situation.

- The SWHA does not provide meals or snacks. Instead, SWHA provides each veteran with a $30.00 grocery voucher for purchasing food over 1 week. They also complete an application for food stamps, which takes approximately 2 weeks to be processed. Once the food stamps are received, the SWHA director discontinues distribution of the grocery vouchers to the veterans. Cigarettes can be purchased with the grocery voucher but not with food stamps. Some veterans who smoke may not be pleased when their grocery vouchers are discontinued.

- The SWHA halfway house sponsors recovery groups every evening, and residents must obtain the initials of the group leader on a card as proof of attendance. This card must be complete with the group leader's initials and presented each Friday in order for the resident to receive the grocery and transportation vouchers. Those who have not attended these recovery groups may perceive retaliation when denied the vouchers.

- We were told that there are very few, all-female, halfway houses available in the community. When problems arise, such as interpersonal conflicts, transfer to a different female-only residence is difficult. For this reason, women veterans who

request but are denied relocation may perceive staff as unsympathetic and uncaring.

We interviewed the medical center Patient Advocate, the Chief of Quality Management, and the Georgia Office of Regulatory Services.[1] According to these interviews, no veterans made complaints regarding the SWHA or care provided by the MHSL.

We found no evidence of mistreatment of or reprisal against veterans enrolled in the HWVP, or that they received uncompassionate care. We concluded that enforcement of program policies and consequences when rules were broken may have been perceived as mistreatment or reprisal. A structured program that consistently enforces policies is an integral part of treatment and recovery efforts.

We made no recommendations.

Issue 3: MHSL Leadership

We did not substantiate the allegation that MHSL leadership was not involved in programs. Overall, staff members described MHSL managers as "receptive to feedback," "involved," having "an open door policy," and providing "support" and "excellent communication." Further, the managers have initiated new processes for idea sharing, staff meetings, and program improvements.

The performance measures specific to the MHSL have been met or exceeded for most indicators during the past 2 fiscal years. Additionally, the Homeless Program was accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) in August 2007.

We found that appropriate medical center staff visited the halfway house as required by VHA Handbook 1103.1, *Mental Health and Behavioral Sciences Service Procedures Handbook for Specific Program* (March 27, 1996). The handbook states that a multidisciplinary VA team consisting of a social worker, nurse, safety officer, and other designees must conduct surveys of a halfway house prior to the award of a contract and on a yearly basis. It is neither customary nor expected that a Service chief or other high level manager would serve on such an interdisciplinary team.

We made no recommendations.

[1] The Georgia Office of Regulatory Services monitors, inspects, and licenses halfway houses, as well as other healthcare programs.

Issue 4: Contracting Issues

While not specifically an allegation, we identified deficiencies specific to the SWHA contract and services during this review and site visit. These included the following:

- Potential problems exist with patient privacy since the medical records and medications maintained by the SWHA business office were not stored in locked cabinets.

- The medical center pays $280.00 weekly for each veteran residing at the SWHA From this, the transportation and grocery vouchers are purchased by the SWHA owner. These vouchers may be withheld if a veteran fails to participate in the evening group sessions at the halfway house. The contract had no provision to monitor or reduce the VA payment for withheld vouchers.

- An evaluation of the adequacy of $30.00 grocery vouchers to provide a week's worth of nutritious meals has not been completed.

- The contract requires annual inspections. We found no inspection for 2006. The medical center conducted inspections in 2005 and 2007; however, the forms were incomplete. Further, there was no evidence that deficiencies and corrective actions were communicated and followed to closure.

- SWHA residents are told to direct complaints to a phone number within the Georgia Office of Regulatory Services. When we called that number, the telephone mailbox was full and the caller was instructed to try again later. Although we found additional contact information through an internet search, such access may not be readily available to SWHA residents.

Without an effective contract and inspection process, medical center managers can not be assured that veterans receive appropriate care and that medical center resources are appropriately managed.

Conclusion

We did not substantiate the allegation that the subject patient committed suicide because of inadequate care and compassion by staff, or that other female veterans feared reprisal for reporting inadequate care and compassion. We found that homeless women received appropriate care in accordance with program guidelines. We found no evidence of reprisal against veterans who may have reported their dissatisfaction with some program elements. We did not substantiate the allegations that MHSL leadership was not involved in programs or that there was any neglect of duty related to community facility visitation. Appropriate staff visited the facility as required. We did, however, find that the medical

center's contract with and inspection reports for the SWHA halfway house required management attention.

Recommendation

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director requires that the SWHA contract be revised and upheld to assure that care and medical center resources are managed appropriately.

Comments

The VISN and Medical Center Directors agreed with the findings and recommendation and provided acceptable plans to ensure that contract revisions are identified, addressed, and upheld. 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

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: 10/20/2008

From: Director, VA Southeast Network (10N7)

Subject: **Healthcare Inspection – Allegations Regarding the Homeless Women Veterans Program, VA Medical Center, Atlanta, GA**

To: Director, Atlanta Office of Healthcare Inspections (54AT)

Thru: Director, Management Review Office (105B)

1. I have reviewed the draft report and I concur with the recommendations.
2. Additionally, I concur with the Atlanta VA Medical Center's responses, and we will follow-up to ensure that all actions are completed.

(original signed by:)

Lawrence A. Biro

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: 10/16/2008

From: Director, Atlanta VA Medical Center (508/00)

Subject: **Healthcare Inspection – Allegations Regarding the Homeless Women Veterans Program, VA Medical Center, Atlanta, GA**

To: Director, VA Southeast Network (10N7)

Thru: Director, Management Review Office (105B)

1. I have reviewed the draft report and concur with the findings. I acknowledge that the SWHA contract should be revised and upheld to assure that care and medical center resources are managed appropriately.

2. The Atlanta VA Medical Center Mental Health Service Line, under my direction, performed an environment of care and safety inspection immediately after these recommendations were received. It was determined by Mental Health Service Line Leadership that the women housed in SWHA would be relocated until such time as the contract could be revised and corrections made. I supported this relocation as it was in the best interest of our female veterans.

3. An interim emergency contract was put into place and the women veterans residents of SWHA were relocated to a facility that meets the requirements of the recommendations of the OIG Inspection Team.

4. A cure letter was sent to the owner of SWHA with specific requirements to increase funding for food and environmental enhancements. The owner has 30 days to respond to the contracting officer. It was noted that the owner of SWHA had taken immediate actions to ensure patient privacy items were secured under lock. She was in agreement with the issues identified in the cure notice, and is in the process of looking for other apartments that will better meet our standards.

5. The Mental Health Service Line Manager will ensure that annual inspections are conducted and reported appropriately. Corrective actions will be taken immediately if there are any findings or violations.

6. The language in the contract is under revision to address the recommendations made by the inspection team.

7. We can not ensure that numbers published by the Georgia Office of Regulatory Services will be answered or responded to in a timely manner should a resident need to make a complaint. The half-way house is now required to furnish contact information for the Atlanta VA Medical Center Womens Veterans Homeless Program to VA residents as an alternative for complaint filings, if needed.

8. If you have additional questions or concerns please contact Ms. Vicki Heggen, Quality Management Coordinator at 404-321-6111 extension 7653.

(original signed by:)

James A. Clark, MPA

Director's Comments to Office of Inspector General's Report

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

OIG Recommendation

Recommendation 1. We recommended that the VISN Director ensure that the Medical Center Director requires that the SWHA contract be revised and upheld to assure that care and medical center resources are managed appropriately.

Concur

- On September 29, 2008, an Environment of Care and Safety inspection was performed at SWHA by the Atlanta VA Medical Center. A decision was made to relocate homeless female veterans residing in SWHA until contract revisions can be made and accepted by the Atlanta VA Medical Center and SWHA, and corrections can be made to the environment of care by SWHA.

- A cure letter was sent to the owner of SWHA on October 6, 2008, and included specific requirements to increase funding for food (to match the amount provided by the food stamp office monthly) and to disallow the withholding of transportation and/or grocery vouchers. This has also been addressed in the contract revision.

- An emergency, interim contract was initiated with an alternate female veteran homeless facility that meets VHA requirements (per inspection), and transfer of homeless female veterans from SWHA to this alternate facility was accomplished on October 8, 2008.

- The Mental Health Service Line Director will ensure that annual inspections are conducted and acted upon per VHA requirements.

- We can not ensure that numbers published by the Georgia Office of Regulatory Services will be answered or responded to in a timely manner should a resident need to make a complaint. The half-way house is now required to furnish contact information for the Atlanta

VA Medical Center Womens Veterans Homeless Program to VA Residents as an alternative for complaint filings, if needed.

Appendix B

OIG Contact and Staff Acknowledgments

OIG Contact	Victoria H. Coates Director, Atlanta Office of Healthcare Inspections (404) 929-5962
Acknowledgments	Melanie Cool, Project Leader Michael Shepherd, M.D. Toni Woodard

Appendix C

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