



DEPARTMENT OF VETERANS AFFAIRS

## OFFICE OF INSPECTOR GENERAL

*Office of Healthcare Inspections*

VETERANS HEALTH ADMINISTRATION

# Deficiencies in Mental Health Care and Facility Response to a Patient's Suicide, VA Portland Health Care System in Oregon and Treatment Program Referral Processes at the VA Palo Alto Health Care System in California



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## Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to evaluate OIG-identified concerns regarding a patient's mental health care at the VA Portland Health Care System (facility) in Oregon and leaders' response to the patient's death by suicide including care coordination, leaders' administrative actions following the patient's death, and non-VA community care procedures. The OIG also evaluated referral processes at the VA Palo Alto Health Care System (VA Palo Alto) in California posttraumatic stress disorder (PTSD) residential rehabilitation treatment program (RRTP) and staff compliance with Veterans Health Administration (VHA) admission criteria procedure requirements and service animal policy.

### Synopsis of the Patient's Care Spring 2018–Early 2019

The patient, who was in their fifties at the time of death by suicide in early 2019, had a medical history that included diagnoses of [PTSD](#), [major depression](#), [alcohol dependence](#), [cannabis abuse](#), and [nicotine dependence](#).<sup>1</sup>

In spring 2018, the patient established care at the facility and a psychologist requested weekly nurse care manager calls to monitor suicidal ideation while the patient awaited an appointment. Approximately one month later, the patient requested to restart medication management and agreed to telemental health appointments with a same-gendered provider. A medical support assistant scheduled a telemental health appointment with a same-gendered psychiatrist approximately five weeks later.

Approximately three weeks later, the psychiatrist identified the patient as high risk for suicidal behavior. The patient agreed to the suicide prevention team being notified and agreed to a VA Palo Alto RRTP referral. The psychiatrist placed a non-VA community care consult for the patient to receive individual psychotherapy and the same day, a Suicide Prevention Coordinator placed a category I high risk for suicide patient record flag.<sup>2</sup> Thirteen days later, the RRTP Admissions Coordinator completed a telephone screening with the patient and noted that the patient had “a service dog that [the patient] needs to bring” and stated “I will only attend if my

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<sup>1</sup> The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the “alt” and “left arrow” keys together. The OIG uses the singular form of they (their) in this report for patient privacy.

<sup>2</sup> VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008. VHA Deputy Under Secretary for Health for Operations and Management (DUSHOM) Memorandum, “Update to High Risk for Suicide Patient Record Flag Changes,” January 16, 2020. VHA uses a Patient Record Flag Category I High Risk for Suicide to identify a patient as high risk for suicide in the electronic health record and requires intensive follow-up by providers while the patient remains flagged.

dog can come.” Two weeks later, a non-VA mental health provider met with the patient and discussed a safety plan.

Twelve days later, the RRTP Admissions Coordinator documented in the patient's electronic health record (EHR) that the screening and admission committee recommended that the patient “first engage in outpatient treatment” and that the patient's service dog could not be cleared for admission due to RRTP staff's inability to store the service dog's medications. Two days later, the psychiatrist reviewed RRTP staff's recommendations with the patient and reminded the patient of an upcoming telemental health appointment scheduled for 20 days later. The patient subsequently canceled the scheduled psychiatry appointment. The psychiatrist made two outreach calls and sent the patient a letter without response. The following day, the non-VA mental health provider completed a “Choice Program - Episode Completion Form,” noting that the “Final Session Date” had occurred four weeks prior.

In fall 2018, the Suicide Prevention Coordinator made three unsuccessful attempts to reach the patient by telephone. In late fall 2018, the Suicide Prevention Coordinator left a voicemail. The next day, the patient called, reported “doing fine,” and “working through” the RRTP decision with a non-VA therapist that the patient was paying out-of-pocket for services. The Suicide Prevention Coordinator inactivated the patient's high risk for suicide patient record flag and documented that the patient “no longer meets criteria for placement on the high risk list.”

In early 2019, the patient called the Veterans Crisis Line, denied current suicidal ideation, reported recent suicidal ideation with a “plan and means,” and had not followed through with the plan “because [the patient] was scared.” The patient requested reengagement with mental health services, reported that the service dog had died a month prior, and was “currently struggling” with “no support system.” The patient reported receiving a call that day regarding eligibility for another service dog and that the call helped the patient realize the need for help. The Veterans Crisis Line staff member discussed a safety plan to utilize that night and placed a suicide prevention consult to the facility.

That same day, the Suicide Prevention Coordinator called the patient who reported having an active plan for suicide but “that (suicide plan) is on the back burner” due to possibly getting another service dog.

One week later, a medical support assistant called the patient, who declined both an in-person appointment with a provider not of the same gender and a telemental health appointment with a same-gendered provider. The patient declined further scheduling attempts and reported a plan to “seek VA care for [mental health] as needed in the future.”

Three days later, the Suicide Prevention Coordinator called the patient and left a voicemail message requesting a return call. One week later, a decedent affairs administrative support assistant documented notification of the patient's death by suicide from the sheriff's office.

## OIG Findings

The OIG found that facility staff made reasonable efforts to accommodate the patient's treatment preferences, completed safety planning with the patient as required, and conducted military sexual trauma (MST) screening and provided related care to the patient as required.<sup>3</sup> Facility staff followed VHA policy and the patient received both non-VA primary care and mental health care through the Veterans Choice Program. VHA staff verified the patient's eligibility and ensured timely appointment scheduling.

The OIG determined that facility leaders and staff did not assign the patient a Mental Health Treatment Coordinator (MHTC) and had not established an MHTC policy as required by VHA. A facility psychiatrist assumed responsibilities for mental health care coordination and patient engagement consistent with the role of an MHTC. However, providers may not always assume those responsibilities, and therefore staff's failure to assign an MHTC may have contributed to care coordination deficiencies. Further, an absence of facility policy to standardize MHTC identification and assignment procedures may have contributed to staff's inconsistent practices and noncompliance with VHA requirements.<sup>4</sup>

Facility staff did not review the patient's high risk for suicide patient record flag within 90 days of placement, as required by VHA.<sup>5</sup> Further, staff did not ensure that the facility's High Risk Review Workgroup approved the patient's high risk for suicide patient record flag inactivation, as required by facility policy.<sup>6</sup> Failure to review the patient's high risk for suicide patient record flag in the High Risk Review Workgroup resulted in inactivation of the patient's flag without interdisciplinary team input, thereby potentially limiting important clinical perspectives applied to making the inactivation decision.<sup>7</sup>

Facility staff inadequately managed the patient's high risk for suicide patient record flag, and failed to assess suicide risk or assess for placement of a high risk for suicide patient record flag following the patient's call to the Veterans Crisis Line.<sup>8</sup> Failure to assess the patient's suicide risk following the patient's Veterans Crisis Line call resulted in insufficient consideration to reactivate the patient's high risk for suicide patient record flag and a lack of information regarding the patient's immediate treatment and care management needs.

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<sup>3</sup> VHA Directive 1115, *Military Sexual Trauma (MST) Program*, May 8, 2018.

<sup>4</sup> VHA DUSHOM Memorandum, "Assignment of the Mental Health Treatment Coordinator."

<sup>5</sup> VHA Directive 2008-036.

<sup>6</sup> Facility Policy 11-38, *VA Portland Patient Record Flags*, August 23, 2016.

<sup>7</sup> In March 2020, in response to an OIG recommendation, VHA formalized high risk for suicide patient record flag inactivation procedures that included factors that must "be considered and documented" in a patient's EHR. VA OIG, [\*Alleged Deficiencies in Mental Health Care Prior to a Death by Suicide at the VA San Diego Healthcare System, California\*](#), Report No. 19-00501-175, August 7, 2019. VHA Notice 2020-13, *Inactivation Process for Category I High Risk for Suicide Patient Record Flags*, March 27, 2020.

<sup>8</sup> VHA DUSHOM Memorandum, "Assignment of the Mental Health Treatment Coordinator," March 26, 2012.

The OIG identified inconsistencies between VHA policy and guidance related to suicide behavior reporting and facility leaders did not follow VHA staff-specific suicide behavior reporting guidance.<sup>9</sup> Inconsistent guidance between the 2008 VHA directive, 2015 VA Suicide Prevention Coordinator Guide, and 2017 memorandum may have contributed to unclear understanding by staff of who should complete the suicide behavior report regarding the patient's death.<sup>10</sup> In 2019, VHA provided updated staff-specific guidance and training related to suicide behavior reporting. However, the updated guidance and training still offered inconsistent information regarding which staff should complete the suicide behavior report.

In 2012, VHA implemented the Behavioral Health Autopsy Program and required that suicide prevention coordinators complete a behavioral health autopsy report within 30 days of notification of a patient's death by suicide.<sup>11</sup> Facility staff did not complete the behavioral health autopsy following the patient's death within the expected time frame.<sup>12</sup> In an interview with the OIG, the Suicide Prevention Coordinator reported the delay in completion of the behavioral health autopsy report was due to competing priorities. Although not within the required time frame, the OIG concluded that staff's delay in completion of the behavioral health autopsy was unlikely to negatively affect quality improvement and program evaluation efforts. However, the OIG would expect facility staff to adhere to VHA timeframe requirements.

In 2010, VHA established RRTP admission criteria including that patients: do not meet criteria for acute inpatient admission, are not a significant risk of harming self or others, require structure and support, and have identified treatment and rehabilitation needs consistent with what the program offers.<sup>13</sup> Patients may apply directly to RRTP services or be referred by providers within or outside VHA. A screening assessment, conducted by a team including a licensed mental health provider and physician or physician extender, is required within five business days

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<sup>9</sup> VHA Directive 2008-036; VHA Guide, *Suicide Prevention Coordinator Guide*; VHA DUSHOM, "High Risk for Suicide Patient Record Flag Changes."

<sup>10</sup> VHA Directive 2008-036; VHA DUSHOM Memorandum, "High Risk for Suicide Patient Record Flag Changes," October 3, 2017. This memorandum was in effect at the time of the events discussed in this report and was rescinded and replaced with VHA DUSHOM Memorandum, "Update to High Risk for Suicide Patient Record Flag Changes," January 16, 2020. The updated memorandum provides new guidance regarding activation and training about the high risk for suicide patient record flag. VHA Guide, *Suicide Prevention Coordinator Guide*, June 19, 2015. This guide was in effect at the time of the events discussed in this report and was rescinded and replaced with VHA Guide, *Suicide Prevention Guide*, November 1, 2020.

<sup>11</sup> VHA DUSHOM Memorandum, "Behavioral Autopsy Program Implementation," December 11, 2012.

<sup>12</sup> VHA DUSHOM Memorandum, "Behavioral Autopsy Program Implementation," December 11, 2012. A behavioral health autopsy is a "standardized medical record review" utilizing a national template and submitted via an approved suicide prevention SharePoint portal.

<sup>13</sup> VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010. This policy was in effect during the time frame of the events discussed in this report and was rescinded and replaced by VHA Directive 1162.02, *Mental Health Residential Rehabilitation Treatment Program*, July 15, 2019.

of receipt of the referral.<sup>14</sup> In September 2018, VA Palo Alto RRTP staff completed the patient's screening eight business days after receipt of the interfacility consult from the facility psychiatrist, exceeding VHA's requirement that screenings be completed within five business days of consult receipt.<sup>15</sup> The OIG determined that VA Palo Alto RRTP did not accept patient self-referrals as required by VHA.<sup>16</sup>

VHA allows service animals to accompany patients in RRTPs provided the animal is "up to date with all core vaccinations." VHA staff cannot require the dog's medical documentation, training documentation, or request the dog demonstrate "work or tasks."<sup>17</sup> VHA staff can only ask the patient if the service animal is required because of a disability and what work or tasks the dog is trained to perform.<sup>18</sup> The OIG found that RRTP staff appropriately considered the request for the patient's service animal to accompany the patient if admitted to the RRTP. However, inconsistent with VHA policy, the VA Palo Alto policy required the completion of an animal health screening, that service dogs to be trained to perform a minimum of three specific tasks, and wear visible identification as an assistance dog.<sup>19</sup>

The OIG made two recommendations to the Under Secretary for Health related to suicide behavior and overdose report staff-specific guidance and timeframe expectations for RRTP admission decisions.<sup>20</sup> The OIG made three recommendations to the Facility Director related to mental health treatment coordinator policy and assignment, suicide behavior and overdose report staff-specific guidance, and behavioral health autopsy report timeliness. The OIG made two recommendations to the VA Palo Alto Director related to aligning facility RRTP procedures and assistance dog policies with VHA requirements.

## Comments

The Deputy to the Deputy Under Secretary for Health, performing the delegable duties of the Under Secretary for Health and Veterans Integrated Service Network and Facility Directors

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<sup>14</sup> In 2015, the VA established a time requirement for completion of RRTP screening assessments. VHA Acting DUSHOM Memorandum, "Access and Wait Times for Admission to a Mental Health Residential Rehabilitation Treatment Program (MH RRTP) (VAIQ 7570870)" VHA Handbook 1162.02.

<sup>15</sup> VHA Acting DUSHOM Memorandum, "Access and Wait Times for Admission to a Mental Health Residential Rehabilitation Treatment Program (MH RRTP) (VAIQ 7570870)," August 21, 2015.

<sup>16</sup> VA Palo Alto Policy 352-16-10.01, *Referral, Screening, and Admission*, February 1, 2016; VHA Handbook 1162.02; VHA Directive 1162.02.

<sup>17</sup> VHA Directive 1188, *Animals on Veterans Health Administration (VHA) Property*, August 26, 2015.

<sup>18</sup> VHA Directive 1188.

<sup>19</sup> VA Palo Alto Health Care System Policy 11K-18-04, *Assistance Dog Policy*, March 31, 2018; VHA Directive 1188.

<sup>20</sup> Recommendations addressed to the Under Secretary for Health were submitted to the Deputy to the Deputy Under Secretary for Health, performing the delegable duties of the Under Secretary for Health.

concurred with the recommendations and provided acceptable action plans (see appendixes A, B, C, D, and E). The OIG will follow up on the planned actions until they are completed.

A handwritten signature in black ink, reading "John D. Daigh, Jr., M.D." in a cursive script.

JOHN D. DAIGH, JR., M.D.  
Assistant Inspector General  
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## Abbreviations

EHR	electronic health record
MHTC	mental health treatment coordinator
MST	military sexual trauma
OIG	Office of Inspector General
PTSD	posttraumatic stress disorder
RRTP	residential rehabilitation treatment program
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



## Introduction

The VA Office of Inspector General (OIG) conducted an inspection to evaluate concerns regarding a patient's mental health care at the VA Portland Health Care System (facility) in Oregon and leaders' response to the patient's death by suicide. The OIG also evaluated referral processes at the VA Palo Alto Health Care System (VA Palo Alto) in California posttraumatic stress disorder (PTSD) residential rehabilitation treatment program (RRTP).

## Background

### VA Portland Health Care System

The facility, part of Veterans Integrated Service Network (VISN) 20, provides healthcare services to more than 95,000 patients yearly. The facility provides a range of inpatient, outpatient, long-term, and emergent care services across the facility and 10 community-based outpatient clinics.

### VA Palo Alto Health Care System

VA Palo Alto, part of VISN 21, provides services to more than 85,000 patients and provides a full range of patient care services including medicine, surgery, psychiatry, and extended care. VA Palo Alto operates the National Center for PTSD and approximately 800 beds including nursing homes, a 100-bed homeless RRTP, a 21-bed men's PTSD RRTP, and a 10-bed women's PTSD RRTP.<sup>1</sup>

## Prior OIG Reports

In a July 2021 report, the OIG identified concerns with facility staff's review of high risk for suicide patient record flags within the required time frame.<sup>2</sup> This finding is relevant to the current inspection.

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<sup>1</sup> In response to a congressional mandate for a center of excellence, VA established the National Center for PTSD in 1989 "to address the needs of Veterans and other trauma survivors with PTSD." VA established seven divisions across the country including one in Palo Alto. PTSD: National Center for PTSD, "History of the National Center for PTSD," accessed on March 8, 2021, [https://www.ptsd.va.gov/about/work/ncptsd\\_history.asp](https://www.ptsd.va.gov/about/work/ncptsd_history.asp). For the purposes of this report, the OIG refers to the PTSD RRTPs as VA Palo Alto RRTP.

<sup>2</sup> VA OIG, *Comprehensive Healthcare Inspection of the VA Portland Health Care System in Oregon*, Report No. 20-1257-180, July 13, 2021.

## Concerns

In September 2020, the OIG Office of Healthcare Inspections conducted a Comprehensive Healthcare Inspection Program review at the facility and identified concerns with a patient's mental health care. In October 2020, the OIG initiated a hotline inspection at the facility to evaluate the following concerns:

1. Care Coordination
  - Accommodation of the patient's treatment preferences
  - Assignment of a mental health treatment coordinator (MHTC)
  - Safety planning
  - Management of the high risk for suicide patient record flag
  - Response to the patient's Veterans Crisis Line call<sup>3</sup>
  - Military sexual trauma (MST) coordinator consultation
2. Leaders' administrative actions following the patient's death
3. Non-VA community care procedures

The OIG also evaluated VA Palo Alto RRTP staff compliance with Veterans Health Administration (VHA) admission criteria procedure requirements and service animal policy.

## Scope and Methodology

The OIG initiated the healthcare inspection on October 15, 2020, and conducted a virtual site visit from December 14–17, 2020.<sup>4</sup>

The OIG team interviewed facility leaders and staff, a VA Palo Alto RRTP manager and VA Palo Alto staff familiar with the patient's care and relevant processes.

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<sup>3</sup> Veterans Crisis Line network website, accessed February 8, 2021, <https://www.veteranscrisisline.net/about/what-is-vcl>. The Veterans Crisis Line is a confidential resource available to veterans to provide crisis support and referrals 24 hours a day, seven days a week.

<sup>4</sup> The site visit was conducted virtually due to the coronavirus (COVID-19) pandemic. World Health Organization (WHO), "WHO Director-General's Opening Remarks at the Media Briefing on COVID-19," March 11, 2020, accessed November 10, 2020, <https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020>. Merriam Webster, *Definition of pandemic*, accessed November 10, 2020, <https://www.merriam-webster.com/dictionary/pandemic>. A pandemic is a disease outbreak over a wide geographic area that affects most of the population. The World Health Organization, *Naming the Coronavirus Disease (COVID-19) and the Virus that Causes It*, accessed November 10, 2020, [https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-\(covid-2019\)-and-the-virus-that-causes-it](https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it). COVID-19 is caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).

The OIG team reviewed relevant VHA directives, handbooks, and memoranda, and facility and VA Palo Alto policies, standard operating procedures, and organizational charts. The OIG team also reviewed the patient's electronic health record (EHR) and internal review documents related to the patient's care.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, Pub. L. No. 95-452, 92 Stat. 1105, as amended (codified at 5 U.S.C. App. 3). The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

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

## Patient Case Summary

The patient, who was in their fifties at the time of death by suicide in early 2019, had a medical history that included diagnoses of [PTSD](#), [major depression](#), [alcohol dependence](#), [cannabis abuse](#), and [nicotine dependence](#).<sup>5</sup> The patient first established VA care in 2001 and received health care at several other VA facilities through late December 2017.

In spring 2018, the patient presented to the facility to establish care after relocating to the area. A mental health nurse screened the patient who reported chronic [suicidal ideation](#) without a plan or intent and discontinuation of prescribed [Prozac](#) and [lamotrigine](#) since early 2018. The patient endorsed daily alcohol consumption to the point of [blackouts](#), denied access to weapons, and requested to restart medications. The mental health nurse completed a comprehensive suicide risk evaluation (comprehensive evaluation), noted a suicide attempt 35 years prior, and assessed the patient as not "at significant risk for self-harm."<sup>6</sup> The mental health nurse documented that

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<sup>5</sup> The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together. The OIG uses the singular form of they (their) in this report for patient privacy.

<sup>6</sup> VHA Deputy Under Secretary for Health for Operations and Management (DUSHOM) Memorandum, "Suicide Risk Screening and Assessment Requirements," May 23, 2018. VHA DUSHOM Memorandum, "Eliminating Veteran Suicide: Implementation Update on Suicide Risk Screening and Evaluation (Risk ID Strategy) and the Safety Planning for Emergency Department (SPED) Initiatives," October 17, 2019. In May 2018, VHA introduced a suicide risk screening and assessment process that included a comprehensive suicide risk evaluation to ask detailed information about the patient's suicidal ideation, previous suicide attempts, warning signs, risk factors, protective factors, clinical impression of acute and chronic risk, and required the provider to establish a plan to mitigate risk, per The Joint Commission suicide risk screening criteria.

the patient declined to review a documented safety plan.<sup>7</sup> A psychologist documented that the patient's mental health "needs are best addressed with Outpatient services" and requested weekly nurse care manager calls to monitor suicidal ideation while the patient awaited an appointment.

Six days later after establishing care, during a weekly nurse care manager call, the patient reported daily suicidal ideation and denied plan or intent. The patient agreed to a telemental health psychiatry appointment scheduled for two weeks later. During the week after the nurse manager call, a telemental health nurse could not reach the patient for a weekly call and emailed the patient a letter. One day before the scheduled telemental psychiatry appointment, a medical support assistant documented that the patient canceled the next day appointment, reported "no longer living in the area," and declined to receive further services.

Nine days later, the telemental health nurse documented that in an email response to the medical support assistant's outreach, the patient reported a lack of permanent housing, unsuccessful efforts to receive trauma-related treatment, daily suicidal ideation, and no support other than an 11-year-old [service dog](#). The patient wrote "I am scared." The telemental health nurse notified a Suicide Prevention Coordinator through the patient's EHR. The next day, the telemental health nurse was unable to reach the patient by phone and left a voicemail message requesting a return call.

Three days later, the patient requested to restart medication management and agreed to telemental health appointments with a same-gendered provider. The patient reported chronic, daily suicidal ideation with a "plan to hang self" and without intent to act on the plan. The telemental health nurse documented that the patient denied access to weapons and agreed to call the Veterans Crisis Line if going to "follow through with [the] plan." A medical support assistant scheduled a telemental health appointment with a same-gendered psychiatrist for approximately one month later.

One week after the patient requested to restart medication management, during a call with the telemental health nurse, the patient reported daily suicidal ideation and agreed to call the Veteran's Crisis Line if the patient "thought would follow through with" suicidal ideation. The telemental health nurse documented that the patient was tearful when discussing feelings of hopelessness and reported use of "12 beers a day" and marijuana "once or twice a day," sleep difficulties, decreased energy, and overeating. Seven days later, the patient did not respond to the telemental health nurse's weekly call.

Two days later, the patient requested an appointment with a same-gendered primary care physician at a community-based outpatient clinic. A medical support assistant placed a non-VA

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<sup>7</sup> VHA, *Suicide Prevention Manual*, June 19, 2015. VA Manual, *Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version*, August 20, 2008. Safety plans should be developed collaboratively with patients at risk for suicide. The basic components of a safety plan include warning signs, coping strategies, social contacts, family and friend contacts, professional contacts, and reducing access to lethal means.

community care consult through the Veterans Choice Program because no appointments were available within 90 days.<sup>8</sup> The next day, the patient did not respond to the telemental health nurse's weekly check-in call. One week later, a facility voucher examiner documented that the patient had a scheduled appointment with a non-VA primary care provider for approximately four weeks later.<sup>9</sup>

Two weeks after the patient did not respond to the weekly check-in call, the telemental health nurse documented that the patient did not respond to telephone and letter outreach attempts, and during the last phone call, was tearful and reported that discussing issues "makes [the patient] upset" and did not appear interested in nurse care management. Five days later, the psychiatrist met with the patient for a scheduled telemental health appointment. The patient reported symptoms of depression occurring most of the day, nearly every day, including periods of tearfulness, isolation, difficulty sleeping, feelings of helplessness and hopelessness "which is very scary," and loss of motivation. Additionally, the patient reported spending anywhere from two hours to all day having thoughts of trauma related to "MST, and physical, sexual, and emotional abuse in childhood." The patient reported having a service dog that the patient had promised to take care of, "but if something happened to [the patient's] dog, [the patient] would have to go to the [emergency department]." The psychiatrist documented that the patient had a "moderate imminent risk for harm to self or others."

The patient reported continued daily substance use consisting of 12 beers, three packs of cigarettes, and one joint of marijuana, and 1.75 liters of vodka per week. The psychiatrist documented that the patient was not interested in alcohol use treatment options or decreased use at that time, but "would like to possibly do so in the future." The psychiatrist completed a comprehensive evaluation and noted that the patient had thoughts of suicide in the past six months with a plan, a past suicide attempt, and access to firearms. The psychiatrist "discussed limiting access" to firearms and documented that the patient was "not willing to give them up." The patient declined to complete a suicide prevention safety plan and reported having a safety plan from another VA facility.

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<sup>8</sup> VA OIG, [\*Review of the Implementation of the Veterans Choice Program\*](#), Report No. 15-04673-333, January 30, 2017. Following the establishment of the Veterans Access, Choice, and Accountability Act of 2014 into law, the Veterans Choice Program was established to provide medical services to eligible veterans through non-VA community healthcare providers. VA Fact Sheet, *Veteran Community Care – Sunset of Veterans Choice Program VA MISSION Act of 2018*, May 2019. United States Senate Committee on Veterans' Affairs, *The VA MISSION Act of 2018*, accessed November 13, 2020, [https://www.veterans.senate.gov/imo/media/doc/One%20Pager\\_The%20VA%20MISSION%20Act%20of%202018.pdf](https://www.veterans.senate.gov/imo/media/doc/One%20Pager_The%20VA%20MISSION%20Act%20of%202018.pdf). The Veterans Choice Program ended on June 6, 2019, and was replaced by the new veterans' non-VA community care program under the VA MISSION Act, which streamlined seven non-VA community care programs. The episode of care and the patient's death was prior to implementation of the VA MISSION Act; and therefore, the MISSION Act is not relevant to this report.

<sup>9</sup> A voucher examiner manages authorizations for non-VA care.



The psychiatrist prescribed [citalopram](#) and lamotrigine “to target [the patient’s] severe symptoms” and because the patient benefited from the medications in the past. The patient declined a pharmacist referral and nurse care manager calls. The patient was scheduled for a follow-up appointment with the psychiatrist one month later.

Approximately two weeks prior to the scheduled follow-up appointment, a pharmacist alerted the psychiatrist in the patient’s EHR that a non-VA community care provider prescribed the patient [hydroxychloroquine](#) and noted a potential drug interaction between hydroxychloroquine and citalopram. Over the next two days, the psychiatrist attempted to contact the patient to discuss the potential drug interaction, request an [electrocardiogram](#), and discuss alternate medications, and left the patient a voicemail. Three days after the pharmacist alerted the psychiatrist, the patient left a voicemail for the psychiatrist and requested to “stop citalopram” and declined an electrocardiogram. The patient rescheduled a telemental health appointment with the psychiatrist eight days sooner than the initial appointment.

At the rescheduled appointment, the patient reported taking lamotrigine for two weeks and discontinuing citalopram due to the potential hydroxychloroquine interaction. The psychiatrist added [fluoxetine](#) and [trazodone](#) to the patient’s medication regimen. The patient was tearful and requested weekly therapy “to talk about issues with [patient’s] family.” The psychiatrist explained that rural telemental health did not provide “long term therapy” and that the patient’s current alcohol use was “an exclusionary criteria.” The psychiatrist noted that the patient purchased a gun “for the [the patient’s] birthday (3 weeks ago) and made prepaid cremation plans at that time,” would “kill [self] if something happens to [the patient’s] dog,” and “made arrangements for [the] dog to be cremated with [the patient] should something happen” to the dog. The patient reported unlikely use of a gun for suicide “due to fear of failing” and discussed hanging as a potential suicide method.

The psychiatrist completed a comprehensive evaluation that identified the patient as high risk for suicidal behavior. The psychiatrist documented that the patient continues to be at “moderate imminent risk for harm to self or others today and a high long-term risk.” The psychiatrist noted that the patient did “not meet criteria for a hospital hold” and “declined voluntary admission” due to being unable to bring the service dog.

The patient agreed to the suicide prevention team being notified and identified a goal of admission to the VA Palo Alto RRTP. The psychiatrist placed a VA Palo Alto RRTP referral and also referred the patient for non-VA community care to receive individual psychotherapy to address “PTSD, alcohol use disorder, depression, [suicidal ideation].” The patient denied feeling at imminent risk of self-harm and reported a goal of admission to the RRTP and “getting a weekly therapist.” The psychiatrist requested weekly nurse care manager calls for “alcohol use,

mood, medication titration, and sleep.” That same day, a Suicide Prevention Coordinator reviewed the patient’s EHR and placed a category I high risk for suicide patient record flag.<sup>10</sup>

The following two days, the mental health nurse and psychiatrist contacted the patient to provide information to establish non-VA community care for psychotherapy but were unable to reach the patient and left voicemails. Two days later, an RRTP Admissions Coordinator documented an unsuccessful attempt to reach the patient to schedule a telephone screening. That same day, the Suicide Prevention Coordinator contacted the patient by telephone for a weekly outreach call. The patient could not speak at that time due to being in a public place, and agreed to a follow-up call the next day. The same day, a mental health nurse made an unsuccessful attempt to schedule the patient for the non-VA psychotherapy appointment.

The next day, the Suicide Prevention Coordinator called the patient, who reported having a safety plan from another VA facility and verbalized contact numbers to call if “acutely suicidal.” The patient discussed the service dog as the patient’s “only support system.” The patient reported receiving a voicemail message from the RRTP Admissions Coordinator the day before, had returned the call, and was “eagerly awaiting to speak with them.” The following day, the Suicide Prevention Coordinator completed a safety plan for the patient that included one contact person and noted a lack of family or friends. The Suicide Prevention Coordinator documented that the patient had sold the previously owned firearm and did not have access to firearms.

That same day, the RRTP Admissions Coordinator scheduled a telephone screening with the patient for one week later. A mental health nurse made a second unsuccessful attempt to contact the patient regarding the non-VA community care psychotherapy referral, documented a plan to send the patient an outreach letter, and alerted the Suicide Prevention Coordinator through the patient’s EHR. On the same day the RRTP Admissions Coordinator scheduled a telephone screening, a medical support assistant contacted the patient and provided notification that telemental health “PTSD Symptoms Management Groups” were not offered at the facility and referred the patient to the psychiatrist for assistance.

On the following day, the psychiatrist called the patient and left a voicemail message providing non-VA community care psychotherapy contact information for scheduling an appointment. That same day, the Suicide Prevention Coordinator mailed the patient the safety plan. The next day, the Suicide Prevention Coordinator called the patient and documented that the patient had contacted non-VA community care to schedule psychotherapy. The Suicide Prevention Coordinator noted that the patient “sounded more engaged,” reported doing “pretty well today,” and discussed the importance of the service dog in the patient’s life.

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<sup>10</sup> VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008. VHA DUSHOM Memorandum, “Update to High Risk for Suicide Patient Record Flag Changes,” January 16, 2020. VHA uses a Patient Record Flag Category I High Risk for Suicide to identify a patient as high risk for suicide in the EHR and requires intensive follow-up by providers while the patient remains flagged.

Five days later, the RRTP Admissions Coordinator completed the telephone screening with the patient and noted that the patient had “a service dog that [the patient] needs to bring” and stated, “I will only attend if my dog can come.” The patient reported the recent firearm purchase and the Admissions Coordinator discussed “gun safety” with the patient. The patient denied intent or plan for suicide and the Admissions Coordinator provided the patient the Veterans Crisis Line phone number.

Two days later, the telemental health nurse conducted a follow-up call to the patient who reported “doing about the same” and “hopeful” to be accepted into a residential treatment program. The patient reported continued substance use and denied suicidal or homicidal ideation, stating, “I’m stable.” The patient requested to discontinue future nurse care manager calls. Twelve days later, a non-VA mental health provider met with the patient and discussed a safety plan that included emergency contacts when experiencing suicidal or homicidal ideation. The non-VA mental health provider documented a plan for “Medication and psychotherapy” with a follow-up appointment one week later.

Six days later, the psychiatrist met with the patient for a telemental health appointment and noted that the patient discussed completing the RRTP screening and had “a strong interest” in the program. The psychiatrist documented that the patient was tolerating medications, had decreased alcohol use to “8 beers 4-5 days per week,” and had a “more hopeful” mood. The psychiatrist noted the patient’s chronic suicidal ideation, time mostly spent with the service dog, and “barely any” social interaction. The psychiatrist documented the patient’s safety risk as “low to moderate imminent risk for harm to self or others today and a moderate to high long-term risk.” The psychiatrist prescribed the patient [prazosin](#), increased the patient’s fluoxetine dosage, continued lamotrigine, and noted that the patient had discontinued trazodone due to lack of effect. The psychiatrist added a comment to the RRTP consult requesting a referral status update and noted the patient’s reduced alcohol intake. The next day, the patient attended a second non-VA telemental health appointment for psychotherapy.

Five days later, the RRTP Admissions Coordinator documented in the patient’s EHR that the screening and admission committee recommended that the patient “first engage in outpatient treatment” related to substance use and “actively engage in mental health treatment.” Additionally, the RRTP Admissions Coordinator noted that the patient’s service dog could not be cleared for admission due to inability to store the service dog’s medications. Two days later, the patient contacted a medical support assistant inquiring about an update on the RRTP referral. Later that day, the psychiatrist contacted and documented informing the patient that the RRTP application was “rejected” and the RRTP could not accommodate the patient’s service dog. The psychiatrist reviewed RRTP staff’s recommendations to engage in outpatient substance use disorder treatment and continue engagement in mental health treatment. The psychiatrist reminded the patient of an upcoming telemental health appointment scheduled for 20 days later.

Eight days prior to the scheduled psychiatry appointment, the patient canceled. Nine days later, the psychiatrist called the patient regarding the canceled appointment and the patient's medications nearing expiration. The psychiatrist noted making two outreach calls and sending a letter to the patient without response since the last successful contact with the patient three weeks prior. That same day, the non-VA mental health provider completed a "Choice Program - Episode Completion Form," noting that the "Final Session Date" had occurred four weeks prior. The non-VA mental health provider documented a discharge plan for the patient to follow up with a primary care physician, that the patient intended to attend the RRTP once admitted, and that a safety plan was discussed with the patient.

Nine days after the non-VA mental health provider completed the form, the Suicide Prevention Coordinator called the patient who did not answer and left a voicemail message requesting a return call. The Suicide Prevention Coordinator documented that the patient remained "flagged high risk-suicide" and had not responded to phone calls or a letter. Approximately three weeks later, the Suicide Prevention Coordinator called the patient "to check on [the patient's] overall welfare and mood. The patient did not answer and the Suicide Prevention Coordinator left a voicemail message requesting a return call. The Suicide Prevention Coordinator noted that the patient's EHR did not have an emergency contact or next of kin listed and a safety contact was not designated in the patient's suicide prevention safety plan. That same day, a Lead Suicide Prevention Coordinator conducted a "90 DAY EVALUATION" of the patient's high risk for suicide patient record flag and noted "Flag being administratively continued pending review [in 13 days]."

Four days prior to the pending review, the Suicide Prevention Coordinator called the patient who did not answer and left a voicemail requesting a return phone call. Six days later, in late 2018, the Suicide Prevention Coordinator left another voicemail, noting that if the patient did not call back by the next day, the Suicide Prevention Coordinator would contact local law enforcement to check on the patient. The next day, the patient called the Suicide Prevention Coordinator and reported "doing fine," that the RRTP denial "crushed me," and that the patient was "working through" the RRTP decision with a non-VA therapist that the patient was paying out-of-pocket for services. The patient reported "difficulty accepting" telemental health services and "never really felt comfortable with that process." Following the call with the patient, the Suicide Prevention Coordinator inactivated the patient's high risk for suicide patient record flag and documented that the patient "no longer meets criteria for placement on the high risk list."

Approximately 11 weeks later, in early 2019, the patient called the Veterans Crisis Line, denied current suicidal ideation, reported recent suicidal ideation with a "plan and means," and did not follow through with the plan "because [the patient] was scared." The patient requested reengagement with a "psychiatrist, therapist, available services in the area; medication management; reenroll in PTSD program if eligible." The patient reported that the service dog died a month prior and was "currently struggling" with "no support system." The patient

reported receiving a call that day regarding eligibility for another service dog and that the call helped the patient realize the need for help. The Veterans Crisis Line staff member discussed a safety plan to utilize that night and placed a suicide prevention consult to the facility.

That same day, a medical support assistant documented that the patient left a voicemail requesting a return call to “discuss treatment options,” and alerted the patient’s psychiatrist and a Suicide Prevention Coordinator through the patient’s EHR. The Suicide Prevention Coordinator called the patient who reported discontinuing mental health treatment and medications in summer 2018. The patient also acknowledged not actually having been engaged in non-VA mental health services at the time of the late 2018 call with the Suicide Prevention Coordinator. The patient reported grief and isolation, leaving home “only twice,” since the service dog’s death, and that the process for getting another service dog could take six months. The patient reported having an active plan for suicide but “that (suicide plan) is on the back burner” due to possibly getting another service dog.

The patient also described telemental health services as “awkward and strange,” and wanted in-person VA mental health services with “someone who can prescribe medications” “even if it means I have to drive several hours to a VA clinic or hospital.” The patient reportedly discarded the safety plan from summer 2018 and declined receiving another safety plan by mail because other residents in the patient’s community “sometimes get [the patient’s] mail and open it up.” The patient reported a plan to call the Veterans Crisis Line if in need of support and the patient agreed to a call the following day “to check in.” The Suicide Prevention Coordinator documented a plan to reassess the need for a high risk for suicide patient record flag following the call the next day. The Suicide Prevention Coordinator alerted the psychiatrist through the patient’s EHR of the patient’s willingness to reengage in outpatient mental health services and preference to meet in person.

The next day, the patient expressed a preference for in-person appointments at either a specified VA community-based outpatient clinic or VA clinic. The patient agreed to weekly suicide prevention check-in calls while awaiting an appointment.

The following day, a psychiatric mental health nurse practitioner covering for the patient’s psychiatrist placed a consult for the patient to be seen for an in-person appointment with a prescribing provider at one of the requested clinics. Five days later, a medical support assistant called the patient, who declined both an in-person appointment with a provider not of the same gender, and a telemental health appointment with a same-gendered provider. The patient declined further scheduling attempts and reported a plan to “seek VA care for [mental health] as needed in the future.”

Three days later, the Suicide Prevention Coordinator called the patient and left a voicemail message requesting a return call. One week later, a decedent affairs administrative support assistant documented notification of the patient’s death by suicide from the sheriff’s office. The documentation included that the patient died by “fatal gunshot to head.”

## Inspection Results

### 1. Care Coordination

The OIG found that facility staff made reasonable efforts to accommodate the patient's treatment preferences and completed safety planning with the patient, as required. However, the OIG determined that facility leaders and staff did not assign the patient an MHTC or establish an MHTC policy as required, inadequately managed the patient's high risk for suicide patient record flag, and failed to assess suicide risk or assess for placement of a high risk for suicide patient record flag following the patient's call to the Veterans Crisis Line.<sup>11</sup> Facility staff also conducted MST screening and provided MST-related care to the patient as required, so consultation with the MST coordinator was not necessary.<sup>12</sup>

#### Accommodation of Patient's Treatment Preferences

VHA encourages staff to honor provider gender preferences for patients being treated for MST or other mental health conditions when clinically indicated.<sup>13</sup> VHA requires that patients residing in rural areas have access to mental health services and if a patient's needs cannot be accommodated, facility staff should refer the patient to another VA facility or non-VA community care.<sup>14</sup>

In early summer 2018, the patient requested mental health treatment with a same-gendered prescribing provider and willingness to engage in telemental health services. That day, the patient was scheduled with a same-gendered psychiatrist. For approximately three weeks in midsummer 2018, the patient participated in rural telemental health treatment with the psychiatrist. In midsummer 2018, in response to the patient's requests "to talk through recent familial issues" with a therapist, the patient's psychiatrist entered a non-VA community care mental health consult for psychotherapy. The following week, the mental health nurse unsuccessfully phoned the patient on two days to discuss the non-VA mental health care referral and sent a letter advising the patient to contact the community care contractor directly to schedule care. The following month, the patient attended two non-VA "telecare" mental health appointments with a same-gendered non-VA mental health provider.<sup>15</sup>

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<sup>11</sup> VHA DUSHOM Memorandum, "Assignment of the Mental Health Treatment Coordinator," March 26, 2012.

<sup>12</sup> VHA Directive 1115, *Military Sexual Trauma (MST) Program*, May 8, 2018.

<sup>13</sup> VHA Handbook 1160.0, *Uniform Mental Health Services*, September 11, 2008, amended November 16, 2015; VHA Directive 1115.

<sup>14</sup> VHA Handbook 1160.0.

<sup>15</sup> The patient ended treatment with the non-VA psychiatric nurse practitioner. Approximately one month later, the patient's non-VA psychiatric nurse practitioner completed an "episode completion form" for the patient.

In early 2019, the patient requested to reengage in medication management and in-person mental health treatment. One week later, a medical support assistant who spoke with the patient documented that the patient declined an appointment with both the available in-person provider who did not meet the patient's gender preference and the same-gendered telemental health provider.

The OIG found that in 2018 when the patient initially established mental health care, facility staff accommodated the patient's preference for a same-gendered provider. When the patient requested to reengage in treatment in 2019, facility staff offered the patient in-person treatment but were unable to accommodate the patient's same-gendered provider request. The Chief of Staff and facility outpatient mental health staff told the OIG that the community-based outpatient clinic did not have a same-gendered therapist available to meet in-person with the patient. In interviews with the OIG, facility outpatient mental health staff reported that staff refer patients to non-VA community care when they are unable to accommodate a patient's treatment preferences. The OIG determined that facility staff made reasonable efforts to accommodate the patient's preferences for a same-gendered provider and in-person treatment and appropriately referred the patient to non-VA community care when unable to accommodate these preferences.

### **Assignment of an MHTC**

Since 2012, VHA requires that staff assign an MHTC no later than a patient's third outpatient mental health visit. The MHTC must be "clearly identified" by documentation in the patient's EHR of the assignment, or subsequent reassignments, using a "separate progress note" titled "MHTC Assignment/Reassignment Note."<sup>16</sup> The MHTC's goal is to ensure continuity of care during care transitions, and assist a patient's engagement in treatment.<sup>17</sup> VHA also requires that leaders at each facility establish a policy that guides procedures for identification of the MHTC and ensures assignment to all patients waiting to transition to another level of care to ensure patients' continuity of care.<sup>18</sup>

From midsummer through early fall 2018, the psychiatrist met with the patient three times for medication management and consult management. The patient's EHR did not include documentation of an MHTC assignment. In an interview with the OIG, the patient's psychiatrist reported receiving instruction not to self-assign as an MHTC but could not recall who provided the instruction. However, the psychiatrist reported attempting to coordinate the patient's care despite not being assigned as the patient's MHTC.

The Clinical Director of Mental Health and Neurosciences and the Rural Mental Health Manager told the OIG that the procedure for MHTC assignment is that a provider self-assigns and places

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<sup>16</sup> VHA DUSHOM Memorandum, "Assignment of the Mental Health Treatment Coordinator."

<sup>17</sup> VHA DUSHOM Memorandum, "Assignment of the Mental Health Treatment Coordinator."

<sup>18</sup> VHA DUSHOM Memorandum, "Assignment of the Mental Health Treatment Coordinator."

an order that prompts administrative staff to designate the provider as the MHTC in the patient's EHR. The Rural Mental Health Manager was not able to locate an MHTC order in the patient's EHR. The Patient Safety and Risk Awareness Operations Manager indicated that the facility did not have an MHTC policy, and the Clinical Director of Mental Health and Neurosciences confirmed to the OIG that facility staff followed national policy.

The OIG found that facility staff did not assign the patient an MHTC and that facility leaders did not establish a facility MHTC policy, as required by VHA.<sup>19</sup> The OIG concluded that the facility psychiatrist assumed responsibilities for mental health care coordination and patient engagement consistent with the role of an MHTC. However, providers may not always assume those responsibilities, and therefore staff's failure to assign an MHTC may have contributed to care coordination deficiencies. Further, an absence of facility policy to standardize MHTC identification and assignment procedures may have contributed to staff's inconsistent practices and noncompliance with VHA requirements.<sup>20</sup>

## **Safety Planning**

VHA instructs providers to complete safety plans in collaboration with the patient to include the patient's warning signs, personal coping skills, mental health and social support contact information, and a plan to identify and reduce access to lethal means.<sup>21</sup> The suicide prevention coordinator is responsible for ensuring that a safety plan is completed for all patients with a high risk for suicide patient record flag. The suicide prevention coordinator must also track that safety plans are regularly updated.<sup>22</sup> Facility guidelines require that a safety plan is completed with a patient within seven days of placement of a high risk for suicide patient record flag.<sup>23</sup>

The psychiatrist met with the patient in summer 2018, and documented the patient's report of possessing a firearm, being unwilling to relinquish it, and having a safety plan from another VA facility. The psychiatrist completed a comprehensive evaluation, determined that the patient's suicide risk was moderate, and documented that the patient declined to complete a new safety plan with the psychiatrist. Approximately three weeks later, the psychiatrist completed another comprehensive evaluation with the patient and determined the patient's suicide risk was high. The psychiatrist documented that the patient reported being familiar with the previously developed safety plan, did not have any safety plan updates, and alerted the Suicide Prevention Coordinator through the patient's EHR. The same day, the Suicide Prevention Coordinator

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<sup>19</sup> VHA DUSHOM Memorandum, "Assignment of the Mental Health Treatment Coordinator."

<sup>20</sup> VHA DUSHOM Memorandum, "Assignment of the Mental Health Treatment Coordinator."

<sup>21</sup> VHA Manual, *Safety Planning Manual*, August 19, 2008.

<sup>22</sup> VHA Guide, *Suicide Prevention Coordinator Guide*, June 19, 2015.

<sup>23</sup> VA Portland Health Care System, *High Risk for Suicide Flagging Guidelines*, 2020.



reviewed the patient's EHR, determined the patient met criteria, and placed a high risk for suicide patient record flag in the patient's EHR.

Five days later, the Suicide Prevention Coordinator called the patient "to check on [the patient's] mood and overall welfare," and documented that the patient verbalized contact numbers to call if feeling "acutely suicidal." The next day, the Suicide Prevention Coordinator documented the patient's completed safety plan that included that the patient sold the firearm and no longer had access to lethal means and, the following day, mailed the patient a copy of the safety plan.

The OIG found that the Suicide Prevention Coordinator completed the suicide safety plan with the patient consistent with VHA and facility expectations, including completion within seven days and mailing a copy of the plan to the patient.<sup>24</sup>

### **Management of the High Risk for Suicide Patient Record Flag**

In 2008, VHA established the high risk for suicide patient record flag to alert staff of immediate clinical safety concerns.<sup>25</sup> The suicide prevention coordinator, in collaboration with a patient's treating providers, was responsible for activating the high risk for suicide patient record flag within 24 hours of determining that it was indicated, reviewing a patient's flag for continuation or inactivation every 90 days, and communicating review outcomes with "the facility-designated advisory group or committee."<sup>26</sup> VHA instructed that the high risk for suicide patient record flag "is removed as soon as it is clinically indicated to do so."<sup>27</sup>

The OIG found that facility staff did not review the patient's high risk for suicide patient record flag within 90 days of placement, as required by VHA.<sup>28</sup> Further, staff did not ensure that the facility's High Risk Review Workgroup approved the patient's high risk for suicide patient record flag inactivation, as required by facility policy.<sup>29</sup>

The Chief of Staff established the High Risk Review Workgroup, consistent with VHA's requirement regarding an advisory group or committee for the high risk for suicide patient record flag activation and review process.<sup>30</sup> The facility's High Risk Review Workgroup was chartered in 2008 and included an interdisciplinary clinical team responsible for reviewing high risk for suicide patient record flags "within 90-100 [days] of initial placement," which is inconsistent

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<sup>24</sup> VHA Manual, *Safety Planning Manual*.

<sup>25</sup> VHA Directive 2008-036.

<sup>26</sup> VHA Directive 2008-036; VHA DUSHOM Memorandum, "High Risk for Suicide Patient Record Flag Changes," October 3, 2017; VHA Guide, *Suicide Prevention Coordinator Guide*.

<sup>27</sup> VHA Directive 2008-036.

<sup>28</sup> VHA Directive 2008-036.

<sup>29</sup> Facility Policy 11-38, *VA Portland Patient Record Flags*, August 23, 2016.

<sup>30</sup> VHA Directive 2008-036.

with VHA's 90 day review requirement.<sup>31</sup> The High Risk Review Workgroup, "in conjunction with the Suicide Prevention Team," is responsible for reviewing and making recommendations whether to inactivate high risk for suicide patient record flags, and maintaining documentation supporting inactivation.<sup>32</sup>

In summer 2018, the Suicide Prevention Coordinator, in collaboration with the patient's treating provider, determined that the patient met criteria for and placed a high risk for suicide patient record flag in the patient's EHR. Three months later, in fall 2018, the day the patient's high risk for suicide patient record flag was due for 90-day review, the Lead Suicide Prevention Coordinator documented that the flag would be "continued pending review" 13 days later.<sup>33</sup> The late 2018 meeting minutes did not include a review of the patient's high risk for suicide patient record flag. In an interview with the OIG, the Suicide Prevention Coordinator was unsure why the patient was not included in the meeting minutes and speculated that the High Risk Review Workgroup discussed the patient and did not document the discussion. The Lead Suicide Prevention Coordinator was unable to explain to the OIG why the patient was omitted from the High Risk Review Workgroup meeting minutes and recalled having a discussion with the Suicide Prevention Coordinator regarding the patient's high risk for suicide patient record flag.

Two days later, the Suicide Prevention Coordinator called the patient and left a voicemail message indicating that if a return call was not received by the following day, "it will be necessary to contact local law enforcement to check on" the patient. The following day, the Suicide Prevention Coordinator spoke to the patient who reported that the VA Palo Alto RRTP admission denial "crushed me," but was "working through" the decision with a non-VA therapist, and "doing fine." The Suicide Prevention Coordinator did not document a suicide risk assessment, and in an interview with the OIG, the Suicide Prevention Coordinator speculated that not asking specifically about suicidality was due to the patient not indicating suicidal intent and agreeing to mental health treatment, and regular calls from the Suicide Prevention Coordinator.

Later the same day, the Suicide Prevention Coordinator inactivated the patient's high risk for suicide patient record flag and indicated that "Documentation supporting this decision is available through the Suicide Prevention Coordinator." However, the Suicide Prevention Coordinator was unable to provide documentation supporting the decision to inactivate the patient's high risk for suicide patient record flag and told the OIG that the reference to

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<sup>31</sup> The facility's High Risk Review Workgroup is chaired by the lead suicide prevention coordinator or designee and includes members from "clinical teams such as Suicide Prevention Team, Mental Health, and other service lines are recruited as appropriate." Facility Charter, *High Risk Review Workgroup*. Facility staff did not provide a dated and signed charter as requested by the OIG team. VHA Directive 2008-036.

<sup>32</sup> Facility Policy 11-38.

<sup>33</sup> VHA Directive 2008-036. The Lead Suicide Prevention Coordinator administratively continued the patient's high risk for suicide patient record flag. However, facility staff did not complete a clinical review to determine continuation or inactivation of the patient's high risk for suicide patient record flag.

supporting documentation in the patient's EHR referred to the High Risk Review Workgroup discussion. The OIG found no evidence that the High Risk Review Workgroup reviewed the patient's care to determine inactivation of the patient record flag. Failure to review the patient's high risk for suicide patient record flag in the High Risk Review Workgroup resulted in inactivation of the patient's flag without interdisciplinary team input thereby potentially limiting important clinical perspectives applied to making the inactivation decision.<sup>34</sup>

## Response to the Patient's Veterans Crisis Line Call

Suicide prevention coordinators are responsible for coordinating facility suicide prevention strategies including responding to patient calls to the Veteran Crisis Line.<sup>35</sup> Upon receiving a Veterans Crisis Line call that requires nonurgent follow-up, the Veterans Crisis Line responder sends a referral in an email to and calls the suicide prevention coordinator.<sup>36</sup> The suicide prevention coordinator is responsible for ensuring that all Veterans Crisis Line referrals are responded to appropriately including patient outreach, a consult request note alerting appropriate care providers, and consideration of a high risk for suicide patient record flag.<sup>37</sup>

VHA guidance instructs that determination of a patient as at high risk for suicide should be based on clinical judgment after an evaluation of risk and protective factors and warning signs, which include having a plan to kill oneself.<sup>38</sup> VHA's assessment guide assists clinicians in "assessment and care decisions" that highlighted three warning signs: (1) threatening to kill oneself, (2) looking for ways to kill oneself, and (3) talking about suicide.<sup>39</sup> Upon identification of warning signs, clinicians should ask the patient about feelings of hopelessness, thoughts of taking one's life, plans to take one's life, and past suicide attempts.<sup>40</sup>

In early 2019, the patient called the Veterans Crisis Line requesting to re-establish mental health treatment. The patient "denied current [suicidal ideation] but reported recent [suicidal ideation] with plan and means" and did not "follow through" because the patient "was scared." The responder and patient created a safety plan that included remaining "occupied on the internet,"

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<sup>34</sup> In March 2020, in response to an OIG recommendation, VHA formalized high risk for suicide patient record flag inactivation procedures that included factors that must "be considered and documented" in the patient's EHR. VA OIG, [\*Alleged Deficiencies in Mental Health Care Prior to a Death by Suicide at the VA San Diego Healthcare System, California\*](#), Report #19-00501-175, August 7, 2019; VHA Notice 2020-13, *Inactivation Process for Category I High Risk for Suicide Patient Record Flags*, March 27, 2020.

<sup>35</sup> VHA Guide, *Suicide Prevention Coordinator Guide*.

<sup>36</sup> VHA Guide, *Suicide Prevention Coordinator Guide*.

<sup>37</sup> VHA Guide, *Suicide Prevention Coordinator Guide*.

<sup>38</sup> VHA Directive 2008-036.

<sup>39</sup> VHA, *Suicide Risk Assessment Guide Reference Manual*.

<sup>40</sup> VHA, *Suicide Risk Assessment Guide Reference Manual*.

sleeping, and calling the Veterans Crisis Line again “if in crisis.” The responder also placed a referral to the facility’s Suicide Prevention Coordinator.

The same day, the patient told the Suicide Prevention Coordinator that the patient discontinued psychiatric medications, the service dog died, and the patient’s suicide plan was “on the back burner” after learning of the possibility of getting another service dog. Despite the patient reporting a suicide plan, the Suicide Prevention Coordinator did not assess risk and protective factors or further develop a safety plan with the patient. The Suicide Prevention Coordinator documented a plan to “check in” with the patient the next day, and “re-assess need for a high risk-suicide flag.”

The following day, the Suicide Prevention Coordinator called the patient as planned and arranged “weekly check in calls” until the patient “gets enrolled/attends” a mental health appointment.<sup>41</sup> However, the Suicide Prevention Coordinator did not document a suicide risk assessment or reassessment of the patient’s need for a high risk for suicide patient record flag. The following week, the Suicide Prevention Coordinator made an unsuccessful follow-up call to the patient.<sup>42</sup> One week later, 17 days after the patient’s call to the Veterans Crisis Line, the County Sheriff’s Office notified a decedent affairs administrative support assistant of the patient’s death by suicide.

The Suicide Prevention Coordinator responded to the patient’s Veterans Crisis Line call the same day, arranged for a follow-up call the next day, and documented a plan to reassess the patient for a high risk for suicide patient record flag. However, the OIG found that, during the follow-up call, the Suicide Prevention Coordinator did not assess the patient’s suicide risk or reassess the patient for a high risk for suicide patient record flag.

The Suicide Prevention Coordinator told the OIG that the patient’s agreement to check-in phone calls and not talking about feeling hopeless may have influenced the decision not to complete a suicide risk assessment during the early 2019 follow-up call. The Suicide Prevention Coordinator also noted not seeing a need to reactivate the patient’s high risk for suicide patient record flag at the time of the call. However, the Suicide Prevention Coordinator told the OIG that it may have been helpful to reactivate the patient’s flag to ensure that the patient engaged in mental health services. Failure to assess the patient’s suicide risk following the patient’s Veterans Crisis Line call resulted in insufficient consideration to reactivate the patient’s high risk for suicide patient

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<sup>41</sup> Six days later, a medical support assistant offered the patient a face-to-face appointment with a provider not of the same gender and a telemental health appointment with a same-gendered provider. The patient declined all scheduling attempts.

<sup>42</sup> The Suicide Prevention Coordinator’s weekly call was delayed due to snow emergency office closure. This was the last call the Suicide Prevention Coordinator made as facility staff were notified of the patient’s death one week later.

record flag and a lack of information regarding the patient's immediate treatment and care management needs.

## **MST Coordinator Consultation**

As of 2015, VHA requires that facility leaders appoint an MST coordinator to ensure that patients are screened for MST.<sup>43</sup> MST coordinators serve as the point of contact and resource for MST-related care issues.<sup>44</sup> Facility leaders must ensure that on-site outpatient and inpatient mental health treatment options are available to patients with "MST-related conditions," including PTSD, substance use, and depression. Additionally, facility leaders must ensure that community-based outpatient clinics provide access to MST-related services on-site or through telemental health. If unable to provide MST-related services in an environment that accommodates a patient's gender and modality preference, such as single gender individual or group therapy, staff must offer patients telemental health or a referral to a vet center or community care.<sup>45</sup>

In spring 2018, during the mental health access screening, the mental health nurse noted the patient's diagnosis of PTSD related to MST and referred the patient to rural telemental health for medication management. The mental health nurse made weekly check-in calls until the patient's scheduled mental health appointment with a psychiatrist. From mid through late summer 2018, the psychiatrist met with the patient three times for psychotherapy and medication management. The psychiatrist provided referrals to the VA Palo Alto RRTP and non-VA mental health treatment with a same-gendered provider because rural telemental health did not provide "long term therapy" and the patient's current alcohol use was an "exclusionary criteria."

The psychiatrist told the OIG that the patient's PTSD related to MST was part of the patient's reason for participating in outpatient mental health treatment. The psychiatrist said that because the patient was receiving mental health care, there was no need to consult with the MST coordinator. In an interview with the OIG, the MST Coordinator also reported that an MST Coordinator consultation was not expected because the patient was already enrolled in outpatient mental health treatment.

The OIG determined that facility staff conducted MST screening and provided MST-related care to the patient in outpatient and non-VA mental health settings, as required.<sup>46</sup> Given that the patient was engaged in MST-related care, the OIG determined that it was not necessary for staff to consult with the MST coordinator.

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<sup>43</sup> VHA Handbook 1160.01.

<sup>44</sup> VHA Directive 1115.

<sup>45</sup> VHA Directive 1115.

<sup>46</sup> VHA Directive 1115.

## 2. Leaders' Administrative Actions Following the Patient's Death

The OIG identified inconsistencies between VHA policy and guidance related to suicide behavior reporting, and facility leaders did not follow VHA staff-specific suicide behavior reporting guidance.<sup>47</sup> The OIG also found that facility staff did not complete the behavioral health autopsy within the expected time frame following the patient's death.<sup>48</sup>

### Suicide Behavior Report

The OIG determined that inconsistent guidance between the 2008 VHA directive, 2015 VA Suicide Prevention Coordinator Guide, and 2017 memorandum may have contributed to unclear understanding by staff as to whom should complete the suicide behavior report regarding the patient's death.<sup>49</sup> In 2019, VHA provided updated staff-specific guidance and training related to suicide behavior reporting. However, the OIG found that the guidance and training again offered inconsistent information regarding which staff should complete the suicide behavior report.

### VHA Guidance at the Time of the Patient's Death

In 2008, VHA established the suicide behavior report, defined as documentation completed by "clinical staff" upon learning of patient suicide attempts or significant suicidal behavior to comply with National Patient Safety reporting requirements.<sup>50</sup> The 2015 VA Suicide Prevention Coordinator Guide instructed that the "first person to receive information of the death by suicide should document the information" in the suicide behavior report and did not specify that the suicide behavior report must be completed by clinical staff.<sup>51</sup> In 2017, VHA instructed suicide prevention coordinators to train "clinical staff" on use of the suicide behavior report.<sup>52</sup>

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<sup>47</sup> VHA Directive 2008-036; VHA Guide, *Suicide Prevention Coordinator Guide*; VHA DUSHOM, "High Risk for Suicide Patient Record Flag Changes."

<sup>48</sup> VHA DUSHOM Memorandum, "Behavioral Autopsy Program Implementation," December 11, 2012. A behavioral health autopsy is a "standardized medical record review" utilizing a national template and submitted via an approved suicide prevention SharePoint portal.

<sup>49</sup> VHA Directive 2008-036; VHA DUSHOM Memorandum, "High Risk for Suicide Patient Record Flag Changes," October 3, 2017. This memorandum was in effect at the time of the events discussed in this report and was rescinded and replaced with VHA DUSHOM Memorandum, "Update to High Risk for Suicide Patient Record Flag Changes," January 16, 2020. The updated memorandum provides new guidance regarding activation and training about the high risk for suicide patient record flag. The two memoranda contain the same or similar language related to the guidance all facilities must follow for the management of high risk for suicide patient record flags. VHA Guide, *Suicide Prevention Coordinator Guide*, June 19, 2015. This guide was in effect at the time of the events discussed in this report and was rescinded and replaced with VHA Guide, *Suicide Prevention Guide*, November 1, 2020. The two guides contain the same or similar language related to the guidance all facilities must follow for suicide behavior reports.

<sup>50</sup> VHA Directive 2008-036.

<sup>51</sup> VHA Guide, *Suicide Prevention Coordinator Guide*.

<sup>52</sup> VHA DUSHOM Memorandum, "High Risk for Suicide Patient Record Flag Changes," October 3, 2017.

### *Facility Staff's Suicide Behavior Report Regarding the Patient*

Facility policy stated that “all medical center employees” with EHR access were responsible for completing the suicide behavior report within 24 hours of becoming aware of the behavior.<sup>53</sup> In early 2019, the Decedent Affairs Administrative Support Assistant learned of the patient's death by suicide, entered the suicide behavior report into the patient's EHR, and notified the Suicide Prevention Coordinator. The Decedent Affairs Administrative Support Assistant did not complete information in the suicide behavior report template, including the patient's last pain score, family and other support, treatment plan changes, primary care and mental health providers, and a “Brief Plan/Disposition.”<sup>54</sup> The Decedent Affairs Administrative Support Assistant told the OIG that the patient's suicide behavior report was based solely on the information in the death certificate.

The Suicide Prevention Coordinator acknowledged receipt of the suicide behavior report notification the same day and did not add further information. The Lead Suicide Prevention Coordinator told the OIG that the Decedent Affairs Administrative Support Assistant received one-on-one suicide behavior report training in late 2018, and completed the suicide behavior report consistent with facility policy.

The OIG found that the Decedent Affairs Administrative Support Assistant completed the suicide behavior report consistent with the 2015 VA Suicide Prevention Coordinator Guide and facility policy, although not consistent with the 2008 VHA directive and 2017 VHA memorandum.<sup>55</sup>

### *VHA Updated Guidance*

In April 2019, VHA provided additional suicide behavior report guidance that delineated specific staff allowed to complete the suicide behavior report and did not include non-clinical staff.<sup>56</sup> In April 2021, Office of Mental Health and Suicide Prevention leaders also reported to the OIG that non-clinical staff do not complete suicide behavior reports. However, the Office of Mental Health and Suicide Prevention implemented related training that continued to provide inconsistent guidance. Specifically, the training instructed both that the suicide behavior report “can be completed by the first staff member” who learns of a completed suicide event or

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<sup>53</sup> Facility Policy 11-04, *Suicides, Attempts, and Suicidal Behavior*, December 11, 2015. The Suicide Prevention Coordinator provided a draft version of the facility policy that was not in place as of January 29, 2021.

<sup>54</sup> The OIG modified a portion of the quoted text from upper to lower case for readability purposes.

<sup>55</sup> VHA Directive 2008-036; VA Guide, *Suicide Prevention Coordinator Guide*; VHA DUSHOM Memorandum, “High Risk for Suicide Patient Record Flag Changes.”

<sup>56</sup> In April 2019, VHA revised the suicide behavior report to a new template and renamed it, “Suicide Behavior and Overdose Report.” For the purposes of this report, the OIG will refer to both reports as the suicide behavior report. VHA DUSHOM Memorandum, *Suicide Behavior and Overdose Report Computerized Patient Record System (CPRS) Note Template Implementation*, April 8, 2019.



overdose and also referred to staff-specific guidance detailing the specific clinical staff allowed to complete the suicide behavior report.

In an interview with the OIG, the facility's Lead Suicide Prevention Coordinator acknowledged that more recent VHA guidance did not allow all staff with EHR access to complete the suicide behavior report; however, indicated that facility leaders decided to continue to have every staff member with EHR access complete the suicide behavior report. A September 2019 facility policy revision, developed with mental health and facility leaders' input, maintained responsibility of "all medical center employees" with EHR access to complete the suicide behavior report.<sup>57</sup> The Lead Suicide Prevention Coordinator told the OIG that requiring "all medical center employees with [EHR] access" to complete the suicide behavior report "would actually maintain a higher standard."

The OIG found that facility policy was inconsistent with the 2019 VHA requirement for specified clinical staff to complete the suicide behavior report.<sup>58</sup> Facility leaders' failure to adhere to VHA suicide behavior report guidance may result in the omission of significant clinical information when staff not deemed qualified by VHA complete the suicide behavior report in response to a patient's death by suicide.

## **Behavioral Health Autopsy Program**

In 2012, VHA implemented the Behavioral Health Autopsy Program and required that suicide prevention coordinators complete a behavioral health autopsy report within 30 days of notification of a patient's death by suicide.<sup>59</sup> Information obtained from the behavioral health autopsy report was intended to "be used for quality improvement efforts and program evaluation services."<sup>60</sup>

In early 2019, the Decedent Affairs Administrative Support Assistant alerted the Suicide Prevention Coordinator of the patient's death by suicide through the EHR and the Suicide Prevention Coordinator acknowledged the notification the same day. The Suicide Prevention Coordinator completed a behavioral health autopsy report in spring 2019, 47 calendar days (33 business days) after notification of the patient's death. In an interview with the OIG, the Suicide Prevention Coordinator reported the delay in completion of the behavioral health autopsy report was due to competing priorities.

Although not within the required time frame, the OIG concluded that staff's delay in completion of the behavioral health autopsy was unlikely to negatively affect quality improvement and

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<sup>57</sup> Facility Policy 11-04.

<sup>58</sup> Facility Policy 11-04.

<sup>59</sup> VHA DUSHOM Memorandum, "Behavioral Autopsy Program Implementation."

<sup>60</sup> VHA DUSHOM Memorandum, "Behavioral Autopsy Program Implementation."



program evaluation efforts. However, the OIG would expect facility staff to adhere to VHA time frame requirements.

### 3. Non-VA Community Care Procedures

Facility staff referred the patient to non-VA community care for primary care in summer 2018 and for mental health treatment in summer 2018, and the patient received the requested non-VA community care through the Veterans Choice Program within expected time frames.<sup>61</sup>

The Veterans Access, Choice, and Accountability Act of 2014 established the Veterans Choice Program that expanded patient eligibility for non-VA health care to include patients enrolled in the VA health care system who were (1) unable to schedule an appointment within the wait time goals of the VHA, or (2) resided more than 40 miles from the closest VHA facility.<sup>62</sup> In October 2016, VHA established policy to guide implementation of the Veterans Choice Program and in 2017 clarified wait times as “30 days from the clinically indicated date.”<sup>63</sup>

VHA advises staff to initiate authorization for non-VA care, complete authorization, send authorization to the Veterans Choice Program contractor, and contact the patient to inform the patient that a Veterans Choice Program contractor will call regarding scheduling.<sup>64</sup> Veterans Choice Program contractors are responsible for contacting the patient; establishing the patient's availability, provider preferences, and needs; and scheduling the patient with an “accredited/licensed network provider” within five days of receiving authorization.<sup>65</sup> The patient's appointment was required to occur within 30 days of scheduling.<sup>66</sup>

#### Non-VA Primary Care

In summer 2018, the patient called the facility to request primary care appointment at a community-based outpatient clinic. A medical support assistant informed the patient that no new patient appointments were available at the community-based outpatient clinic within 90 days, entered a non-VA community care consult, and mailed a Veterans Choice Program fact sheet to

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<sup>61</sup> VHA Directive 1700, *Veterans Choice Program*, October 25, 2016. The VA Choice and Quality Employment Act, Pub. L. No. 115-46, 131 (2017).

<sup>62</sup> The Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146, 131 (2014). The introduction of the VA MISSION Act of 2018, Pub. L. No. 115-182, § 132 (2018) replaced the Veterans Choice Program on June 6, 2019.

<sup>63</sup> Acting Principal Deputy Under Secretary for Health (10A) Memorandum, “Options for Providing Community Care,” June 12, 2017; VHA Directive 1232(2), *Consult Processes and Procedures*, August 24, 2016. VHA defines the clinically indicated date as the earliest date a VHA provider deems the care is appropriate.

<sup>64</sup> Veterans Choice Program contracted with TriWest and Health Net to manage the non-VA appointment process. *VHA Process Guide*, “Patient-Centered Community Care (PC3) Appointment Management Process Guide,” June 30, 2017.

<sup>65</sup> *VHA Process Guide*, “Patient-Centered Community Care (PC3) Appointment Management Process Guide.”

<sup>66</sup> *VHA Process Guide*, “Patient-Centered Community Care (PC3) Appointment Management Process Guide.”

the patient.<sup>67</sup> The following day, a community care nurse case manager approved the authorization for the patient's non-VA community care consult. A facility voucher examiner documented verification of the patient's eligibility based on wait time and transmitted documentation to the Veterans Choice Program contractor four days later.<sup>68</sup> Three days later, the voucher examiner documented that the patient was scheduled with a non-VA primary care provider approximately four weeks later. The patient attended the scheduled non-VA primary care appointment with a plan to follow up in three months.<sup>69</sup> Approximately six weeks later, a file clerk completed the non-VA community care consult.

## **Non-VA Mental Health Care**

In summer 2018, the patient's psychiatrist entered a community care consult for non-VA mental health treatment to address "PTSD, alcohol use disorder, depression, [suicidal ideation]." The following day, a social worker documented that the patient was eligible for non-VA care based on living more than 40 miles from the nearest VHA facility and could call the Veterans Choice Program contractor directly to schedule non-VA mental health care. The next week, on two different days, a mental health nurse unsuccessfully attempted to schedule the patient and left voicemail messages for the patient including Veterans Choice Program contractor contact information. The following day, the psychiatrist called the patient and left a voicemail message with the number for the Veterans Choice Program contractor to "get set up with a therapist." Approximately two weeks later, a medical support assistant documented that the patient was scheduled for an appointment with a non-VA outpatient mental health provider in five days.

That month, the patient attended two non-VA outpatient mental health appointments. In fall 2018, the non-VA mental health provider completed a Choice Program Episode Completion Form, documented that the patient "was hoping to be accepted" into the RRTP program, and that services ended.<sup>70</sup>

The OIG found that facility staff followed VHA policy and the patient received both non-VA primary care and mental health care through the Veterans Choice Program. VHA staff verified the patient's eligibility and ensured timely appointment scheduling.

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<sup>67</sup> A medical support assistant provides administrative patient support including scheduling appointments and managing non-VA community care consultation requests.

<sup>68</sup> A voucher examiner manages authorizations for non-VA care.

<sup>69</sup> The OIG did not find EHR documentation that provided the reason that the patient's care was discontinued or indicated that the patient received additional non-VA primary care services. The non-VA primary care provider did not respond to the OIG's interview requests.

<sup>70</sup> The OIG did not find EHR documentation that provided the reason that the patient's care was discontinued or indicated that the patient received additional non-VA mental health care services. The non-VA mental health care provider was no longer employed at the non-VA treatment agency, and the agency did not respond to an OIG subpoena.

#### 4. VA Palo Alto Health Care System's RRTP Processes

The OIG found that VA Palo Alto RRTP staff completed the patient's screening eight business days after receipt of the interfacility consult, exceeding VHA's requirement that screenings be completed within five business days of consult receipt.<sup>71</sup> The OIG determined that VA Palo Alto RRTP did not accept patient self-referrals as required by VHA.<sup>72</sup> The OIG found that RRTP staff considered the request for the patient's service animal to accompany the patient if admitted to the RRTP. However, the OIG found that the VA Palo Alto policy was inconsistent with VHA policy.<sup>73</sup>

##### RRTP Admission Criteria and Procedures

In 2010, VHA established RRTP admission criteria including that patients must not meet criteria for acute inpatient admission, not be a significant risk of harm to self or others, require structure and support, and have identified treatment and rehabilitation needs consistent with what the program offers.<sup>74</sup>

The RRTP program manager is responsible for "screening policies and admission decisions."<sup>75</sup> Patients may apply directly to RRTP services or be referred by providers within or outside VHA. A screening assessment, conducted by a team including a licensed mental health provider and physician or physician extender, is required within five business days of receipt of the referral.<sup>76</sup>

VHA policy states that RRTPs are not suitable settings for patients requiring medically monitored detoxification; however, patients are not to be denied admission based solely on length of abstinence.<sup>77</sup> When a patient is not accepted for admission, RRTP staff are required to

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<sup>71</sup> VHA Acting DUSHOM Memorandum, "Access and Wait Times for Admission to a Mental Health Residential Rehabilitation Treatment Program (MH RRTP) (VAIQ 7570870)," August 21, 2015.

<sup>72</sup> VA Palo Alto Health Care System Policy 352-16-10.01, *Referral, Screening, and Admission*, February 1, 2016. VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010. This policy was in effect during the time frame of the events discussed in this report and was rescinded and replaced by VHA Directive 1162.02, *Mental Health Residential Rehabilitation Treatment Program*, July 15, 2019. The new policy included the same or similar language regarding patient self-referrals.

<sup>73</sup> VA Palo Alto Health Care System Policy 11K-18-04, *Assistance Dog Policy*, March 31, 2018; VHA Directive 1188, *Animals on Veterans Health Administration (VHA) Property*, August 26, 2015.

<sup>74</sup> VHA Handbook 1162.02. The 2010 and 2019 handbooks contain the same or similar language related to admission criteria.

<sup>75</sup> VHA Handbook 1162.02. The 2010 and 2019 handbooks contain the same or similar language related to the requirement that RRTP program manager's responsibility regarding screening policies and admissions decisions.

<sup>76</sup> In 2015, the VA established a time requirement for completion of RRTP screening assessments. VHA Acting DUSHOM Memorandum, "Access and Wait Times for Admission to a Mental Health Residential Rehabilitation Treatment Program (MH RRTP) (VAIQ 7570870)." VHA Handbook 1162.02. The 2010 and 2019 handbooks contain the same or similar language related to patients' ability to apply directly to the program.

<sup>77</sup> VHA Handbook 1162.02. The 2010 and 2019 handbooks contain the same or similar language related to the requirement that RRTP program manager's responsibility regarding screening policies and admissions decisions.

document the decision in the patient's EHR, provide the patient the reason for denial, explore "alternative sources of care," and provide appropriate referrals.<sup>78</sup>

VA Palo Alto RRTP policy requires a treating clinician or case manager to submit a referral for consideration of a patient's admission.<sup>79</sup> The Screening and Admissions Committee determines admission acceptance based on a review of the patient's medical records and an interview with the patient.<sup>80</sup> The Admissions Coordinator is responsible for contacting the referring clinician to communicate the Screening and Admissions Committee's decision and treatment recommendations.<sup>81</sup>

In summer 2018, the facility psychiatrist placed an interfacility consult for the patient to be considered for admission at the VA Palo Alto RRTP. The Admissions Coordinator documented that the consult was received. Four days later, the Admissions Coordinator attempted to call the patient and left a voicemail. Two days later, the Admissions Coordinator documented the patient's telephone screening assessment was scheduled for one week later.

Thirteen days after the psychiatrist place the interfacility consult, the Admissions Coordinator completed the patient's screening assessment and noted the patient's high risk for suicide patient record flag and alcohol use as "Challenges/Barriers." The Admissions Coordinator told the patient that the Screening and Admissions Committee would review the referral and inform the referring provider of the treatment team's recommendations, and provided the patient with RRTP contact information. Two days later, the Screening and Admission Committee noted a plan for the RRTP Medical Director (Medical Director) "to review," and the patient was denied due to "risk for alcohol/drug withdrawal."<sup>82</sup> The Admissions Coordinator told the OIG that the Medical Director wanted to further review the patient's EHR to assess alcohol withdrawal risk. Three days later, the Admissions Coordinator documented that the consult was completed. Three days later, the Admissions Coordinator emailed the Medical Director with the subject "Medical Clearance." The Admissions Coordinator informed the OIG that the email was intended as a reminder for the Medical Director to complete the patient's medical clearance.

Approximately two weeks later, the patient's facility psychiatrist added a comment to the consult inquiring, "Is there an update on [the patient's] application to this program?" The next day, the

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<sup>78</sup> VHA Handbook 1162.02. The 2010 and 2019 handbooks contain the same or similar language related to patients not accepted for admission.

<sup>79</sup> VA Palo Alto Health Care System Policy 352-16-10.01.

<sup>80</sup> VA Palo Alto Health Care System Policy 352-16-10.01. The Screening and Admissions Committee is an interdisciplinary team "comprised of the admissions coordinators, psychiatrist, psychologists, and social workers," and reviews referrals to determine admission disposition.

<sup>81</sup> VA Palo Alto Health Care System Policy 352-16-10.01. The RRTP interdisciplinary team includes the admissions coordinators, psychiatrist, psychologists, and social workers.

<sup>82</sup> The Admissions Coordinator, Medical Director, and a psychologist attended the Screening and Admission Committee meeting.

Admissions Coordinator added a comment to the consult that the “medical doctor [*sic*] is currently doing a chart review on this veteran [*sic*] for medical clearance.” That day, the Admissions Coordinator emailed the Medical Director that the facility psychiatrist reported the patient “cut back” on drinking. Two days later, the Medical Director emailed the Admissions Coordinator that the patient “is still drinking very heavily” and “will likely need [alcohol detoxification]” that “might be best done on an acute psychiatry unit” because of the patient’s “chronic suicidality and high risk.”

In fall 2018, 39 days after the RRTP’s receipt of the interfacility consult, the Admissions Coordinator documented the Screening and Admissions Committee’s recommendations “against admission,” and that the patient “first engage in outpatient treatment related to [the patient’s] substance use, as well as, actively engage in mental health treatment.” The note further indicated that “the program is unfortunately unable to store the dog’s medications and therefore the dog cannot be cleared for an admission.” Two days later, the facility psychiatrist reviewed the information with the patient.

The OIG concluded that RRTP staff completed an interdisciplinary team review and screening assessment.<sup>83</sup> However, the RRTP referral procedures exceeded the VHA required time frame of screening within five days of referral.<sup>84</sup> Additionally, the OIG found that the Admissions Coordinator notified the facility psychiatrist of the denial decision 26 days after the patient’s RRTP screening.<sup>85</sup> At the time of the patient’s care, VHA policy did not establish an expected time frame for communication of admission decisions to the referring provider and the patient.<sup>86</sup> In July 2019, VHA established a requirement for RRTP screening and admission decisions to be completed within seven business days of referral. However, VHA did not delineate timeframe expectations for referring provider and patient notification of RRTP admission decisions.<sup>87</sup>

The OIG found that in the communication of the admission decision and treatment recommendations to the referring psychiatrist, the Admissions Coordinator documented a recommendation for outpatient substance use disorder treatment but did not accurately document the Medical Director’s treatment recommendation for inpatient alcohol detoxification. The inaccurate documentation may have resulted in both the referring facility psychiatrist’s and the patient’s lack of awareness of a clinical factor contributing to the decision against admission. In

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<sup>83</sup> VHA Handbook 1162.02. The 2010 and 2019 handbooks contain the same or similar language related to RRTP screening and admission assessment policy. VA Palo Alto Health Care System Policy 352-16-10.01.

<sup>84</sup> VHA Acting DUSHOM Memorandum, “Access and Wait Times for Admission to a Mental Health Residential Rehabilitation Treatment Program (MH RRTP) (VAIQ 7570870).”

<sup>85</sup> VHA Acting DUSHOM Memorandum, “Access and Wait Times for Admission to a Mental Health Residential Rehabilitation Treatment Program (MH RRTP) (VAIQ 7570870).”

<sup>86</sup> VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*.

<sup>87</sup> VHA Directive 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, July 15, 2019.

an interview with the OIG, the Admissions Coordinator did not recall the reason for the inconsistency between the recommendation documented in the patient's EHR, and the Medical Director's recommendation, but speculated that there may have been conversations with the patient that were not documented in the EHR that influenced the recommendations. The Admissions Coordinator told the OIG that consult-related conversations with patients and referring providers were often written on paper and provided to administrative staff with the assumption the notes would be scanned into the patient's EHR.

The OIG determined that VA Palo Alto RRTP policy did not align with VHA requirements related to self-referrals. Specifically, facility policy required a treating clinician or case manager to complete all referrals, while VHA policy states that patients could "apply directly" for RRTP services.<sup>88</sup> The VHA National Director of Mental Health RRTP told the OIG that the VHA policy to allow patients to apply directly was intended to remove access barriers to treatment. A VA Palo Alto RRTP Manager, the Admissions Coordinator, and the current Medical Director told the OIG that the rationale for requiring a mental health provider to make all referrals was based on a desire to ensure the availability of an outpatient mental health professional upon discharge from the program.<sup>89</sup> In contrast with the VHA requirement to consider patient self-referrals, VA Palo Alto RRTP policy required a staff referral that could result in barriers to patients' treatment access.

## Service Animal Policy

In 2015, VHA defined a service animal as "a dog that is trained to do work or perform tasks for the benefit of an individual with a disability," and not "any other animal that merely provides emotional support." VHA allows service animals to accompany patient's to VHA areas accessible to the general public but not areas where "patient care, patient safety and infection prevention and control standards" could not be met. Service animals are allowed to accompany patients in RRTPs provided the animals are "up to date with all core vaccinations." VHA specifically identifies that VHA staff cannot require a dog's medical documentation, training documentation, or request the dog demonstrate "work or tasks."<sup>90</sup> VHA staff can only ask the patient if the service animal is required because of a disability and what work or tasks the dog is trained to perform.<sup>91</sup>

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<sup>88</sup> VA Palo Alto Health Care System Policy 352-16-10.01; VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010.

<sup>89</sup> The RRTP Medical Director who held the position during the time of the patient's referral no longer works for the VA and was unavailable for an interview with the OIG.

<sup>90</sup> VHA Directive 1188, *Animals on Veterans Health Administration (VHA) Property*, August 26, 2015.

<sup>91</sup> VHA Directive 1188.

Facility directors are responsible to ensure that facility staff are “aware of and comply with” VHA service animal policy.<sup>92</sup> VHA policy does not address service animal medication storage.<sup>93</sup> VA Palo Alto policy defines an assistance dog as one that is “specially trained to mitigate an individual’s disability” and includes psychiatric service dogs.<sup>94</sup> A psychiatric service dog is defined as a dog “trained to perform a minimum of three specific tasks for an individual who lives with a psychiatric condition.”<sup>95</sup> VA Palo Alto allows “individuals with a disability, who have a specially trained assistance dog” access to all areas accessible to patients and visitors.<sup>96</sup> If an assistance dog requires medication, a patient must have a medication plan in place with the program staff prior to admission.<sup>97</sup>

During the summer 2018, screening assessment, the patient reported willingness to attend the program only if the service dog was allowed to accompany the patient. An RRTP Manager told the OIG that the program accepted service animals and the Admissions Coordinator indicated that further assessment of a service animal’s appropriateness was completed after a patient was approved for admission. Although the Admissions Coordinator completed the consult with a notation of the patient’s admission denial, 16 days later, the Admissions Coordinator requested additional information regarding the service animal’s prescribed medications and the following day, the facility psychiatrist provided the requested information.<sup>98</sup> Approximately four weeks later, the Admissions Coordinator documented that the patient was not accepted for admission and that the dog would not have been allowed due to the RRTP’s inability to store the dog’s medications.

The OIG found that RRTP staff appropriately considered the request for the patient’s service animal to accompany the patient if admitted to the RRTP. However, the OIG found that the VA Palo Alto policy was inconsistent with VHA policy.<sup>99</sup> Specifically, VA Palo Alto policy requires the completion of an animal health screening, and that service dogs be trained to perform a minimum of three specific tasks and wear visible identification as an assistance dog.<sup>100</sup> In an interview with the OIG, the Executive Director, Veterans Canteen Service, who reported

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<sup>92</sup> VHA Directive 1188.

<sup>93</sup> VHA Directive 1188.

<sup>94</sup> VA Palo Alto Health Care System Policy 11K-18-04, *Assistance Dog Policy*, March 31, 2018.

<sup>95</sup> VA Palo Alto Health Care System Policy 11K-18-04.

<sup>96</sup> VA Palo Alto Health Care System Policy 11K-18-04.

<sup>97</sup> VA Palo Alto Health Care System Policy 11K-18-04.

<sup>98</sup> The service dog was prescribed Vetprofen 100 milligrams, twice a day, as needed. National Institute of Health. “Vetprofen<sup>TM</sup> (carprofen) Caplets,” accessed November 5, 2020, <https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=7e2aa393-411b-4ff6-a583-de9ff7eb0287&type=display>. Vetprofen is a non-steroidal anti-inflammatory medicine for the treatment of pain in dogs.

<sup>99</sup> VA Palo Alto Health Care System Policy 11K-18-04; VHA Directive 1188.

<sup>100</sup> VA Palo Alto Health Care System Policy 11K-18-04; VHA Directive 1188.



reviewing the VHA animal access policy as a collateral duty, reported that medical center staff were not permitted to require a service animal (1) health screening, (2) to demonstrate specific tasks, or (3) to wear identification.<sup>101</sup> Failure to comply with VHA animal access policy may contribute to barriers in accessing VHA services for patients with service animals.

## Conclusion

The OIG found that facility staff made reasonable efforts to accommodate the patient's preferences for a same-gendered provider and in-person treatment and appropriately referred the patient to non-VA community care when unable to accommodate these preferences. The Suicide Prevention Coordinator completed the suicide safety plan with the patient consistent with VHA and facility expectations including completion within seven days and mailing a copy of the plan to the patient.<sup>102</sup> Facility staff followed VHA policy and the patient received both non-VA primary care and mental health care through the Veterans Choice Program. VHA staff verified the patient's eligibility and ensured timely appointment scheduling.

The OIG determined that facility leaders and staff did not assign the patient an MHTC or establish an MHTC policy as required.

The OIG concluded that the facility psychiatrist assumed responsibilities for care coordination and patient engagement consistent with the role of an MHTC. However, providers may not always assume those responsibilities, and therefore staff's failure to assign an MHTC may have contributed to care coordination deficiencies. An absence of facility policy to standardize MHTC identification and assignment procedures may have contributed to staff's inconsistent practices and noncompliance with VHA requirements.<sup>103</sup>

Facility leaders and staff inadequately managed the patient's high risk for suicide patient record flag and failed to assess suicide risk or assess for placement of a high risk for suicide patient record flag following the patient's call to the Veterans Crisis Line. The Suicide Prevention Coordinator did not review the patient's high risk for suicide patient record flag within 90 days of activation, as required, and failed to follow facility policy for management of high risk for suicide patient record flags.<sup>104</sup> Failure to follow facility policy resulted in inactivation of the patient's flag without interdisciplinary team input thereby potentially limiting the important clinical perspectives applied when making the inactivation decision. Failure to assess the patient's suicide risk following the patient's Veterans Crisis Line call resulted in insufficient

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<sup>101</sup> VHA Directive 1188.

<sup>102</sup> VHA Manual, *Safety Planning Manual*; VA Portland Health Care System, *High Risk for Suicide Flagging Guidelines*, 2020.

<sup>103</sup> VHA DUSHOM Memorandum, "Assignment of the Mental Health Treatment Coordinator."

<sup>104</sup> VHA Directive 2008-036; Facility Policy 11-38, *VA Portland Patient Record Flags*, August 23, 2016.



consideration to reactivate the patient's high risk for suicide patient record flag and a lack of information regarding the patient's immediate treatment and care management needs.

Facility staff conducted MST screening and provided MST-related care to the patient in outpatient and non-VA mental health settings, as required.<sup>105</sup> Given that the patient was engaged in MST-related care, the OIG determined a consult with the MST coordinator was not necessary.

VHA's inconsistent information regarding completion of the suicide behavior report, that was available at the time of the patient's death, may have contributed to unclear expectations of who was allowed to complete the suicide behavior report.<sup>106</sup> Further, facility policy was inconsistent with the updated 2019 VHA requirement for specified clinical staff to complete the suicide behavior report.<sup>107</sup> Facility leaders' failure to adhere to VHA suicide behavior report guidance may result in the omission of significant clinical information when staff not deemed qualified by VHA complete the suicide behavior report in response to a patient's death by suicide.

Facility staff did not complete the behavioral health autopsy timely following the patient's death.<sup>108</sup> Although not within the required time frame, the OIG concluded that staff's delay in completion of the behavioral health autopsy was unlikely to negatively affect quality improvement and program evaluation efforts. However, the OIG would expect facility staff to adhere to VHA timeframe requirements.

VA Palo Alto RRTP staff completed the patient's screening three business days beyond VHA's requirement<sup>109</sup> Through the communication of the admission and treatment recommendations to the referring psychiatrist, the Admissions Coordinator documented a recommendation for outpatient substance use disorder treatment and did not accurately document the Medical Director's treatment recommendation for inpatient alcohol detoxification. Inaccurate documentation of the Medical Director's treatment recommendation may have resulted in both the referring facility psychiatrist's and the patient's lack of awareness of a clinical factor contributing to the decision against admission. VA Palo Alto RRTP policy did not allow patients to "apply directly" for RRTP services, as required by VHA, which may result in barriers to necessary treatment for patients.<sup>110</sup>

RRTP staff appropriately considered the request for the patient's service animal to accompany the patient if admitted to the RRTP. However, the OIG found that the VA Palo Alto policy was

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<sup>105</sup> VHA Directive 1115.

<sup>106</sup> VHA Directive 2008-036; *VHA Guide, Suicide Prevention Coordinator Guide*; VHA DUSHOM, "High Risk for Suicide Patient Record Flag Changes."

<sup>107</sup> Facility Policy 11-04.

<sup>108</sup> VHA DUSHOM, "Behavioral Autopsy Program Implementation."

<sup>109</sup> VHA Acting DUSHOM Memorandum, "Access and Wait Times for Admission to a Mental Health Residential Rehabilitation Treatment Program (MH RRTP) (VAIQ 7570870)."

<sup>110</sup> VA Palo Alto Health Care System Policy 352-16-10.01; VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010.

inconsistent with VHA policy.<sup>111</sup> Specifically, VA Palo Alto policy required the completion of an animal health screening and that a service dog be trained to perform a minimum of three specific tasks, and wear visible identification as an assistance dog.<sup>112</sup> Failure to comply with VHA animal access policy may contribute to barriers in accessing VHA services for patients with service animals.

## Recommendations 1–7

1. The VA Portland Health Care System Director establishes a mental health treatment coordinator policy, consistent with Veterans Health Administration policy, and includes procedures for mental health treatment coordinator assignment.
2. The VA Portland Health Care System Director develops procedures consistent with Veterans Health Administration suicide behavior and overdose report staff-specific guidance and monitors for compliance.
3. The Under Secretary for Health aligns policy and training to reflect staff-specific guidance and requirements for suicide behavior and overdose report procedures and disseminates updated information to medical center leaders.<sup>113</sup>
4. The VA Portland Health Care System Director ensures completion of behavioral health autopsy reports within the Veterans Health Administration required time frame.
5. The Under Secretary for Health clarifies timeframe expectations for notification of Residential Rehabilitation Treatment Programs admission decisions to referring providers and patients, and takes action as warranted.
6. The VA Palo Alto Health Care System Director ensures that Residential Rehabilitation Treatment Program procedures are consistent with Veterans Health Administration requirements, including screening and admission decision timeliness, communication of treatment recommendations to referring provider and patient, and acceptance of patient self-referrals.
7. The VA Palo Alto Health Care System Director makes certain that the VA Palo Alto Health Care System Policy 11K-18-04, *Assistance Dog Policy*, is consistent with Veterans Health Administration policy.

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<sup>111</sup> VA Palo Alto Health Care System Policy 11K-18-04; VHA Directive 1188.

<sup>112</sup> VA Palo Alto Health Care System Policy 11K-18-04; VHA Directive 1188.

<sup>113</sup> Recommendations addressed to the Under Secretary for Health were submitted to the Deputy to the Deputy Under Secretary for Health, performing the delegable duties of the Under Secretary for Health.

## Appendix A: Under Secretary for Health Memorandum

### Department of Veterans Affairs Memorandum

Date: August 17, 2021

From: Deputy to the Deputy Under Secretary for Health, Performing the Delegable Duties of the Under Secretary for Health (10)

Subj: OIG Draft Report, Deficiencies in Mental Health Care and Facility Response to a Patient's Suicide, VA Portland Health Care System in Oregon and Residential Rehabilitation Treatment Program Referral Processes at the VA Palo Alto Health Care System in California

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report regarding the Deficiencies in Mental Health Care and Facility Response to a Patient's Suicide, VA Portland Health Care System in Oregon and Treatment Program Referral Processes at the VA Palo Alto Health Care System in California. We appreciate OIG's recommendations and acknowledge there are improvements to be made. We are committed to ensuring a safe environment for all Veterans.
2. The Veterans Health Administration's (VHA) Office of Mental Health and Suicide Prevention is committed to ensuring ongoing advancements of training to support implementation of best practices to prevent Veteran suicide and has continued to review and refine its process for reporting of suicidal behaviors, including policy, guidance and training materials. Revisions to VHA Directive 1162.02, *Mental Health Residential Rehabilitation Treatment Program*, published in July 2019 reflect VHA's broader focus on removing barriers to admission and outlines clear criteria for admission and factors that should not preclude admission for residential treatment.
3. Since the event in 2019, VHA has continued to review and refine its process for reporting of suicidal behaviors including policy, guidance, and training materials. These refinements enhance reporting of non-suicidal overdose events, which can further inform risk to Veterans of adverse outcomes. VHA is committed to ensuring its processes and training align with policy.
4. Since this incident, the following documents have been published and disseminated to support process and policy alignment:
  - a. VHA Memorandum 2019-04-06, Suicide Behavior and Overdose Report Computerized Patient Record System (CPRS) Note Template Implementation, April 8, 2019  
[https://vaww.va.gov/vhapublications/ViewPublication.asp?pub\\_ID=8314](https://vaww.va.gov/vhapublications/ViewPublication.asp?pub_ID=8314)
  - b. VHA Memorandum 2020-10-13, Eliminating Veteran Suicide: Implementation Update on Suicide Risk Screening and Evaluation (Risk ID Strategy) and the Safety Planning for Emergency Department (SPED) Initiatives: Department of Veterans Affairs (VA) Suicide Prevention Safety Plan and Suicide Behavior and Overdose Report (SBOR) Templates *Staff Specific Guidance*, dated 10/17/2019 contains explicit language indicating which clinical staff may complete SBORs.
  - c. VHA Memorandum 2020-11-01, Update to High Risk for Suicide Patient Record Flag Changes, dated January 16, 2020 (rescinded VHA Memorandum High Risk for Suicide Patient Record Flag Changes, dated October 3, 2017)  
[https://vaww.va.gov/vhapublications/ViewPublication.asp?pub\\_ID=8671](https://vaww.va.gov/vhapublications/ViewPublication.asp?pub_ID=8671)

- d. VHA Guide, Suicide Prevention Program Guide was created and is designed to equip suicide prevention teams with the materials and resources necessary to serve effectively in their duties at VA medical facilities, dated November 1, 2020, section SBOR, references:
- VHA Memorandum 2019-04-06, Suicide Behavior and Overdose Report Computerized Patient Record System (CPRS) Note Template Implementation
  - VHA Memorandum 2020-10-13, Eliminating Veteran Suicide: Implementation Update on Suicide Risk Screening and Evaluation (Risk ID Strategy) and the Safety Planning for Emergency Department (SPED) Initiatives, Attachment C: Department of Veterans Affairs (VA) Suicide Prevention Safety Plan and Suicide Behavior and Overdose Report (SBOR) Templates Staff Specific Guidance
  - VHA Memorandum 2020-11-01, Update to High Risk for Suicide Patient Record Flag Changes
5. VHA notes that on page iv, footnote 10, lines 5-7, the correct title of the replacement for VHA Guide, *Suicide Prevention Coordinator Guide* is *VHA Guide, Suicide Prevention Program Guide*, November 1, 2020.
6. VHA notes language in the report regarding responsibility for completion of safety plans, (page 21, paragraph 3, lines 1-6) but recommends use of VHA policy documents in lieu of or in addition to guidance documents. VHA Memorandum, 2018-06-18, Suicide Prevention Safety Plan National CPRS Note Templates Implementation, dated June 1, 2018, and VHA Memorandum 2008-04-04, Patients at High-Risk for Suicide, dated April 24, 2008, were in effect at the time of this incident and remain current policy.
7. VHA agrees the language on page 27, paragraph 3, lines 5-6 referencing who can complete suicide behavior reports should be further clarified, but notes that VHA Guide, *Suicide Prevention Coordinator Guide*, dated June 15, 2015, did not specify that the suicide behavior report must be completed by clinical staff. Page 13 of the VHA Guide, under the section Monthly Suicide Prevention Coordinators SPAN (Suicide Prevention Application Network) Data Entry, states that the SBR (Suicide Behavior Report) is a CPRS document that clinicians and providers use to report any suicidal behavior.
8. I concur with the OIG's recommendations to the Office of the Under Secretary for Health and provide the attached action plan. Comments and action plans for recommendations 1, 2, and 4 are provided by the Medical Center Director at VA Portland Health Care System and recommendations 6 and 7 are provided by the Medical Center Director at Palo Alto Health Care System.
9. Comments regarding the contents of this memorandum may be directed to the GAO OIG Accountability Liaison Office at [VHA10BGOALAction@va.gov](mailto:VHA10BGOALAction@va.gov).

(Original signed by:)

Steven L. Lieberman, M.D.

## Deputy to the Deputy Under Secretary for Health, Performing the Delegable Duties of the Under Secretary for Health

**Recommendation 3:** The Under Secretary for Health aligns policy and training to reflect staff specific guidance and requirements for suicide behavior and overdose report procedures and disseminates updated information to medical center leaders.

**VA Comments:** Concur. VHA is committed to ensuring its processes and training align with policy. Since the event in 2019, VHA has continued to review and refine processes for reporting of suicidal behaviors. These refinements enhance reporting of non-suicidal overdose events, which can further inform the risk to veterans of adverse outcomes.

Specific to policy and written guidance, these relevant documents have been published and disseminated since the event: VHA Memorandum 2019-04-06, Suicide Behavior and Overdose Report Computerized Patient Record System (CPRS) Note Template Implementation, dated April 8, 2019; VHA Memorandum 2020-10-13, Eliminating Veteran Suicide: Implementation Update for Suicide Risk Screening and Evaluation (Risk ID Strategy) and the Safety Planning for Emergency Department (SPED) Initiatives, dated October 17, 2019 and VA Suicide Prevention Safety Plan and Suicide Behavior and Overdose Report (SBOR) Templates Staff Specific Guidance, dated April 17, 2019; VHA Memorandum 2020-01-11, Update to High Risk for Suicide Patient Record Flag Changes, dated January 16, 2020; VHA Guide, Suicide Prevention Program Guide, dated November 1, 2020.

On-going technical training and guidance to the field is provided by the VHA Office of Mental Health and Suicide Prevention (OMHSP) in the form of multiple monthly conference calls that are nationally accessible to clinical staff. Additionally, all Suicide Prevention staff may submit questions to a national community of practice mail group that is monitored by OMHSP staff.

For future improvement in aligning policy, training, and practice, the OMHSP is in the process of drafting further refinements to the existing memorandum and will schedule new implementation trainings to further assist the field.

Status: In Progress Target Completion Date: September 2021

**Recommendation 5:** The Under Secretary for Health clarifies timeframe expectations for notification of Residential Rehabilitation Treatment Programs admission decisions to referring providers and patients, and takes action as warranted.

**VA Comments:** Concur. VHA Directive 1162.02, *Mental Health Residential Rehabilitation Treatment Program*, requires that screening for residential treatment with an admission decision must be completed within 7 business days of the referral. OMHSP will develop guidance clarifying expectations for notification of both the Veteran and, if appropriate, the referring provider, and defining appropriate timelines for completion of this notification. Clarifying guidance will be disseminated through existing communication mechanisms (e.g., National calls, Community of Practice email groups) and will be published on the Mental Health Residential Rehabilitation Treatment Program policy SharePoint site.

Status: In Progress Target Completion Date: October 2021

## Appendix B: VISN Director Memorandum

### Department of Veterans Affairs Memorandum

Date: July 14, 2021

From: Director, Northwest Network (10N20)

Subj: Healthcare Inspection—Deficiencies in Mental Health Care and Facility Response to a Patient's Suicide, VA Portland Health Care System in Oregon and Residential Rehabilitation Treatment Program Referral Processes at the VA Palo Alto Health Care System in California

To: Director, Office of Healthcare Inspections (54MH00)  
Director, GAO/OIG Accountability Liaison Office (VHA 10BGOAL Action)

1. Thank you for the opportunity to provide a response to the findings from the Healthcare Inspection—Deficiencies in Mental Health Care and Facility Response to a Patient's Suicide, VA Portland Health Care System in Oregon and Residential Rehabilitation Treatment Program Referral Processes at the VA Palo Alto Health Care System in California.
2. I concur with your findings and recommendations, as well as VA Portland Health Care System's submitted action plans.

*(Original signed by:)*

John A. Mendoza  
Deputy Network Director

for Teresa Boyd, DO, Network Director

## Appendix C: Facility Director Memorandum

### Department of Veterans Affairs Memorandum

Date: July 12, 2021

From: Director, VA Portland Health Care System (648)

Subj: Healthcare Inspection—Deficiencies in Mental Health Care and Facility Response to a Patient's Suicide, VA Portland Health Care System in Oregon and Residential Rehabilitation Treatment Program Referral Processes at the VA Palo Alto Health Care System in California

To: Director, Northwest Network (10N20)

1. Thank you for the opportunity to provide a response to the findings from the Healthcare Inspection—Deficiencies in Mental Health Care and Facility Response to a Patient's Suicide, VA Portland Health Care System in Oregon and Residential Rehabilitation Treatment Program Referral Processes at the VA Palo Alto Health Care System in California.
2. VA Portland Health Care System concurs with the findings and recommendations and will ensure that actions to correct these findings are completed as described in the responses.

*(Original signed by:)*

Darwin G. Goodspeed, FACHE  
Director



## **Facility Director Response**

### **Recommendation 1**

The VA Portland Health Care System Director establishes a mental health treatment coordinator policy, consistent with Veterans Health Administration policy, and includes procedures for mental health treatment coordinator assignment.

Concur.

Target date for completion: 11/1/2021

### **Director Comments**

VA Portland Health Care System is developing a mental health treatment coordinator policy, consistent with Veterans Health Administration policy, including procedures for mental health treatment coordinator assignment, and is under review for approval.

### **Recommendation 2**

The VA Portland Health Care System Director develop procedures consistent with Veterans Health Administration suicide behavior and overdose report staff-specific guidance and monitors for compliance.

Concur.

Target date for completion: 1/1/2022

### **Director Comments**

The VA Portland Health Care System developed a standard operating procedure (SOP) consistent with the Veterans Health Administration suicide behavior and overdose report staff-specific guidance. Monitoring will be completed by the Program Manager for Suicide Prevention and reported out to Mental Health Executive Council (MHEC) quarterly until 90% compliance is reached for six consecutive months.

### **Recommendation 4**

The VA Portland Health Care System Director ensures completion of behavioral health autopsy reports within the Veterans Health Administration required time frame.

Concur.

Target date for completion: 1/1/2022

## **Director Comments**

The VA Portland Health Care System has developed a process to monitor the submission of Behavioral Health autopsy reports to ensure completion within the Veterans Health Administration required time frame. Monitoring will be completed by the Program Manager for Suicide Prevention and reported quarterly MHEC until 90% compliance is reached for six consecutive months.

## Appendix D: VISN Director Memorandum

### Department of Veterans Affairs Memorandum

Date: July 13, 2021

From: Director, Sierra Pacific Network (10N21)

Subj: Healthcare Inspection—Deficiencies in Mental Health Care and Facility Response to a Patient's Suicide, VA Portland Health Care System in Oregon and Residential Rehabilitation Treatment Program Referral Processes at the VA Palo Alto Health Care System in California

To: Director, Office of Healthcare Inspection (54MH00)  
Director, GAO/OIG Accountability Liaison Office (VHA 10BGOAL Action)

1. Thank you for the opportunity to review the draft report entitled "Deficiencies in Mental Health Care and Facility Response to a Patient's Suicide, VA Portland Health Care System in Oregon and Residential Rehabilitation Treatment Program Referral Processes at the VA Palo Alto Health Care System in California."
2. I have reviewed and concur with VA Palo Alto Health Care System Medical Center Director's response. The attachment contains the action plan from the facility addressing the recommendations in the report.
3. Thank you for the opportunity to focus on continuous performance improvement. If you have any questions, please contact the VISN 21 Accreditation Program Manager.

*(Original signed by:)*

John A. Brandecker, MBA, MPH  
VISN 21 Network Director

## Appendix E: VA Palo Alto Health Care System Director Memorandum

### Department of Veterans Affairs Memorandum

Date: July 12, 2021

From: Director, VA Palo Alto Health Care System (640)

Subj: Healthcare Inspection—Deficiencies in Mental Health Care and Facility Response to a Patient's Suicide, VA Portland Health Care System in Oregon and Residential Rehabilitation Treatment Program Referral Processes at the VA Palo Alto Health Care System in California

To: Director, Sierra Pacific Network (10N21)

1. We appreciate the Office of Inspector General's review of the allegations of deficiencies of the Mental Health Residential Rehabilitation Treatment Program (MHR RTP) Referral Processes at the VA Palo Alto Health Care System.
2. The requested concurrence and corrective action plans are attached.
3. If any additional information is required, please contact the Chief of Quality, Safety and Value.

*(Original signed by:)*

Lisa M. Howard  
Director

## Facility Director Response

### Recommendation 6

The VA Palo Alto Health Care System Director ensures that Residential Rehabilitation Treatment Program procedures are consistent with Veterans Health Administration requirements, including screening and admission decision timeliness, communication of treatment recommendations to referring provider and patient, and acceptance of patient self-referrals.

Concur.

Target date for completion: September 1, 2021

#### Director Comments

The VA Palo Alto Health Care System Mental Health Residential Rehabilitation Treatment Program (MHR RTP) reviewed program processes and policies. Monitoring is in place to ensure procedures are consistent with Veterans Health Administration requirements. Documentation guidelines and MHR RTP timelines/policies will be reviewed annually by MHR RTP Staff and when there are changes in national directives or policy.

### Recommendation 7

The VA Palo Alto Health Care System Director makes certain that the VA Palo Alto Health Care System Policy 11K-18-04, *Assistance Dog Policy* is consistent with Veterans Health Administration policy.

Concur.

Target date for completion: May 1, 2021

#### Director Comments

The VA Palo Alto Health Care System Memorandum Number 11K-18-04, *Assistance Dog Policy* was rescinded in May 2021. It was replaced with VHA Directive 1188, *Animals on Veterans Health Administration (VHA) Property*, August 26, 2015, amended April 25, 2019.

#### OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

## Glossary

*To go back, press “alt” and “left arrow” keys.*

**alcohol dependence.** Habitual use of alcohol that can cause impairments in an individual's day to day functioning. Alcohol abuse and dependence are now referred to as alcohol use disorder.<sup>114</sup>

**blackouts.** A period during alcohol intoxication when an intoxicated person cannot recall events.<sup>115</sup>

**cannabis abuse.** Habitual use of cannabis that can cause impairments in an individual's day to day functioning. Cannabis abuse and dependence are now referred to as cannabis use disorder.<sup>116</sup>

**citalopram.** A medication used to treat depression known as a selective serotonin reuptake inhibitor.<sup>117</sup>

**electrocardiogram.** A test used to detect and monitor heart problems.<sup>118</sup>

**fluoxetine.** A medication used to treat depression.<sup>119</sup>

**hydroxychloroquine.** A medication used to treat lupus.<sup>120</sup>

**lamotrigine.** A medication used to treat bipolar disorder.<sup>121</sup>

**major depression.** A disorder characterized by a period of at least two weeks with depressed mood and/or loss of pleasure or interest in activities. Symptoms must be present much of the day

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<sup>114</sup> Diagnostic and Statistical Manual of Mental Disorders, “Alcohol Use Disorder,” accessed March 1, 2021, <https://dsm.psychiatryonline.org/doi/full/10.1176/appi.books.9780890425596.dsm16>. Substance Abuse and Mental Health Services Administration. “Impact of the DSM-IV to DSM-5 Changes on the National Survey on Drug Use and Health,” accessed February 18, 2021, <https://www.samhsa.gov/data/sites/default/files/NSDUH-DSM5ImpactAdultMI-2016.pdf>.

<sup>115</sup> American Addiction Centers, “Blackout Drinking,” updated February 3, 2020, accessed June 10, 2021, <https://americanaddictioncenters.org/alcoholism-treatment/blackout>.

<sup>116</sup> Diagnostic and Statistical Manual of Mental Disorders, “Cannabis Use Disorder,” accessed February 19, 2021, <https://dsm.psychiatryonline.org/doi/full/10.1176/appi.books.9780890425596.dsm16>.

<sup>117</sup> Mayo Clinic, “Citalopram (Oral Route),” accessed March 2, 2021, <https://www.mayoclinic.org/drugs-supplements/citalopram-oral-route/description/drg-20062980>.

<sup>118</sup> Mayo Clinic, “Electrocardiogram,” accessed March 2, 2021, <https://www.mayoclinic.org/tests-procedures/ekg/about/pac-20384983>.

<sup>119</sup> Mayo Clinic, “Fluoxetine (Oral Route),” accessed March 2, 2021, <https://www.mayoclinic.org/drugs-supplements/fluoxetine-oral-route/precauwieght%20loss%20drugs%27ons/drg-20063952?p=1>.

<sup>120</sup> Mayo Clinic, “Hydroxychloroquine (Oral Route),” accessed March 2, 2021, <https://www.mayoclinic.org/drugs-supplements/hydroxychloroquine-oral-route/description/drg-20064216>.

<sup>121</sup> National Alliance on Mental Illness, “Lamotrigine,” accessed February 4, 2021, [https://www.nami.org/About-Mental-Illness/Treatments/Mental-Health-Medications/Types-of-Medication/Lamotrigine-\(Lamictal\)](https://www.nami.org/About-Mental-Illness/Treatments/Mental-Health-Medications/Types-of-Medication/Lamotrigine-(Lamictal)).

nearly every day during the two-week period. Symptoms must be a marked change from one's prior functioning and not better explained by a medical condition.<sup>122</sup>

**nicotine dependence.** Nicotine is a chemical in tobacco. Difficulties in quitting the habit come from dependence.<sup>123</sup>

**prazosin.** A medication for high blood pressure that has also been used to treat nightmares associated with PTSD.<sup>124</sup>

**Prozac.** A name brand for the generic medication fluoxetine used to treat depression.<sup>125</sup>

**posttraumatic stress disorder.** A disorder defined by exposure to a traumatic event followed by the development of characteristic symptoms. Symptoms of posttraumatic stress disorder may include fear-based emotional and behavioral reactions, loss of pleasure in activities and negative cognitions, heightened arousal and externalizing behavior, and dissociative symptoms.<sup>126</sup>

**service dog.** "Dogs that are individually trained to do work or perform tasks for people with disabilities."<sup>127</sup>

**suicidal ideation.** "Thoughts of engaging in suicidal-related behavior."<sup>128</sup>

**trazodone.** A medication for depression that can also be used for sleep problems.<sup>129</sup>

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<sup>122</sup> Diagnostic and Statistical Manual of Mental Disorders, "Depressive Disorder," accessed February 19, 2021, <https://dsm.psychiatryonline.org/doi/full/10.1176/appi.books.9780890425596.dsm04>.

<sup>123</sup> Mayo Clinic, "Nicotine Dependence," accessed February 23, 2021, <https://www.mayoclinic.org/diseases-conditions/nicotine-dependence/symptoms-causes/syc-20351584>.

<sup>124</sup> Mayo Clinic, "Prazosin (Oral Route)," accessed March 9, 2021, <https://www.mayoclinic.org/drugs-supplements/prazosin-oral-route/proper-use/drg-20065617>; Mayo Clinic, "Post-traumatic stress disorder (PTSD)," accessed March 9, 2021, from <https://www.mayoclinic.org/diseases-conditions/post-traumatic-stress-disorder/diagnosis-treatment/drc-20355973>.

<sup>125</sup> National Alliance on Mental Illness, "Fluoxetine (Prozac)," accessed March 2, 2021, [https://www.nami.org/About-Mental-Illness/Treatments/Mental-Health-Medications/Types-of-Medication/Fluoxetine-\(Prozac\)](https://www.nami.org/About-Mental-Illness/Treatments/Mental-Health-Medications/Types-of-Medication/Fluoxetine-(Prozac)).

<sup>126</sup> Diagnostic and Statistical Manual of Mental Disorders. "Posttraumatic Stress Disorder," accessed February 19, 2021, <https://dsm.psychiatryonline.org/doi/10.1176/appi.books.9780890425596.dsm07#BABJAEHE>.

<sup>127</sup> U.S. Department of Justice, Americans with Disabilities Act, "Service Animal," accessed February 23, 2021, [https://www.ada.gov/service\\_animals\\_2010.htm](https://www.ada.gov/service_animals_2010.htm).

<sup>128</sup> VA Mental Illness Research, Education, and Clinical Center, Center of Excellence, *Self-Directed Violence Classification System*, accessed March 2, 2021, <https://www.mirecc.va.gov/visn19/docs/SDVCS.pdf>.

<sup>129</sup> Medline Plus, "Trazodone," accessed April 6, 2021, <https://medlineplus.gov/druginfo/meds/a681038.html>.

## OIG Contact and Staff Acknowledgments

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