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VETERANS HEALTH ADMINISTRATION

Deficiencies in Inpatient Mental Health Suicide Risk Assessment, Mental Health Treatment Coordinator Processes, and Discharge Care Coordination

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Executive Summary

The VA Office of Inspector General (OIG) conducted a review of Veterans Health Administration (VHA) requirements related to suicide risk identification processes and suicide prevention safety plans (safety plans) for patients discharged from VHA inpatient mental health units (mental health units).[1] The OIG also evaluated national compliance with mental health treatment coordinator (MHTC) role requirements, including the establishment of written procedures as well as MHTC assignment and involvement for mental health unit patients.[2] Further, the OIG reviewed select requirements for mental health unit discharge care coordination, including documentation of discharge instructions, coordination with the MHTC, and patients' post-discharge treatment engagement.

The OIG requested MHTC policies from 106 facilities with mental health units and conducted electronic health record (EHR) reviews of a sample of 200 patients with a mood disorder diagnosis who were discharged from a VHA mental health unit from October 1, 2019, through September 30, 2020.[3] The OIG interviewed select Veterans Integrated Service Network (VISN) chief mental health officers, facility associate chiefs of staff of mental health, and MHTCs to assess knowledge and perspectives of MHTC requirements, roles, and responsibilities.[4] The OIG also conducted telephone surveys (patient surveys) with 73 patients who had been discharged from mental health units to determine patients' awareness of assigned MHTCs and perceived supports and barriers to outpatient mental health follow-up care.

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[1] A safety plan includes a written list of coping strategies and sources of support for patients who are at high risk for suicide to use before or during a crisis. VA, *Safety Plan Quick Guide for Clinicians*, March 2012.

[2] VHA Handbook 1160.01(1), *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015, rescinded and replaced by VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service,* April 27, 2023. The policies contain similar language related to administration of mental health services. In 2008, VHA referred to the role as principal mental health provider and changed it to MHTC in 2012. Deputy Under Secretary for Health for Operations and Management, "Assignment of the Mental Health Treatment Coordinator," memorandum to Network Directors (10N1-23), Chief Medical Officer, and VISN Mental Health Liaisons, March 26, 2012. Assistant Under Secretary for Health for Clinical Services/Chief Officer, "Informational: Mental Health Treatment Coordinator (MHTC) 2.0 Operational Guidance," memorandum to Veterans Integrated Services Network Directors (10N1-23), March 4, 2024. The MHTC responsibilities included in the 2008 and 2015 handbook were updated by the 2024 memorandum.

[3] For analyses of the entire sample of 200, the OIG calculated 95 percent confidence intervals and determined that the sample effectively reflects the overall VHA population of mental health unit patients with a mood disorder diagnosis. A confidence interval provides lower and upper values within which an estimate is expected to fall if the population was re-sampled with the same sample size and study design. The 95 percent confidence interval indicates that 95 out of 100 samples would yield a value between the lower and upper confidence values.

[4] The OIG identified five facilities with three or more patients reviewed and all were assigned an MHTC and four facilities for which not all of the reviewed patient EHRs included MHTC assignments. The OIG selected two VISN 8 facilities with all reviewed patients' EHRs including assigned MHTCs, one with an established MHTC policy and one without a policy.

VHA mental health unit treatment focuses on patients' crisis stabilization and acute mental health symptom management. VHA reported that approximately 97 and 90 percent of patients admitted to mental health units in fiscal years 2021 and 2022, respectively, had a confirmed or possible mood disorder, which may increase a person's risk of suicidal thoughts and behaviors.[5] Patients admitted to mental health units are at high risk for suicide in the months after discharge with approximately 40 percent of suicidal behaviors occurring within 90 days of discharge.[6] Following a mental health unit discharge, continuity of care is an important factor in decreasing a patient's suicide risk.[7] Starting in 2008, VHA has required that every patient receiving mental health services was assigned a principal mental health provider to serve as a patient's main point of contact and to ensure care coordination. [8] In 2012, VHA retitled the principal mental health provider to MHTC. MHTCs are expected to ensure continuity of care during transitions between levels of care, such as discharge from a mental health unit to outpatient mental health treatment, and to promote patient treatment engagement.[9]

Review Results

Suicide Risk Identification and Safety Planning

VHA requires staff to complete a suicide risk screening within 24 hours before a patient's discharge using the Columbia-Suicide Severity Rating Scale (C-SSRS), which includes specific questions about a patient's past preparatory or suicidal behavior, recent intent, and thoughts of a

[5] "Mental Health Disorder Statistics," Johns Hopkins Medicine, accessed February 22, 2024, https://www.hopkinsmedicine.org/health/wellness-and-prevention/mental-health-disorder-statistics; VHA Northeast Program Evaluation Center, *National Hospital Mental Health Program Performance Monitoring System: FY 2021 Annual Report,* May 6, 2022; VHA Northeast Program Evaluation Center, *Acute Inpatient Mental Health Services, FY 2022 Annual Report,* August 18, 2023; A fiscal year is a 12-month cycle that spans October 1 through September 30. Fiscal year 2021 began on October 1, 2020, and ended on September 30, 2021, and fiscal year 2022 began on October 1, 2021, and ended on September 30, 2022; "VA Finance Terms and Definitions," VA/VHA Employee Health Promotion Disease Prevention Guidebook, July 2011, accessed March 13, 2024, https://www.publichealth.va.gov/docs/employeehealth/14-Finance-Terms.pdf. Mood disorders are mental health conditions characterized by emotional state disturbances such as persistent sadness, hopelessness, suicidal thoughts, elation, and anger.

[6] Alberto Forte et al., "Suicidal Risk Following Hospital Discharge: A Review," Harvard Review of Psychiatry 27, no. 4 (July/August 2019): 209-216, https://journals.lww.com/hrpjournal/fulltext/2019/07000/suicidal_risk_following_hospital_discharge__a.1.aspx#:~:text=The%20time%20following%20discharge%20after,high%20risk%20for%20suicidal%20behavior.&text=Risks%20of%20completed%20suicide%20and,can%20remain%20elevated%20for%20months.

[7] Annemiek Huisman, J.F.M. Kerkhof, and Paul B.M. Robben, "Suicides in Users of Mental Health Care Services: Treatment Characteristics and Hindsight Reflections," Suicide and Life-Threatening Behavior 41, no. 1 (February 2011): 41-49, https://onlinelibrary.wiley.com/doi/10.1111/j.1943-278X.2010.00015.x.

[8] VHA Handbook 1160.01(1); Deputy Under Secretary for Health for Operations and Management, "Assignment of the Mental Health Treatment Coordinator," memorandum.

[9] Deputy Under Secretary for Health for Operations and Management, "Assignment of the Mental Health Treatment Coordinator," memorandum.

method and plan.[10] A negative C-SSRS completes the process; a positive C-SSRS requires same-day completion of a more detailed suicide risk assessment called the Comprehensive Suicide Risk Evaluation (CSRE).[11]

VHA also requires clinicians to collaboratively develop a safety plan with patients who (1) recently attempted suicide or expressed suicidal ideation, (2) are at risk of suicide prior to mental health unit discharge, or (3) are determined to be at "high or intermediate acute or chronic risk" of suicide.[12] The safety plan elements include warning signs, coping strategies, social contacts, family and friend supports, professional contacts, and lethal means safety.[13]

Facility staff are required to place a high risk for suicide patient record flag (high-risk flag) in a patient's EHR when a patient is determined to be at high risk for suicide (high-risk patients) to alert VA staff of the patient's risk in an effort to protect the patient's health and safety.[14]

The OIG found that mental health unit staff failed to document a completed C-SSRS or CSRE for 27 percent of patients and did not complete safety plans for 12 percent of patients prior to discharge, as required.[15] The OIG found that mental health unit staff did not complete a required safety plan for a patient who had an adverse clinical outcome within a week of discharge.[16] Although the OIG cannot conclude that a completed safety plan would have prevented the patient's nonfatal accidental overdose, it is likely that a safety plan might have helped mitigate the patient's risk factors. Further, more than one-quarter of patients identified as high-risk patients did not have a completed suicide risk screening or evaluation although most had a documented safety plan.

[10] Deputy Under Secretary for Health for Operations and Management, "Suicide Risk Screening and Assessment Requirements," memorandum to VISN leaders, attachment B, May 23, 2018, rescinded and replaced by Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy)," memorandum to VISN leaders (10N1-23) and Medical Center Directors (00), November 13, 2020. The policies contain similar language regarding suicide risk identification.

[11] VHA Office of Mental Health and Suicide Prevention, "Risk ID" (fact sheet), September 21, 2021. VHA acknowledges that in some clinical circumstances, it may not be feasible to complete the CSRE the same day. In those situations, the CSRE must be completed within 24 hours of a positive C-SSRS.

[12] VHA Office of Mental Health and Suicide Prevention, "Suicide Prevention Safety Plan Template FAQ" (fact sheet), May 24, 2019.

[13] VHA Office of Mental Health and Suicide Prevention, *Suicide Prevention Coordinator Guide*, June 19, 2015; VHA Office of Mental Health and Suicide Prevention, *Suicide Prevention Program Guide*, November 2020; VHA Office of Mental Health and Suicide Prevention, *Suicide Prevention Program Guide*, December 2022. The 2015, 2020, and 2022 guides include references to the same six elements.

[14] VHA Directive 2008-036; VHA Directive 1166.

[15] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy)," memorandum.

[16] Within the context of this report, the OIG considered an adverse clinical outcome to be death, a progression of disease, worsening prognosis, or a need for higher level care.

The OIG concluded that mental health unit staff's failure to complete required suicide risk identification processes may result in an underestimation of patients' suicide risk and an overestimation of discharge readiness contributing to unmitigated risk. Further, failure to provide patients with a safety plan upon discharge from mental health units can contribute to patients' diminished ability to identify specific coping strategies and supportive resources to use in times of crisis.

MHTC Policy, Assignment, and Patient Awareness

Since 2012, VHA has required that each facility establish a policy to outline the process by which the MHTC is identified and define expectations for the frequency of contact with patients.[17] The OIG found that over 30 percent of VHA facility leaders did not establish an MHTC policy. Of the 71 facility MHTC policies reviewed, over 80 percent included a process for staff to identify and assign patients an MHTC and less than 50 percent defined the expected frequency of contact with patients. Failure to provide written guidance that outlines MHTC procedures may contribute to staff's lack of awareness of responsibilities and result in patients not being assigned an MHTC to offer resources and support during transitions in care.

Mental health unit staff failed to assign an MHTC for nearly 40 percent of the patients, and did not use the required MHTC note template for over 30 percent of documented MHTC assignments.[18] VHA also requires the name of the employee assigned as a patient's MHTC to be entered into the patient centered management module (PCMM), a software application that allows the name of the MHTC to be easily accessible in a patient's EHR and generates reports that promote oversight, including identification of patients not assigned an MHTC.[19]

Seven of eight interviewed VISN chief mental health officers identified PCMM entry as an administrative burden and barrier to maintaining accurate MHTC assignments.[20] Additionally, three of nine interviewed associate chiefs of staff of mental health mentioned to the OIG that PCMM utilization was challenging, and one noted that PCMM was designed for primary care and does not work well for mental health processes.

[17] Deputy Under Secretary for Health for Operations and Management, "Assignment of the Mental Health Treatment Coordinator," memorandum.

[18] Deputy Under Secretary for Health for Operations and Management, "Suicide Prevention Safety Plan National CPRS Note Templates Implementation," memorandum to VISN Directors and Mental Health Leads (10N1-23), June 1, 2018.

[19] VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended February 29, 2024.

[20] The OIG did not inquire about PCMM as a potential barrier with one of the eight VISN chief mental health officers.

VHA expects patients to be able to identify their assigned MHTC and have the MHTC's contact information.[21] However, the OIG found that over half of surveyed patients with an assigned MHTC were not able to identify the MHTC or another VHA staff member to contact for help with care. The OIG concluded that the MHTC model failed to effectively fulfill the primary responsibility of care coordination during patients' transitions from a mental health unit to outpatient care. The OIG recognizes that the appointment of a dedicated MHTC, one component of the Behavioral Health Interdisciplinary Program being implemented in VHA, is likely to improve the MHTC assignment and identification procedures; however, this role still might not foster the relational continuity to effectively support patients during care transitions given limited contact between the MHTC and patient.[22]

Discharge Care Coordination

Although mental health unit staff generally documented discharge instructions and provided patients a copy, only 81 percent of the EHRs included a required seven-day follow-up mental health appointment scheduled.[23] VHA expects MHTC involvement in care transitions; however, 28 percent of EHRs did not include documentation of MHTC involvement in discharge care coordination and 31 percent of assigned MHTCs did not participate in patients' transitions from the mental health unit to outpatient care.[24]

Starting in 2008, VHA required staff to provide patients with appointments for follow-up at the time of discharge and complete a mental health evaluation within one week of discharge (7-day follow-up appointment).[25] As of 2023, VHA no longer required the follow-up appointment to be completed within seven days and advised mental health unit staff to review "all [mental health unit staff] and consultants' recommendations for discharge planning and post-discharge care."[26]

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[21] Deputy Under Secretary for Health for Operations and Management, "Assignment of the Mental Health Treatment Coordinator," memorandum.

[22] The Behavioral Health Interdisciplinary Program is based on an interdisciplinary team care approach consisting of outpatient mental health providers and administrative support staff for patients diagnosed with mental health disorders. VHA Office of Mental Health and Suicide Prevention, "BHIP Team-Based Care: Behavioral Health Interdisciplinary Program-Collaborative Chronic Care Model," accessed May 21, 2024, https://dvagov.sharepoint.com/sites/VACOMentalHealth/SitePages/Behavioral-Health-Interdisciplinary-Program-(BHIP).aspx. (This site is not publicly accessible.)

[23] VHA Handbook 1160.01(1).

[24] VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013, rescinded and replaced by VHA Directive 1160.06, *Inpatient Mental Health Services*, September 27, 2023. The 2013 handbook, in place during the time frame under review, required discharge planning to be coordinated with the patient's MHTC. The 2023 directive states that the "MHTC is responsible for coordinating care with facility mental health providers and working with the patient post-discharge."

[25] VHA Handbook 1160.01(1).

[26] VHA Directive 1160.01; VHA Handbook 1160.06; VHA Directive 1160.06; VHA Office of Mental Health and Suicide Prevention, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06."

The OIG found that, regardless of whether patients had a scheduled 7-day follow-up appointment, over 90 percent of patients attended at least one outpatient mental health follow-up appointment in the 90 days post-discharge and most appointments occurred in the first 30 days. Consistent with VHA's discontinuation of a required 7-day follow-up appointment, the OIG recognizes that post-discharge follow-up appointments are most effectively scheduled in consideration of a patient's treatment needs, preferences, and availability rather than an arbitrary timeliness expectation. However, the OIG proposes VHA leaders provide written guidance regarding expectations for post-discharge mental health appointment scheduling with the aim of promoting patient treatment engagement.

Within the 90 days following patients' mental health unit discharge, 60 of the 87 (69 percent) MHTCs involved in care coordination attempted to contact or contacted patients an average of approximately four times. The OIG determined that MHTC assignment at the time of discharge was not associated with a patient's likelihood of attending post-discharge mental healthcare appointments.

Patients with a high-risk flag must have a minimum of four mental health visits in the 30 days following discharge from a mental health unit.[27] The OIG found that in the 30 days following mental health unit discharge, 24 of the 50 (48 percent) patients with a high-risk flag attended four or more mental health outpatient appointments, 17 (34 percent) patients attended one to three appointments, and 9 (18 percent) did not attend any appointments.

The OIG determined post-discharge appointment attendance for the 73 surveyed patients was comparable for those patients assigned an MHTC and those not assigned an MHTC. Over half of the 66 surveyed patients who attended an outpatient appointment in the 90 days following discharge told the OIG that self-motivation was a primary contributor to appointment attendance while 20 percent reported that encouragement from a family member or friend prompted appointment attendance. In March 2024, VHA provided updated guidelines for MHTC involvement in patients' care; however, the findings of this national review suggest that the assignment of a staff member to oversee care coordination has not resulted in improved continuity of care for patients.[28]

The OIG made eight recommendations to the Under Secretary for Health related to suicide risk identification, suicide prevention safety plans, facility-level MHTC written guidance, MHTC assignment, MHTC effectiveness in enhancing patient treatment engagement, post-discharge mental health appointment scheduling, identification of supportive factors that contribute to patients' attendance at outpatient mental health appointments following discharge from an

[27] VHA Office of Mental Health and Suicide Prevention, *Suicide Prevention Coordinator Guide*.

[28] Assistant Under Secretary for Health for Clinical Services/Chief Officer, "Informational: Mental Health Treatment Coordinator (MHTC) 2.0 Operational Guidance," memorandum.

inpatient mental health unit, and consideration of the establishment of a process to facilitate patient awareness of, and accessibility to, behavioral health interdisciplinary team members.

The Under Secretary for Health concurred with recommendation(s) 1–6 and 8, concurred in principle with recommendation 7, and provided acceptable action plans (see appendix C). The OIG will follow up on the planned actions until they are completed.

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Contents

Abbreviations

BHIP	behavioral health interdisciplinary program
CSRE	Comprehensive Suicide Risk Evaluation
C-SSRS	Columbia-Suicide Severity Rating Scale
EHR	electronic health record
MHTC	mental health treatment coordinator
OIG	Office of Inspector General
PCMM	patient centered management module
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a review of Veterans Health Administration (VHA) requirements related to suicide risk identification processes and suicide prevention safety plans (safety plans) for patients discharged from VHA inpatient mental health units (mental health units).[1] The OIG also evaluated national compliance with mental health treatment coordinator (MHTC) role requirements, including the establishment of written procedures as well as MHTC assignment and involvement for mental health unit patients.[2] Further, the OIG reviewed select mental health unit discharge care coordination requirements, including documentation of discharge instructions, coordination with the MHTC, and patients' post-discharge treatment engagement.

The OIG conducted telephone surveys (patient surveys) with patients who had been discharged from mental health units to determine patients' awareness of assigned MHTCs and perceived supports, and barriers to outpatient mental health follow-up care.

Background

Mental Health Unit Care, Suicide Risk, and Mood Disorders

VHA mental health unit treatment focuses on patients' crisis stabilization and acute mental health symptom management using medication, psychoeducation, and psychological interventions. The ultimate goal of mental health unit care is a patient's return to daily living with participation in a less restrictive level of mental health treatment, such as outpatient or residential care.[3] Patients admitted to mental health units are at high risk for suicide in the

[1] A safety plan includes a written list of coping strategies and sources of support for patients who are at high risk for suicide to use before or during a crisis. VA, *Safety Plan Quick Guide for Clinicians*, March 2012.

[2] VHA Handbook 1160.01(1), *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015, rescinded and replaced by VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service,* April 27, 2023. The policies contain similar language related to administration of mental health services; In 2008, VHA referred to the role as principal mental health provider and changed it to MHTC in 2012; Deputy Under Secretary for Health for Operations and Management, "Assignment of the Mental Health Treatment Coordinator," memorandum to Network Directors (10N1-23), Chief Medical Officer, and VISN Mental Health Liaisons, March 26, 2012. Assistant Under Secretary for Health for Clinical Services/Chief Officer, "Informational: Mental Health Treatment Coordinator (MHTC) 2.0 Operational Guidance," memorandum to Veterans Integrated Services Network Directors (10N1-23), March 4, 2024. MHTC responsibilities included in the 2008 and 2015 handbook were updated by the 2024 memorandum.

[3] VHA Office of Nursing Services (ONS), "Patient Centered Care," module 3 in *Mental Health Nursing Orientation Guidebook,* accessed February 21, 2024, https://dvagov.sharepoint.com/sites/VACOMentalHealth/MH_Inpt/Education%20and%20Training/Forms/AllItems.aspx?id=%2Fsites%2FVACOMentalHealth%2FMH%5FInpt%2FEducation%20and%20Training%2FMHnsgOrientationGuide2017dec%2Epdf&parent=%2Fsites%2FVACOMentalHealth%2FMH%5FInpt%2FEducation%20and%20Training. (This site is not publicly accessible.)

months after discharge with approximately 40 percent of suicidal behaviors occurring within 90 days of discharge.[4] Following a mental health unit discharge, continuity of care is an important factor in decreasing a patient's suicide risk.[5]

VHA reported approximately 97 and 90 percent of patients admitted to mental health units in fiscal years 2021 and 2022, respectively, had a confirmed or possible mood disorder.[6] Mood disorders are mental health conditions characterized by emotional state disturbances such as persistent sadness, hopelessness, suicidal thoughts, elation, and anger. Mood disorders affect approximately 10 percent of the United States adult population and are generally either a depressive or a bipolar disorder.[7] Moods are normally changeable, and to be diagnosed with a mood disorder, symptoms must be present for two weeks or longer. The symptoms can affect a person's sleep, appetite, energy levels, and capacity to function in daily activities such as work.[8]

Symptoms of major depressive disorder, the most prevalent type of depressive disorder, include persistent depressed mood, diminished interest or pleasure in activities, feelings of worthlessness, and recurrent thoughts of death.[9] Bipolar disorders are characterized by changes in mood that include emotional highs, mania or hypomania, and depressive episodes.[10] Suffering from a mood disorder may increase a person's risk of suicidal thoughts and behaviors. Most

[4] Alberto Forte et al., "Suicidal Risk Following Hospital Discharge: A Review," Harvard Review of Psychiatry 27, no. 4 (July/August 2019): 209-216, https://journals.lww.com/hrpjournal/fulltext/2019/07000/suicidal_risk_following_hospital_discharge__a.1.aspx#:~:text=The%20time%20following%20discharge%20after,high%20risk%20for%20suicidal%20behavior.&text=Risks%20of%20completed%20suicide%20and,can%20remain%20elevated%20for%20months.

[5] Annemiek Huisman, J.F.M. Kerkhof, and Paul B.M. Robben, "Suicides in Users of Mental Health Care Services: Treatment Characteristics and Hindsight Reflections," Suicide and Life-Threatening Behavior 41, no. 1 (February 2011): 41-49, https://onlinelibrary.wiley.com/doi/10.1111/j.1943-278X.2010.00015.x.

[6] VHA Northeast Program Evaluation Center, *National Hospital Mental Health Program Performance Monitoring System: FY 2021 Annual Report,* May 6, 2022; VHA Northeast Program Evaluation Center, *Acute Inpatient Mental Health Services, FY 2022 Annual Report,* August 18, 2023; A fiscal year is a 12-month cycle that spans October 1 through September 30. Fiscal year 2021 began on October 1, 2020, and ended on September 30, 2021, and fiscal year 2022 began on October 1, 2021, and ended on September 30, 2022; "VA Finance Terms and Definitions," VA/VHA Employee Health Promotion Disease Prevention Guidebook, July 2011, accessed March 13, 2024, https://www.publichealth.va.gov/docs/employeehealth/14-Finance-Terms.pdf.

[7] Mayo Clinic, "Mood Disorders," accessed February 21, 2024, https://www.mayoclinic.org/diseases-conditions/mood-disorders/symptoms-causes/syc-20365057; "Mental Health Disorder Statistics," Johns Hopkins Medicine, accessed February 22, 2024, https://www.hopkinsmedicine.org/health/wellness-and-prevention/mental-health-disorder-statistics.

[8] Cleveland Clinic, "Mood Disorders," accessed February 22, 2024, https://my.clevelandclinic.org/health/diseases/17843-mood-disorders.

[9] American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders, Fifth edition, Text Revision (DSM-5 TR),* "Depressive Disorders," accessed February 22, 2024, https://dsm.psychiatryonline.org/doi/full/10.1176/appi.books.9780890425787.x04_Depressive_Disorders#BCFJBII%20A.

[10] Mayo Clinic, "Mood Disorders."

people who die by suicide "have a diagnosable mental health disorder -- most commonly a depressive disorder or a substance use disorder."[11]

MHTC Role and Responsibilities

Starting in 2008, VHA has required that every patient receiving mental health services was assigned a principal mental health provider to serve as a patient's main point of contact and to ensure care coordination.[12] In 2012, VHA retitled the principal mental health provider to MHTC.[13] MHTCs are expected to ensure continuity of care during transitions between levels of care, such as discharge from a mental health unit to outpatient mental health treatment, and to promote patient treatment engagement.[14] Relational continuity, "an ongoing therapeutic relationship between a patient and one or more providers," is considered critical during transitions in levels of care and should be addressed in discharge planning.[15]

VHA requires each facility to establish a policy that guides MHTC identification, assignment, and frequency of contact with patients.[16] In addition to licensed independent practitioners, certified addiction therapists, registered nurses, and staff with a college-level degree in health care can serve as an MHTC.[17]

[11] "Mental Health Disorder Statistics," Johns Hopkins Medicine, accessed February 22, 2024, https://www.hopkinsmedicine.org/health/wellness-and-prevention/mental-health-disorder-statistics.

[12] VHA Handbook 1160.01(1).

[13] Deputy Under Secretary for Health for Operations and Management, "Assignment of the Mental Health Treatment Coordinator," memorandum to Network Directors (10N1-23), Chief Medical Officer, and VISN Mental Health Liaisons, March 26, 2012.

[14] Deputy Under Secretary for Health for Operations and Management, "Assignment of the Mental Health Treatment Coordinator," memorandum.

[15] Jeannie L. Haggerty et al., "Continuity of care: a multidisciplinary review," BMJ, no. 327 (November 22, 2003): 1219-1221, https://www.bmj.com/content/327/7425/1219.long.

[16] Deputy Under Secretary for Health for Operations and Management, "Assignment of the Mental Health Treatment Coordinator," memorandum.

[17] Deputy Under Secretary for Health for Operations and Management, "Assignment of the Mental Health Treatment Coordinator," memorandum, attachment A. A licensed independent practitioner is an individual who is authorized by law and VA "to provide patient care services independently, without supervision or direction, within the scope of the individual's license." Addiction therapists serving as MHTCs must have experience providing mental health services and registered nurses are required to have "the competencies needed to be a MHTC" and "at least three years of experience in the field of psychiatric-mental health nursing."; VHA Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021.

Mental health unit staff are required to coordinate patients' discharges with their assigned MHTC.[18] VHA expects patients to be able to identify their assigned MHTC and have the MHTC's contact information.[19] MHTCs serve as a patient's point of contact and must ensure

- regular contact with the patient as clinically indicated,
- communication with the patient about problems or concerns with treatment, and
- continual awareness of the patient's mental health treatment goals.[20]

Updated MHTC Requirements

In 2013, VHA initiated implementation of the Behavioral Health Interdisciplinary Program (BHIP), which is based on an interdisciplinary outpatient team care approach for patients diagnosed with mental health disorders consisting of mental health providers and administrative support staff.[21] BHIP is an evidence-based collaborative chronic care model that aims to facilitate coordinated and proactive care based on patients' treatment needs.[22]

In March 2024, VHA emphasized that every VA medical facility was required to implement BHIP care, including an "MHTC 2.0 care coordination" role that transitions MHTC responsibilities to a full-time, dedicated position on a BHIP team that serves approximately 1,000 patients. VHA suggests that the change to a dedicated MHTC role is needed to "allow for the providers to focus on delivering evidence-based practices and allow for greater attention to

[18] VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013, rescinded and replaced by VHA Directive 1160.06, *Inpatient Mental Health Services*, September 27, 2023. The 2013 handbook, in place during the time frame under review, required discharge planning be coordinated with a patient's MHTC. The 2023 directive states that the MHTC is responsible for coordinating care with facility mental health providers and working with the patient post-discharge.

[19] Deputy Under Secretary for Health for Operations and Management, "Assignment of the Mental Health Treatment Coordinator," memorandum.

[20] Deputy Under Secretary for Health for Operations and Management, "Assignment of the Mental Health Treatment Coordinator," memorandum.

[21] "BHIP Team-Based Care: Behavioral Health Interdisciplinary Program-Collaborative Chronic Care Model," VHA Office of Mental Health and Suicide Prevention, accessed May 21, 2024, https://dvagov.sharepoint.com/sites/VACOMentalHealth/SitePages/Behavioral-Health-Interdisciplinary-Program-(BHIP).aspx. (This site is not publicly accessible.)

[22] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Expanded Implementation of Outpatient Behavioral Health Interdisciplinary Program-Collaborative Chronic Care Model (BHIP-CCM) Team-Based Care," memorandum to VISN leaders (10N1-23), June 28, 2022; VHA, *Behavioral Health Interdisciplinary Program Collaborative Chronic Care Model (BHIP-CCM) Enhancement Guide*, April 2022, accessed July 26, 2023, https://dvagov.sharepoint.com/sites/VACOMentalHealth/BHIP/Lists/Collaborative%20Care%20Model/Attachments/24/BHIP-CCM%20Enhancement%20Guide%20April%202022.pdf. (This site is not publicly accessible.)

proactive population management to prevent loss to follow-up and maximize clinical outcomes."[23]

VHA notes that "lack of care coordination in outpatient mental health settings has been identified as a national limiting factor for Veterans completing an episode of care and successfully transitioning out of VA mental health care to a life worth living."[24] VHA expects BHIP teams to establish processes for assigning new patients to an MHTC and communicating the MHTC assignment to patients.[25]

In the MHTC 2.0 model, VHA specifies that a registered nurse, social worker, or licensed professional mental health counselor can serve as an MHTC, and the position is fully dedicated to care coordination and serving as a point of contact "to support care transitions to and from specialties and subspecialties within mental health."[26]

The MHTC is expected to respond to "critical events," such as emergency department or urgent care clinic visits and inpatient admissions, coordinate care, and follow up with the patient "as needed."[27] Further, VHA advises "when feasible, during the [Mental Health] inpatient admission, the MHTC should outreach the Veteran in the inpatient unit to promote VHA outpatient treatment engagement and participate in discharge planning."[28] VHA additionally provides guidance about the MHTC responsibilities including requirements to develop an initial care coordination plan and document care coordination efforts in a patient's electronic health record (EHR).[29]

Prior OIG Reports

Between February 2021 and April 2024, the OIG published over 50 reports that identified deficiencies in outpatient suicide risk identification processes. In January 2024, the OIG closed two recommendations in response to a November 2022 national review, in which the Under Secretary for Health evaluated staff's perceived barriers to adherence with suicide risk screening

[23] VHA Office of Mental Health and Suicide Prevention, "Mental Health Treatment Coordinator (MHTC) 2.0 Role in the Behavioral Health Interdisciplinary Program Collaborative Chronic Care Model (BHIP-CCM)," accessed April 17, 2024. (This site is not publicly accessible.)

[24] VHA Office of Mental Health and Suicide Prevention, "Mental Health Treatment Coordinator (MHTC) 2.0 Role in the Behavioral Health Interdisciplinary Program Collaborative Chronic Care Model (BHIP-CCM)."

[25] VHA, *Behavioral Health Interdisciplinary Program Collaborative Chronic Care Model (BHIP-CCM) Enhancement Guide*, April 2022.

[26] Assistant Under Secretary for Health for Clinical Services/Chief Officer, "Informational: Mental Health Treatment Coordinator (MHTC) 2.0 Operational Guidance," memorandum.

[27] VHA Office of Mental Health and Suicide Prevention, *Mental Health Treatment Coordinator (MHTC) 2.0 Operational Guidance.*

[28] VHA Office of Mental Health and Suicide Prevention, *Mental Health Treatment Coordinator (MHTC) 2.0 Operational Guidance*.

[29] VHA Office of Mental Health and Suicide Prevention, *Mental Health Treatment Coordinator (MHTC) 2.0 Operational Guidance*.

and evaluation requirements and ensured clinicians complete suicide risk evaluations.[30] In a September 2024 report of a VA facility mental health inspection, the OIG found that mental health unit staff failed to complete the required suicide risk screening for over half of the patients reviewed.[31] Additionally, in a 2024 national review the OIG found that VHA did not monitor compliance with suicide risk identification processes in mental health units.[32]

In 2024 written guidance regarding the updated MHTC role, VHA noted that "lack of consistent care coordination has also been the subject of multiple recent" OIG reports published from 2017 to 2021.[33] In 2021, the OIG published four healthcare inspection reports that included recommendations to a Facility Director related to either the establishment of MHTC policy or compliance with assignment procedures.[34] The four applicable recommendations were closed as of February 2022. In a January 2023 report, the OIG recommended to the Under Secretary for Health strengthening MHTC assignments for patients awaiting admission to mental health residential rehabilitation treatment programs.[35] The OIG closed this recommendation in September 2023. In the September 2024 mental health inspection report, the OIG found that a VA facility did not have required written guidance regarding the MHTC role.[36]

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[30] VA OIG, *Deficiencies in Lethal Means Safety Training, Firearms Access Assessment, and Safety Planning for Patients with Suicidal Behaviors by Firearm*, Report No. 21-00175-19, November 17, 2022.

[31] VA OIG, *Mental Health Inspection of the VA Augusta Healthcare System in Georgia*, Report No. 24-00675-259, September 26, 2024.

[32] VA OIG, *Inadequate Staff Training and Lack of Oversight Contribute to VHA's Suicide Risk Screening and Evaluation Deficiencies,* Report No. 23-02939-13, December 18, 2024.

[33] VHA Office of Mental Health and Suicide Prevention, "Mental Health Treatment Coordinator (MHTC) 2.0 Role in the Behavioral Health Interdisciplinary Program Collaborative Chronic Care Model (BHIP-CCM)," (fact sheet), accessed April 17, 2024, https://dvagov.sharepoint.com/sites/VACOMentalHealth/BHIP/MHTC%2020/Forms/AllItems.aspx?id=%2Fsites%2FVACOMentalHealth%2FBHIP%2FMHTC%2020%2F2024%20MHTC%202%2E0%20Documents%2FMHTC%202%2E0%20%2D%20VHA%20VISN%20Leadership%206%20Essential%20Questions%2Epdf&viewid=3fd481bc%2Df8b5%2D4edb%2Db3fb%2D141529d52587&parent=%2Fsites%2FVACOMentalHealth%2FBHIP%2FMHTC%2020%2F2024%20MHTC%202%2E0%20Documents. (This site is not publicly accessible.)

[34] VA OIG, *Deficiencies in Inpatient Mental Health Care Coordination and Processes Prior to a Patient's Death by Suicide, Harry S. Truman Memorial Veterans' Hospital in Columbia Missouri*, Report No. 20-01521-48, January 5, 2021; VA OIG, *Deficiencies in the Mental Health Care of a Patient who Died by Suicide and Failure to Complete an Institutional Disclosure, VA Southern Nevada Healthcare System in Las Vegas*, Report No. 20-02993-181, July 15, 2021; VA OIG, *Deficiencies in Mental Health Care Coordination and Administrative Processes for a Patient Who Died by Suicide, Ralph H. Johnson VA Medical Center in Charleston, South Carolina*, Report No. 20-02368-202, August 3, 2021; VA OIG, *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*, Report No. 21-00271-258, September 23, 2021.

[35] VA OIG, *Noncompliance with Community Care Referrals for Substance Abuse Residential Treatment at the VA North Texas Health Care System*, Report No. 21-03864-34, January 31, 2023.

[36] VA OIG, *Mental Health Inspection of the VA Augusta Health Care System in Georgia*, Report No. 24-00675-259, September 26, 2024.

Scope and Methodology

The OIG initiated this review in June 2021 and evaluated the MHTC policies or standard operating procedures provided by 71 of 106 (67 percent) facilities with mental health units that included an effective date prior to July 13, 2021, the date of the OIG's initial request. (See Appendix A for details regarding facility responses to the OIG's request for MHTC policies or standard operating procedures.)

The OIG conducted EHR reviews of a random sample of 200 patients from a study population of 16,108 unique patients with a mood disorder diagnosis discharged from across 84 VHA mental health units from October 1, 2019, through September 30, 2020.[37] The OIG reviewed EHRs for staff completion of the following requirements:

- Suicide risk screening or evaluation within 24 hours prior to discharge
- Safety planning
- MHTC assignment
- Discharge care coordination
- Post-discharge treatment engagement

In May 2023, the OIG sent facility leaders of 41 VHA facilities a request for concurrence for 59 patients whom the OIG identified as not having an MHTC assigned at the time of discharge. Facility directors concurred that 49 of the 59 patients did not have an MHTC assigned at the time of discharge and provided nonconcurrence documentation for the remaining 10 patients.

Additionally, the OIG reviewed patient EHRs for adverse clinical outcomes that occurred within the 90 days after discharge and evaluated MHTC involvement in the patients' care.[38]

The OIG identified five facilities with three or more patients reviewed and all were assigned an MHTC, and four facilities for which not all of the reviewed patient EHRs included MHTC assignments (see appendix B).[39] The OIG conducted interviews with the mental health leaders and MHTCs from these 9 facilities, including the 8 Veterans Integrated Service Network (VISN) chief mental health officers, the 9 facility associate chiefs of staff of mental health, and 18

[37] To characterize the uncertainty surrounding the estimates calculated based on this statistical sample, the OIG calculated 95 percent confidence intervals. A confidence interval provides lower and upper values within which an estimate is expected to fall if the population was re-sampled with the same sample size and study design. The 95 percent confidence interval indicates that 95 percent of samples would yield a value between the lower and upper confidence values.

[38] Within the context of this report, the OIG considered an adverse clinical outcome to be death, a progression of disease, worsening prognosis, or a need for higher level care.

[39] The OIG selected two VISN 8 facilities with all reviewed patients' EHRs including assigned MHTCs, one with an established MHTC policy and one without a policy.

MHTCs to assess knowledge and perspectives of MHTC requirements, roles, and responsibilities.

In August 2022, the OIG mailed letters to 183 of the 200 reviewed patients via the United States Postal Service that stated the OIG was "reviewing the quality of mental health care provided by VA, and are hoping to speak with you about your experiences with the VA."[40] Subsequently, the OIG excluded 12 patients after learning that 11 patients were unable to complete the patient survey due to a medical or mental health condition and 1 patient had died after the OIG team mailed the letters.

The OIG called the remaining 171 patients, successfully contacted 89 patients of whom 73 patients agreed to participate in the patient survey. Of 16 patients successfully contacted who did not complete the survey, 6 declined participation and 10 requested to be contacted another time and the OIG's additional contact attempts were unsuccessful.

The OIG asked questions to determine patients' awareness of the MHTC role, ability to identify and contact their assigned MHTC, and perception of supports and barriers to engaging in outpatient mental health care following mental health unit discharge.

The OIG team reviewed relevant VHA polices related to identification and assignment of an MHTC, mental health unit discharge procedures, and suicide risk identification.

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, as amended, 5 U.S.C. §§ 401–424. The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

Results

1. Deficiencies in Suicide Risk Identification and Safety Planning

The OIG found that mental health unit staff failed to document a completed suicide risk screening or assessment within 24 hours before discharge, as required, for 27 percent of the reviewed patients. Mental health unit staff did not complete safety plans with 12 percent of

[40] Based on EHR documentation that noted patient death or incarceration, the OIG did not mail letters to 17 of the 200 patients reviewed.

patients. The OIG found that 36 percent of patients identified as high risk for suicide (high-risk patients) did not have a completed suicide risk screening or evaluation, although most of those patients had a documented safety plan.

VHA requires completion of suicide risk screening and assessment within 24 hours after a patient's admission and before discharge from a mental health unit.[41] Since 2018, VHA has required a standardized suicide risk screening and assessment process using the Columbia-Suicide Severity Rating Scale (C-SSRS) and the Comprehensive Suicide Risk Evaluation (CSRE).[42]

The C-SSRS includes specific questions about a patient's past preparatory or suicidal behavior, recent intent, and thoughts of a method and plan. A negative C-SSRS completes the process; a positive C-SSRS requires same-day completion of the CSRE.[43] The CSRE asks the patient detailed information about suicidal ideation, plan, intent, and behaviors, risk factors, and protective factors, and requires the provider to establish a risk mitigation plan. VHA allows healthcare providers and other select clinicians, including addiction therapists and registered nurses, to complete the C-SSRS.[44] Healthcare providers must complete the CSRE.[45]

Additionally, VHA requires clinicians to collaboratively develop a safety plan with patients

- who made a recent suicide attempt or expressed suicidal ideation,
- prior to mental health unit discharge for patients at risk of suicide,
- determined to be at "high or intermediate acute or chronic risk" of suicide.[46]

[41] Deputy Under Secretary for Health for Operations and Management, "Suicide Risk Screening and Assessment Requirements," memorandum to VISN leaders, attachment B, May 23, 2018, rescinded and replaced by Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy)," memorandum to VISN leaders (10N1-23) and Medical Center Directors (00), November 13, 2020. The policies contain similar language regarding suicide risk identification.

[42] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy)," memorandum. The 2018 memorandum refers to a comprehensive assessment; however, the 2020 memorandum refers to a comprehensive evaluation.

[43] VHA Office of Mental Health and Suicide Prevention, "Risk ID" (fact sheet), September 21, 2021. VHA acknowledges that in some clinical circumstances, it may not be feasible to complete the CSRE the same day. In those situations, the CSRE must be completed within 24 hours of a positive C-SSRS.

[44] Deputy Under Secretary for Health for Operations and Management, "Suicide Risk Screening and Assessment Requirements," memorandum, attachment B. VHA defines healthcare provider as a licensed independent practitioner or advanced practice provider including physicians, nurse practitioners, clinical pharmacists, psychologists, and social workers.

[45] Deputy Under Secretary for Health for Operations and Management, "Suicide Risk Screening and Assessment Requirements," memorandum, attachment B.

[46] VHA Office of Mental Health and Suicide Prevention, "Suicide Prevention Safety Plan Template FAQ" (fact sheet), May 24, 2019.

Since 2018, VHA has required staff to use a safety plan note template and note title that provides nationally standardized documentation elements for suicide prevention safety plans.[47] Staff must provide patients with a copy of the safety plan upon discharge.[48]

VHA advises staff to identify six safety plan elements with patients that include warning signs, coping strategies, social contacts, family and friend supports, professional contacts, and lethal means safety.[49] (See figure 1.)

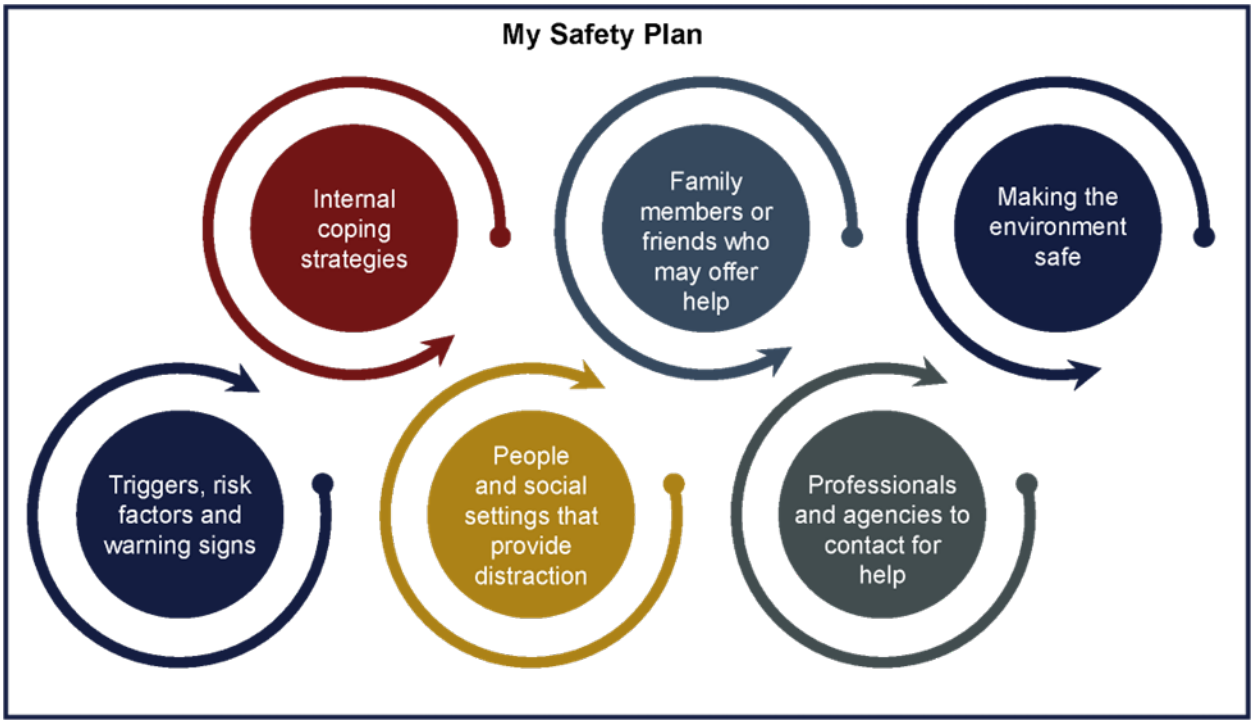

Figure 1. *Six elements identified in safety plans.*
Source: VHA, "My Safety Plan."[50]

[47] Deputy Under Secretary for Health for Operations and Management, "Suicide Prevention Safety Plan National CPRS Note Templates Implementation," memorandum to VISN Directors and Mental Health Leads (10N1-23), June 1, 2018.

[48] VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013, rescinded and replaced by VHA Office of Mental Health and Suicide Prevention, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06," September 29, 2023. These policies contain similar language related to safety plans.

[49] VHA Office of Mental Health and Suicide Prevention, *Suicide Prevention Coordinator Guide*, June 19, 2015; VHA Office of Mental Health and Suicide Prevention, *Suicide Prevention Program Guide*, November 2020; VHA Office of Mental Health and Suicide Prevention, *Suicide Prevention Program Guide*, December 2022. The 2015, 2020, and 2022 guides include references to the same six elements.

[50] "My Safety Plan," VHA Office of Mental Health and Suicide Prevention, https://dvagov.sharepoint.com/sites/VACOMentalHealth/Safety%20Planning%20%20SBR/Safety%20Planning/My%20Safety%20Plan%20-%20Printable%20Blank%20Template.pdf. (This site is not publicly accessible.)

The OIG found that mental health unit staff failed to document a completed C-SSRS or CSRE within 24 hours before discharge, as required.[51] Specifically, 27 percent of patients' EHRs did not include a C-SSRS or CSRE and 30 percent of EHRs with a documented positive C-SSRS did not have a completed CSRE. (See figure 2.)

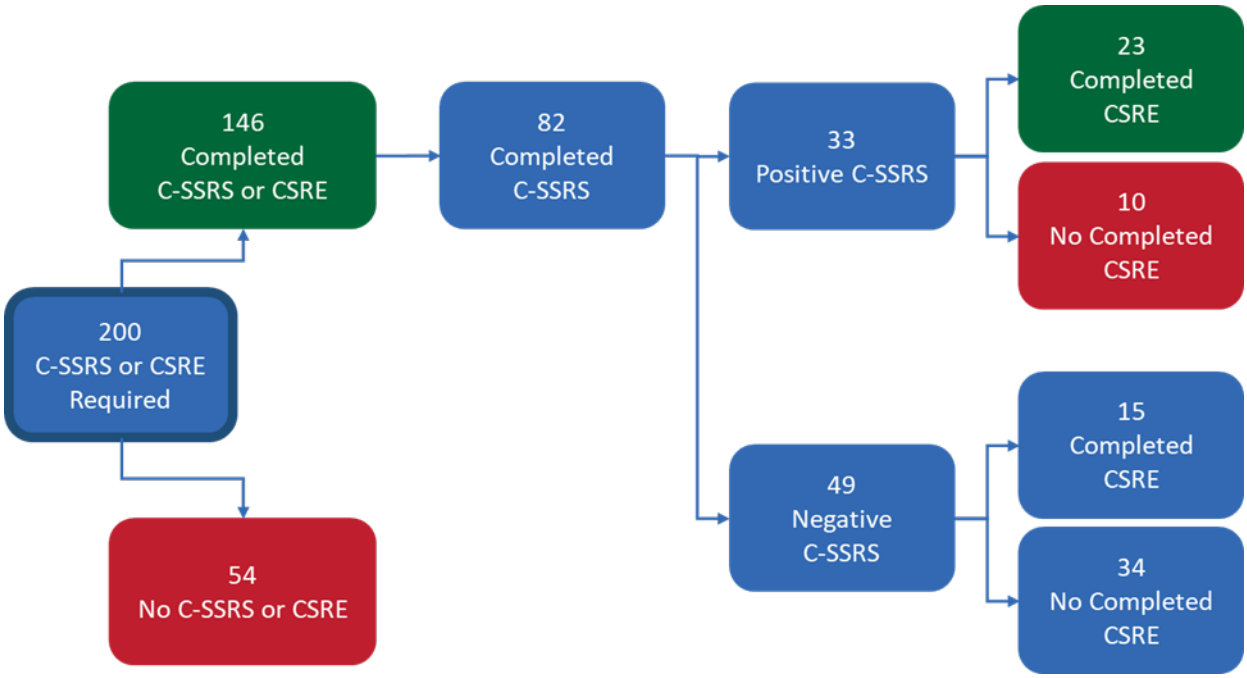

Figure 2. *C-SSRS and CSRE completion for reviewed patients.*
Source: OIG EHR review analysis.

Although not required, the OIG found that mental health unit staff completed a CSRE for 15 of the 49 patients with a negative C-SSRS. Of the patient EHRs reviewed, the OIG determined that 90 percent of patients met the criteria for safety plan completion prior to discharge and found that of the applicable EHRs

- 3 percent included documentation that the patient declined to complete a safety plan,
- 12 percent did not include a safety plan, and
- 84 percent included a completed safety plan.[52]

[51] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy)."

[52] One of the patients' EHRs that did not include a safety plan included documentation that the patient completed a hard copy safety plan although the safety plan was not entered into the EHR. The OIG was unable to evaluate the elements of the safety plan and thus did not consider a safety plan as completed. Numbers do not sum to 100 percent due to rounding.

The OIG determined that, for over 90 percent of the completed safety plans, mental health unit staff documented the required elements and provided a copy to the patients.[53] Of the 12 safety plans that did not contain the required elements, 10 did not contain sufficient contact information for social and professional contacts and 2 failed to include a lethal means assessment.

The OIG found that five patients had an adverse clinical outcome occurring in the 90 days following discharge from the mental health unit.[54] For four of the five patients, the OIG determined that mental health unit care did not contribute to the adverse clinical outcome. However, the OIG found that mental health unit staff did not complete a safety plan prior to one patient's discharge, as required. Although the OIG cannot conclude that a completed safety plan would have prevented the patient's nonfatal accidental overdose within a week of discharge, it is likely that a safety plan might have helped mitigate the patient's risk factors.

High-Risk Patients

VHA requires facility staff to place a high risk for suicide patient record flag (high-risk flag) in a patient's EHR when a patient is determined to be at high risk for suicide.[55] The purpose of the high-risk flag is to alert VA staff that a patient is at high risk for suicide in order to protect the patient's health and safety.[56] Patients assigned a high-risk flag must receive a minimum of four visits within 30 days following discharge from a mental health unit.[57]

The OIG found that 50 of the 200 patients reviewed had a high-risk flag assigned at the time of mental health unit discharge, with 41 (82 percent) of the assignments occurring during the mental health unit admission. Of the 50 high-risk patients, the OIG found that 13 (26 percent) did not have a completed C-SSRS or CSRE, and staff documented a safety plan with 12 of the 13 high-risk patients prior to discharge. Additionally, 1 (3 percent) of the 37 high-risk patients with a documented C-SSRS or CSRE did not have a safety plan completed prior to discharge.

Mental health unit staff's failure to complete required suicide risk identification processes may result in an underestimation of patients' suicide risk and an overestimation of discharge readiness, subsequently contributing to unmitigated risk. Further, the failure to provide patients

[53] VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013, rescinded and replaced by VHA Office of Mental Health and Suicide Prevention, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06," September 29, 2023. These policies contain similar language related to safety plans.

[54] Staff documented the five adverse clinical outcomes as two nonfatal suicide attempts, one fatal and one nonfatal accidental overdose, and one intimate partner violence/assaultive event.

[55] VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008, rescinded and replaced by VHA Directive 1166, *Patient Record Flags*, November 6, 2023. The policies contain similar language related to high-risk flag placement.

[56] VHA Directive 2008-036; VHA Directive 1166.

[57] VHA Office of Mental Health and Suicide Prevention, *Suicide Prevention Program Guide*, November 1, 2020.

with a safety plan upon discharge from mental health units can contribute to patients' diminished ability to identify specific coping strategies and supportive resources to use in times of crisis.

2. Deficiencies in MHTC Policy, Assignment, and Patient Awareness

The OIG found that over 30 percent of VHA facilities did not establish an MHTC policy, as required, and fewer than 50 percent of established policies included all required policy elements. The OIG also determined that mental health unit staff failed to ensure MHTC assignment for nearly 40 percent of the reviewed patients prior to mental health unit discharge, and over 30 percent of MHTC assignments were not documented using the required EHR note template.[58]

Over half of surveyed patients were not able to identify the assigned MHTC or another VHA staff member to contact for help with care. During the patient survey call, 10 percent of the 48 patients with a documented MHTC identified the MHTC accurately while 52 percent were unable to identify an MHTC, and 38 percent identified a VA staff member other than the documented MHTC as their MHTC. Approximately half of the 25 surveyed patients with no documented MHTC assignment identified VHA staff who they would contact if they needed help with their care.

MHTC Policy

Since 2012, VHA has required that each facility establish a policy to outline the process by which the MHTC is identified.[59] For the period of this review, facility policies must ensure staff assign an MHTC to a patient by the third outpatient mental health visit, while awaiting residential treatment, and prior to discharge from a mental health unit. Facility policy should define expectations for the frequency of contact with the patient.[60]

The OIG determined that 35 (33 percent) of 106 facilities with a mental health unit did not have an established MHTC policy. Of the 71 facility MHTC policies reviewed, over 80 percent included a process for staff to identify and assign patients an MHTC and less than 50 percent defined the expected frequency of contact with patients. (See figure 3.) Failure to provide written guidance that outlines MHTC procedures may contribute to staff's lack of awareness of responsibilities and result in patients not being assigned an MHTC to offer resources and support during transitions in care.

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[58] Deputy Under Secretary for Health for Operations and Management, "Suicide Prevention Safety Plan National CPRS Note Templates Implementation," memorandum to VISN Directors and Mental Health Leads (10N1-23), June 1, 2018.

[59] Deputy Under Secretary for Health for Operations and Management, "Assignment of the Mental Health Treatment Coordinator," memorandum.

[60] Deputy Under Secretary for Health for Operations and Management, "Assignment of the Mental Health Treatment Coordinator," memorandum; VHA Handbook 1160.01. Updated guidance requires BHIP teams to establish processes for assigning an MHTC for currently enrolled and new patients. VHA, *Behavioral Health Interdisciplinary Program Collaborative Chronic Care Model (BHIP-CCM) Enhancement Guide*.

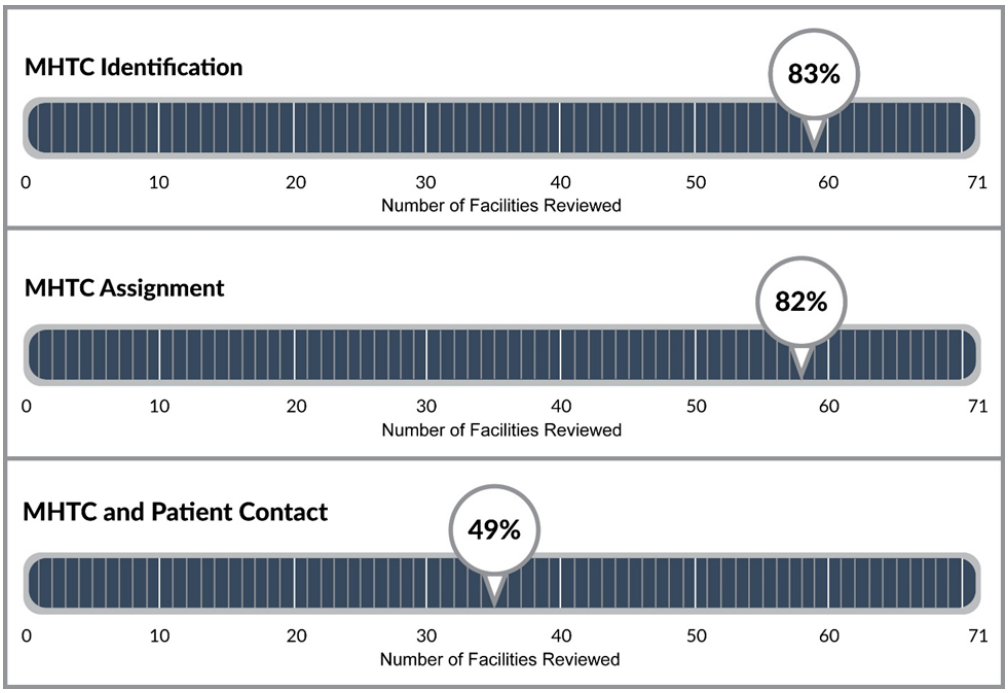

Figure 3. *Facility adherence to required facility MHTC policy elements.*
Source: OIG analysis of applicable facility policies.

National mental health leaders confirmed to the OIG that "facilities should have a local MHTC policy" and reported that "[f]acility and VISN mental health leadership" is responsible for ensuring the implementation of the MHTC policy. Of the eight VISN chief mental health officers interviewed, seven indicated that the facility associate chief of staff of mental health is responsible for development and eight indicated that the facility associate chief of staff of mental health is responsible for oversight of the MHTC policy.[61] The nine associate chiefs of staff of mental health interviewed confirmed being responsible for facility MHTC requirements.

MHTC Assignment and Patient Awareness

VHA requires that an MHTC be identified in a patient's EHR upon discharge from a mental health unit.[62] Staff must document a patient's initial MHTC assignment and reassignments in an EHR progress note titled "MHTC Assignment/Reassignment Note."[63] VHA also requires the name of the employee assigned as a patient's MHTC to be entered into the patient centered management module (PCMM), a software application that allows the name of the MHTC to be easily accessible in a patient's EHR and generates reports that promote oversight, including

[61] One of the eight VISN chief mental health officers indicated that a facility staff member other than the associate chief of staff of mental health is responsible for MHTC policy development.
[62] Deputy Under Secretary for Health for Operations and Management, "Assignment of the Mental Health Treatment Coordinator," memorandum, attachment B.
[63] Deputy Under Secretary for Health for Operations and Management, "Assignment of the Mental Health Treatment Coordinator," memorandum.

identification of patients not assigned an MHTC.[64] In 2012, VHA established an MHTC quality indicator measuring MHTC assignment and has not reached the target goal of 90 percent from fiscal year 2020 up until the first quarter of fiscal year 2024.

Mental health unit staff must ensure a patient's MHTC is included in discharge planning and that outpatient mental health care is coordinated prior to discharge.[65] VHA expects patients to be able to identify their assigned MHTC and have the MHTC's contact information.[66] Updated VHA guidance notes that upon communication from mental health unit staff, the MHTC should participate in discharge planning during a patient's admission "to promote coordinated care planning and post-discharge treatment engagement" and "at minimum, is included as an additional signer on the discharge planning note."

In addition to informing the patient of the MHTC assignment, VHA expects BHIP teams to establish processes for communicating the MHTC assignment to the staff member responsible for PCMM entries.[67] Further, VHA specifies that BHIP teams provide services to a patient until the patient is "stabilized/recovered" and then the team is expected to discharge the patient and unassign the MHTC in PCMM.[68]

The OIG found that mental health unit staff documented evidence of an MHTC assignment at the time of discharge for 121 (61 percent) of 200 patients reviewed.[69] An additional 20 (10 percent) patients' EHRs included a documented MHTC assignment in the 90 days following discharge.[70] (See figure 4.) The OIG found that the assignment of an MHTC was comparable for patients with and without an assigned high-risk flag. The OIG determined that all assigned MHTCs were of an approved discipline.[71]

[64] VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended February 29, 2024.

[65] VHA Handbook 1160.06; VHA Office of Mental Health and Suicide Prevention, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06."

[66] VHA Handbook 1160.06; Deputy Under Secretary for Health for Operations and Management, "Assignment of the Mental Health Treatment Coordinator," memorandum.

[67] VHA, Behavioral Health Interdisciplinary Program Collaborative Chronic Care Model (BHIP-CCM) Enhancement Guide.

[68] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Expanded Implementation of Outpatient Behavioral Health Interdisciplinary Program-Collaborative Chronic Care Model (BHIP-CCM) Team-Based Care," memorandum; VHA, Behavioral Health Interdisciplinary Program Collaborative Chronic Care Model (BHIP-CCM) Enhancement Guide.

[69] Deputy Under Secretary for Health for Operations and Management, "Assignment of the Mental Health Treatment Coordinator," memorandum, attachment B.

[70] One patient was excluded due to death within two months following discharge.

[71] Deputy Under Secretary for Health for Operations and Management, "Assignment of the Mental Health Treatment Coordinator," memorandum, attachment A.

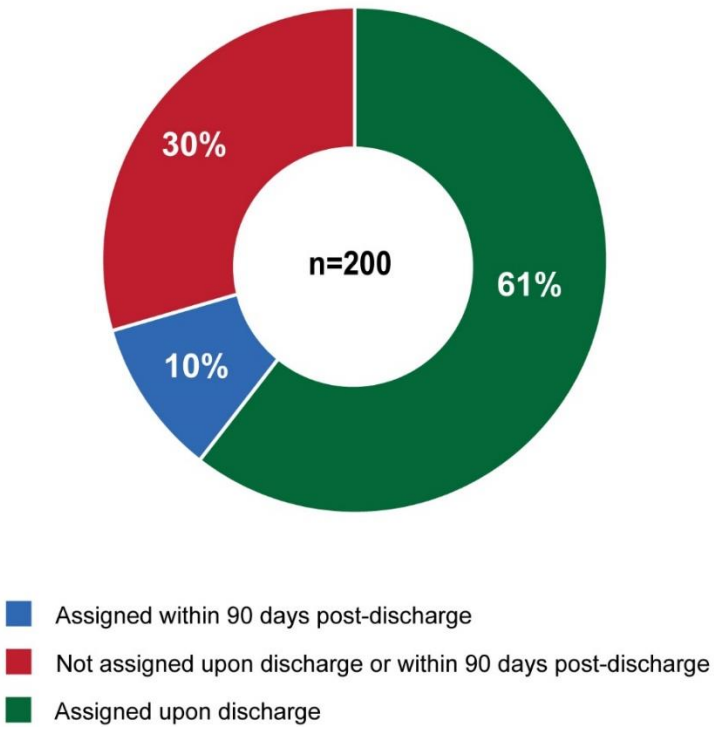

Figure 4. *MHTC assignment at discharge and 90 days post-discharge.*
Source: *OIG EHR analysis.*
Note: Numbers do not sum to 100 percent due to rounding.

The OIG found that of the 121 patients' EHRs with an MHTC documented at the time of discharge, 87 (72 percent) EHRs indicated MHTC involvement, mostly in treatment planning or discharge coordination. However, the OIG found that 31 percent of assigned MHTCs did not have contact or attempt contact with patients in the 90 days after discharge.

In interviews with the OIG, MHTCs reported various ways of learning of being assigned as patients' MHTCs including seeing the display in the EHR, inclusion as an additional signer on EHR documentation, clinic rotation, and supervisor assignment. Thirteen of the 18 MHTCs reported only being included sometimes or not at all on mental health unit documentation, such as treatment plans and discharge summaries.

Among the 141 patients assigned an MHTC within 90 days of discharge, staff documented MHTC assignments in the required EHR template for 96 (68 percent) patients.[72] The remaining 45 patients' EHRs included documentation of MHTC assignment in a treatment plan, safety plan, discharge instructions, discharge summary, or other progress note.

Facility directors concurred with the OIG finding that an MHTC was not assigned at the time of discharge from the mental health unit for 49 (83 percent) of the 59 patients. For 7 of the

[72] Deputy Under Secretary for Health for Operations and Management, "Assignment of the Mental Health Treatment Coordinator," memorandum.

10 nonconcurrences, facility directors provided PCMM entry information. However, the OIG found that five of the seven PCMM-identified MHTCs were not involved in patients' discharge coordination or treatment.

In interviews, seven of the eight VISN chief mental health officers identified PCMM entry as an administrative burden and barrier to maintaining accurate MHTC assignments.[73] Additionally, three associate chiefs of staff of mental health mentioned to the OIG that PCMM utilization was challenging, and one noted that PCMM was designed for primary care and does not work well for mental health processes.

MHTC Reassignment

VHA advised that MHTC assignment changes should

- be minimal,
- not occur at every care transition,
- be planned in collaboration with the patient,
- occur when an assigned MHTC is no longer available, and
- not be related to administrative or workflow issues.[74]

The OIG found that, from October 1, 2018, through September 30, 2020, staff documented an MHTC reassignment for 58 (41 percent) of 141 patients with an assigned MHTC. Although the majority (78 percent) of patients' EHRs reflected one reassignment, over 20 percent of patients' EHRs indicated from two to four reassignments. The OIG determined that the updated MHTC 2.0 care coordination role is likely to reduce the number of reassignments since the MHTC is hired specifically and solely for the role "to support care transitions to and from specialties and subspecialties within mental health."[75]

[73] The OIG did not inquire about PCMM as a potential barrier with one of the eight VISN chief mental health officers.

[74] Deputy Under Secretary for Health for Operations and Management, "Assignment of the Mental Health Treatment Coordinator," memorandum. A new MHTC should be assigned if an assigned MHTC "retires, moves out of the health care system, or moves out of their role within mental health."

[75] Assistant Under Secretary for Health for Clinical Services/Chief Officer, "Informational: Mental Health Treatment Coordinator (MHTC) 2.0 Operational Guidance," memorandum.

Surveyed Patients and MHTC Identification

VHA expects patients to be able to identify their assigned MHTC and have the MHTC's contact information.[76] Of the 73 patients surveyed, 48 (66 percent) patients had a documented MHTC assignment and over half were not able to identify the assigned MHTC or another VHA staff member to contact for help with care. (See figures 5 and 6.)

During the patient survey call, 5 (10 percent) of the 48 patients with a documented MHTC identified the MHTC accurately while 25 (52 percent) patients were unable to identify an MHTC, and 18 (38 percent) patients identified a VA staff member other than the documented MHTC to contact for help with care. (See figure 5). Four of the 5 surveyed patients who identified the documented MHTC and 9 of the 10 patients who identified a different staff member as the MHTC reported knowing how to reach the identified staff member, including by telephone, My HealtheVet, or in the staff member's office.[77]

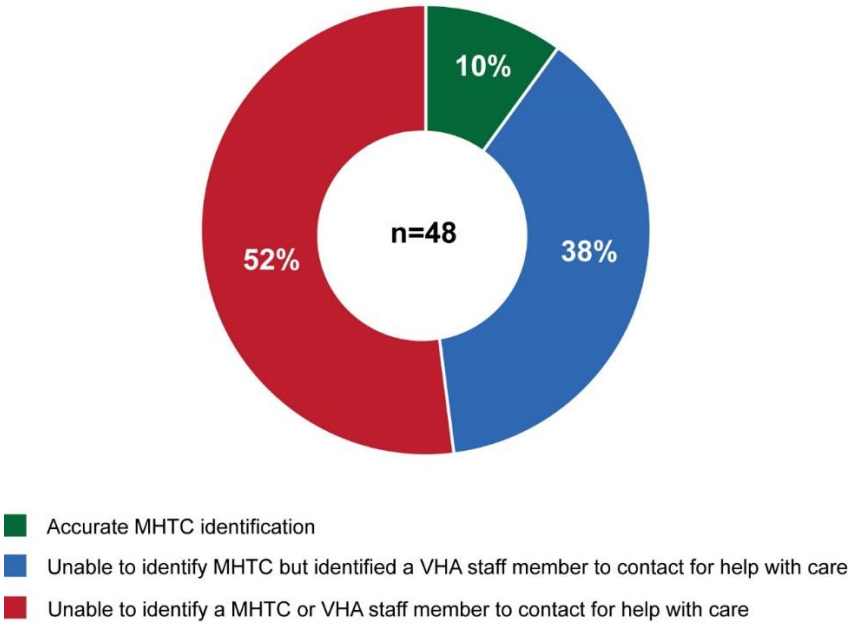

Figure 5. *Patient identification of assigned MHTC and other VHA staff to contact for help. Source: OIG patient survey analysis.*

Approximately half of the 25 surveyed patients with no documented MHTC assignment identified VHA staff who they would contact if they needed help with their care. (See figure 6.)

[76] Deputy Under Secretary for Health for Operations and Management, "Assignment of the Mental Health Treatment Coordinator," memorandum.

[77] My HealtheVet is a secure website that allows VHA patients to access health records, manage appointments, refill prescriptions, and communicate with providers and staff. "How to Use My HealtheVet," VA, accessed April 4, 2024, https://www.myhealth.va.gov/mhv-portal-web/how-to-use-mhv; "Secure Messaging," VA, accessed April 4, 2024, https://www.myhealth.va.gov/secure-messaging-spotlight.

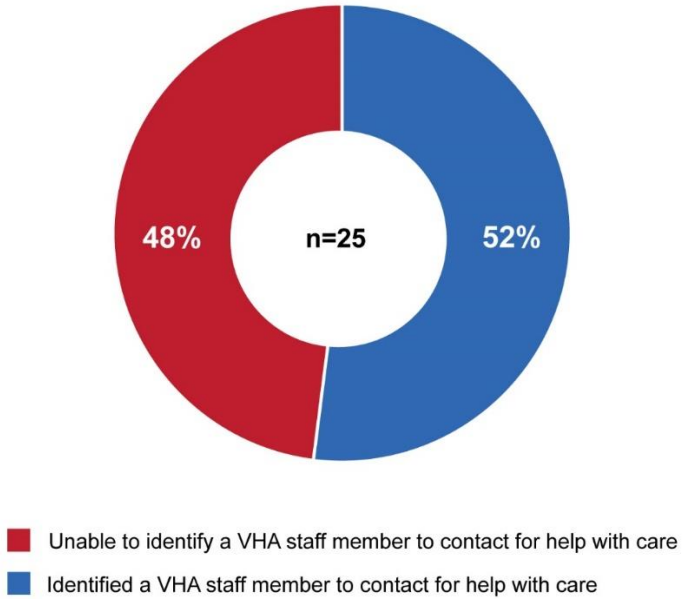

Figure 6. *Identification of a VHA staff member to contact for help by patients without an MHTC assignment.*
Source: OIG patient survey analysis.

The OIG concluded that the MHTC model failed to effectively fulfill the primary responsibility of care coordination during patients' transitions from a mental health unit to outpatient care. The OIG found that although prior and current guidance emphasizes the role of the MHTC as patients' point of contact for care transitions, 40 percent of patients did not have an assigned MHTC at mental health unit discharge and 31 percent of assigned MHTCs did not participate in patients' mental health unit to outpatient care transition. Further, only 10 percent of surveyed patients accurately identified the assigned MHTC.

The OIG recognizes that the appointment of a dedicated BHIP MHTC is likely to improve the MHTC assignment and identification procedures, however, this role still might not foster the relational continuity to effectively support patients during care transitions given limited contact between the MHTC and patient.

3. Inadequate Discharge Care Coordination

Following a mental health unit discharge, continuity of care is an important factor in decreasing a patient's suicide risk.[78] The OIG found that mental health unit staff documented discharge instructions and provided patients a copy, as required, for almost all of the 200 patients

[78] Annemiek Huisman, J.F.M. Kerkhof, and Paul B. M. Robben, "Suicides in Users of Mental Health Care Services: Treatment Characteristics and Hindsight Reflections."

reviewed.[79] However, 81 percent of the EHRs reviewed had a required 7-day follow-up mental health appointment scheduled.[80] Although VHA identifies MHTC involvement in care transitions as expected, 28 percent of EHRs did not include documentation of the patient's MHTC involvement in discharge care coordination and 31 percent of assigned MHTCs did not participate in patients' transition from the mental health unit to outpatient care.[81]

The OIG evaluated patients' attendance to outpatient mental health appointments when a 7-day follow-up appointment was scheduled and when an MHTC was assigned. The OIG found that 90 percent of patients with a scheduled 7-day follow-up appointment upon discharge attended at least one outpatient mental health appointment within the 30 days post-discharge. However, fewer than half of the 50 patients with a high-risk flag attended four or more mental health outpatient appointments in the 30 days following mental health unit discharge, as required.[82]

Within the 90 days following patients' mental health unit discharge, 69 percent of the MHTCs involved in care coordination attempted to contact or contacted patients an average of approximately four times.

For all patients, the percentage of appointments attended in the first 90 days was comparable whether or not an MHTC was assigned. The OIG determined that MHTC assignment at the time of discharge was not associated with a patient's likelihood of attending post-discharge mental health care appointments.

Over half of the 66 surveyed patients who attended an outpatient appointment in the 90 days following discharge told the OIG that self-motivation was a primary contributor to appointment attendance, while 20 percent reported that encouragement from a family member or friend prompted appointment attendance.

Discharge Instructions and Coordination with the MHTC

Effective planning for outpatient mental health care is critical to a patient's recovery and sustained stability in the transition to outpatient care following a mental health unit discharge.[83] Mental health unit staff must include the date and time of follow-up appointments on discharge

[79] VHA Handbook 1160.06; VHA Office of Mental Health and Suicide Prevention, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06." These policies contain similar language related to discharge instructions.

[80] VHA Handbook 1160.01(1).

[81] VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013, rescinded and replaced by VHA Directive 1160.06, *Inpatient Mental Health Services*, September 27, 2023. The 2013 handbook, in place during the time frame under review, required discharge planning to be coordinated with the patient's MHTC. The 2023 directive states that the MHTC is responsible for coordinating care with facility mental health providers and working with the patient post-discharge.

[82] VHA Office of Mental Health and Suicide Prevention, *Suicide Prevention Coordinator Guide*.

[83] VHA Handbook 1160.06; VHA Directive 1160.06.

instructions and provide a written copy to the patient upon discharge.[84] Discharge instructions must also include warning signs, referred to as "red flags," that indicate a patient's need for immediate help as well as the identification of people and resources that the patient can contact for assistance.[85]

The OIG found that mental health unit staff documented discharge instructions in 196 (98 percent) of the 200 patients' EHRs reviewed and provided a written copy to 189 patients (95 percent).[86] Over 90 percent of discharge instructions included "red flags" and numbers to call, as required.[87]

Mental health unit staff must also ensure a patient's MHTC is included in discharge planning and that outpatient mental health care is coordinated prior to discharge.[88] Updated VHA guidance notes that upon communication from mental health unit staff, the MHTC should participate in discharge planning during a patient's admission "to promote coordinated care planning and post-discharge treatment engagement" and "at minimum, is included as an additional signer on the discharge planning note."[89]

In review of the EHRs of the 121 patients with an MHTC assigned at the time of discharge, the OIG found that 87 (72 percent) EHRs indicated MHTC involvement, with most of the MHTCs included in treatment planning or discharge coordination. However, the OIG found that 31 percent of assigned MHTCs did not participate in patients' mental health unit to outpatient care transition. In interviews, 16 of 18 MHTCs reported being involved in care coordination sometimes or not at all for mental health unit patients.

[84] VHA Handbook 1160.06; VHA Directive 1160.06; VHA Office of Mental Health and Suicide Prevention, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06."

[85] VHA Handbook 1160.06; VHA Directive 1160.06; VHA Office of Mental Health and Suicide Prevention, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06"; "Suicide Prevention: Risk Factors and Warning Signs for Family Members and Caregivers," Psychological Health Center of Excellence, accessed April 14, 2023, https://www.healthquality.va.gov/guidelines/MH/srb/PHCoESuicidePreventionTrifold3112020FINALweb508.pdf.

[86] VHA Handbook 1160.06; VHA Directive 1160.06; VHA Office of Mental Health and Suicide Prevention, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06."

[87] VHA Handbook 1160.06; VHA Directive 1160.06; VHA Office of Mental Health and Suicide Prevention, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06"; "Suicide Prevention: Risk Factors and Warning Signs for Family Members and Caregivers," Psychological Health Center of Excellence.

[88] VHA Handbook 1160.06; VHA Directive 1160.06; VHA Office of Mental Health and Suicide Prevention, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06."

[89] VHA Office of Mental Health and Suicide Prevention, *Mental Health Treatment Coordinator (MHTC) 2.0 Operational Guidance,* February 2024.

Post-Discharge Follow-Up and Treatment Engagement

Starting in 2008, VHA required staff to provide patients with appointments for follow-up at the time of discharge and complete a mental health evaluation with the patient within one week of discharge (7-day follow-up appointment).[90] As of 2023, VHA no longer required the follow-up appointment to be completed within seven days and advised mental health unit staff to review "all [mental health unit staff] and consultants' recommendations for discharge planning and post-discharge care."[91]

7-Day Follow-Up Appointments and Outpatient Treatment Attendance

The OIG found that 156 (81 percent) of the 193 applicable EHRs reviewed had a 7-day follow-up mental health appointment scheduled, as required at the time, with most of the appointments in a general mental health clinic.[92] Of the 156 patients with a scheduled 7-day follow-up appointment, 145 (93 percent) attended at least one post-discharge mental health appointment within 90 days and almost all (97 percent) of the appointments occurred in the first 30 days.

Of the 37 (19 percent) patients without a scheduled 7-day follow-up appointment, 31 (84 percent) attended at least one post-discharge mental health appointment within 90 days and 90 percent of the appointments occurred in the first 30 days.

Consistent with VHA's discontinuation of a required 7-day follow-up appointment, the OIG recognizes that post-discharge follow-up appointments are most effectively scheduled in consideration of a patient's treatment needs, preferences, and availability rather than an arbitrary timeliness expectation. However, the OIG proposes VHA leaders provide written guidance regarding expectations for post-discharge mental health appointment scheduling with the aim of promoting patient treatment engagement.

High-Risk Patients Follow-Up Appointments

Patients with a high-risk flag must have a minimum of four mental health visits in the 30 days following discharge from a mental health unit.[93] The OIG found that in the 30 days following mental health unit discharge, 24 (48 percent) of the 50 patients with a high-risk flag attended four or more mental health outpatient appointments, 17 (34 percent) patients attended one to three appointments, and 9 (18 percent) did not attend any appointments. (See figure 7.)

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[90] VHA Handbook 1160.01(1).

[91] VHA Directive 1160.01; VHA Handbook 1160.06; VHA Directive 1160.06; VHA Office of Mental Health and Suicide Prevention, "Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units Under VHA Directive 1160.06."

[92] VHA Handbook 1160.01(1); Seven patients were transferred to inpatient or residential settings and therefore, the 7-day post-discharge appointment was not applicable, resulting in a total of 193 patients expected to have a scheduled 7-day post-discharge appointment.

[93] VHA Office of Mental Health and Suicide Prevention, *Suicide Prevention Coordinator Guide*.

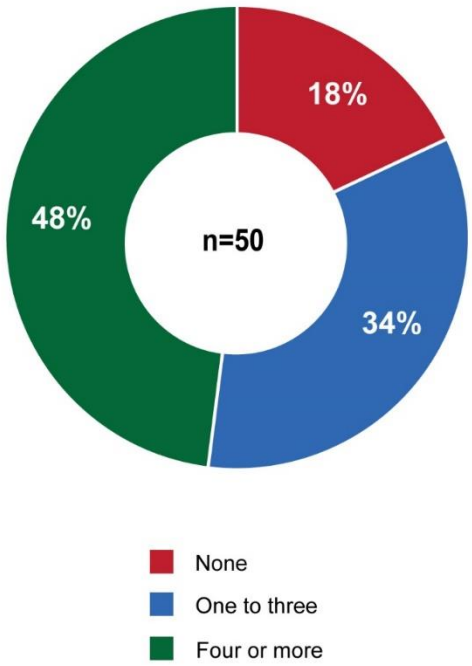

Figure 7. *Number of appointments attended by high-risk patients in the 30 days post-discharge. Source: OIG EHR review analysis.*

The OIG found that the five patients with documented adverse clinical outcomes in the 90 days following discharge from the mental health unit had attended at least one outpatient mental health appointment prior to the adverse clinical outcome and within 30 days following discharge.

MHTC Assignment and Post-discharge Patient Engagement

Within the 90 days following patients' mental health unit discharge, 60 of the 87 (69 percent) MHTCs involved in care coordination attempted to contact or contacted patients an average of approximately four times.

The OIG determined that MHTC assignment at the time of discharge for all patients was not associated with a patient's likelihood of attending or missing post-discharge mental health appointments in the first 90 days following discharge. (See table 1.)

Table 1. Post-Discharge Appointment Attendance and Assigned MHTC at Discharge

MHTC Assignment at Discharge	Appointment Attendance by Days Post-discharge		
	0–30	31–60	61–90
Assigned (121)	100 (83%)	70 (58%)	69 (57%)
Not Assigned (79)	69 (87%)	44 (56%)	40 (51%)

Source: OIG EHR review analysis.

Surveyed Patients' Perspectives on Appointment Attendance

Mental health unit staff documented discharge instructions for the 73 patients who participated in the patient survey; however, 3 of the 73 patients' EHRs did not include documentation that the patient was provided a copy of discharge instructions. The OIG found that 66 (90 percent) of the 73 patients attended at least one mental health outpatient appointment in the 90 days following discharge. The OIG determined that consistent with the above finding for all reviewed patients, appointment attendance for the 73 surveyed patients was comparable for those patients assigned an MHTC and those not assigned an MHTC. (See table 2.)

Table 2. Surveyed Patients' Post-Discharge Appointment Attendance and Assigned MHTC at Discharge

MHTC Assignment at Discharge	Appointment Attendance by Days Post-Discharge		
	0–30	31–60	61–90
Assigned (46)	41 (89%)	26 (57%)	29 (63%)
Not Assigned (27)	23 (85%)	17 (63%)	17 (63%)

Source: OIG EHR review analysis.

Over half of the 66 patients who attended an outpatient appointment in the 90 days following discharge told the OIG that self-motivation was a primary contributor to appointment attendance while 13 (20 percent) reported that encouragement from a family member or friend prompted appointment attendance and 8 (12 percent) indicated a VA reminder or staff were helpful in making appointments.[94]

The OIG found that 59 (81 percent) of the 73 surveyed patients missed at least one appointment in the 90 days following discharge. In interviews with the OIG, patients indicated forgetting or being unaware of the missed appointment (20 percent), scheduling conflicts (20 percent), psychosocial stressors (19 percent), and transportation challenges (15 percent) interfered with attending scheduled appointments.[95]

The OIG found that MHTC assignment at the time of discharge was not associated with a patient's increased likelihood of attending post-discharge mental healthcare appointments. In March 2024, VHA provided updated guidelines for MHTC involvement in patients' care; however, the findings of this national review suggest that the assignment of a staff member to oversee care coordination has not resulted in improved continuity of care for patients.[96]

[94] Patients may have identified one or more contributing factors that supported appointment attendance.

[95] American Psychological Association, *Dictionary of Psychology,* "psychosocial stressor," accessed April 30, 2024, https://dictionary.apa.org/psychosocial-stressor. A psychosocial stressor is "a life situation that creates an unusual or intense level of stress that may contribute to the development or aggravation of mental disorder, illness, or maladaptive behavior" such as divorce or prolonged illness.

[96] Assistant Under Secretary for Health for Clinical Services/Chief Officer, "Informational: Mental Health Treatment Coordinator (MHTC) 2.0 Operational Guidance," memorandum.

For over a decade, VHA has integrated the use of motivational interviewing in primary care settings to enhance patients' healthy behavior changes and to "promote Veteran's decision to accept and **engage** in care."[97] Motivational interviewing—an evidence-based, patient-centered approach—can lead to patients' engagement in follow-up care by strengthening internal motivation and addressing barriers to care.[98]

The OIG concluded that assignment of a staff member to oversee care coordination has not resulted in improved continuity of care for patients during the transition from a mental health unit, and that other mental health unit programmatic considerations might be beneficial, including motivational interviewing for discharge planning goals.[99] The OIG determined that VHA leaders should consider evaluating the effectiveness of a dedicated staff member as planned in the MHTC 2.0 care coordination model as well as implementation of techniques to facilitate patient discharge preparedness and engagement with their outpatient mental health team.

Based on the surveyed patients' reports, the OIG suggests that VHA leaders consider integration of techniques in discharge planning that encourage patients' self-motivation, such as motivational interviewing, as well as inclusion of family and friends to promote post-discharge attendance. In efforts to support relational continuity and the engagement of patients in ongoing outpatient care following a mental health unit discharge, the OIG also suggests that VHA leaders promote patients' orientation to their BHIP team and facilitate awareness of, and accessibility to, team members to achieve more beneficial collaborative care management.

Conclusion

The OIG found that mental health unit staff failed to document a completed suicide risk screening for over half of the patients and did not complete safety plans with12 percent of

[97] Michael A. Cucciare et al., "Teaching Motivational Interviewing to Primary Care Staff in the Veterans Health Administration," *Journal of General Internal Medicine* 27, no. 8 (February 28, 2012): 953-961, https://doi.org/10.1007/s11606-012-2016-6. "PCMHI Collaborative Care Management (PCMHI CoCM): Patient Outreach and Engagement," VHA Center for Integrated Healthcare, accessed May 21, 2024, https://dvagov.sharepoint.com/sites/vhava-center-for-integrated-healthcare/PCMHI%20Care%20Management%20Toolkit. (This site is not publicly accessible.)

[98] Carl Flores et al., "Motivational Interviewing with Veterans and Service Members," chap. 50 in *Interventions Supporting Psychosocial Functioning: An Occupational Therapist's Guide* (2018). "Evidence-Based Therapy," VHA Office of Mental Health and Suicide Prevention, accessed May 21, 2024, https://www.mentalhealth.va.gov/get-help/treatment/ebt.asp. (This site is not publicly accessible.); "Education and Brief Interventions for PCMHI," VHA Center for Integrated Healthcare, accessed May 21, 2024, https://dvagov.sharepoint.com/sites/vhava-center-for-integrated-healthcare/PCMHI%20Care%20Management%20Toolkit. (This site is not publicly accessible.).

[99] Assistant Under Secretary for Health for Clinical Services/Chief Officer, "Informational: Mental Health Treatment Coordinator (MHTC) 2.0 Operational Guidance," memorandum.

patients prior to discharge, as required.[100] More than one-third of high-risk patients did not have a completed suicide risk screening or evaluation although most had a documented safety plan. Failure to complete required suicide risk identification processes and safety planning may result in an underestimation of patients' suicide risk, an overestimation of discharge readiness, and contribute to patients' diminished ability to identify specific coping strategies and supportive resources to use in times of crisis.

Over 30 percent of VHA facilities did not establish an MHTC policy and less than 50 percent of the 71 facility MHTC policies reviewed defined the expected frequency of contact with patients. Mental health unit staff failed to assign an MHTC for nearly 40 percent of the reviewed patients. VISN chief mental health officers and facility chiefs of staff of mental health identified PCMM processes as a barrier to maintaining accurate MHTC assignments.[101]

Over half of surveyed patients with an assigned MHTC were not able to identify the MHTC or another VHA staff member to contact for help with care. VHA identifies MHTC involvement in care transitions as expected; however, 28 percent of EHRs did not include documentation of the patient's MHTC involvement in discharge care coordination and 31 percent of assigned MHTCs did not participate in patients' transition from the mental health unit to outpatient care. [102] The OIG concluded that the MHTC model failed to effectively fulfill the primary responsibility of care coordination during patients' transition from a mental health unit to outpatient care.

Regardless of whether a patient had a scheduled 7-day follow-up appointment, over 90 percent of patients reviewed attended at least one outpatient mental health follow-up appointment in the 90 days post-discharge and most occurred in the first 30 days. Fewer than half (48 percent) of the 50 patients with a high-risk flag attended four or more mental health outpatient appointments in the 30 days following mental health unit discharge.

Within the 90 days following patients' mental health unit discharge, 60 of the 87 (69 percent) MHTCs involved in care coordination attempted to contact or contacted patients an average of approximately four times. Post-discharge appointment attendance for the 73 surveyed patients was comparable for those patients assigned an MHTC and those not assigned an MHTC. The

[100] Deputy Under Secretary for Health for Operations and Management, "Suicide Risk Screening and Assessment Requirements," memorandum to VISN leaders, attachment B, May 23, 2018, rescinded and replaced by Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy)," memorandum to VISN leaders (10N1-23) and Medical Center Directors (00), November 13, 2020. The policies contain similar language regarding suicide risk identification.

[101] The OIG did not inquire about PCMM as a potential barrier with one of the eight VISN chief mental health officers.

[102] VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013, rescinded and replaced by VHA Directive 1160.06, *Inpatient Mental Health Services*, September 27, 2023. The 2013 handbook, in place during the time frame under review, required discharge planning be coordinated with a patient's MHTC. The 2023 directive states that the MHTC is responsible for coordinating care with facility mental health providers and working with the patient post-discharge.

OIG determined that MHTC assignment at the time of discharge was not associated with a patient's likelihood of attending post-discharge mental health care appointments.

Over half of the 66 surveyed patients who attended an outpatient appointment in the 90 days following discharge told the OIG that self-motivation was a primary contributor to appointment attendance while 20 percent reported that encouragement from a family member or friend prompted appointment attendance.

Recommendations 1–8

1. The Under Secretary for Health monitors inpatient mental health unit adherence to suicide risk identification processes and identifies and addresses barriers.

2. The Under Secretary for Health ensures inpatient mental health unit staff complete suicide prevention safety plans as expected, and monitors compliance.

3. The Under Secretary for Health clarifies requirements for facility-level written guidance regarding the processes for mental health treatment coordinator identification, assignment, and care coordination, and monitors compliance.

4. The Under Secretary for Health ensures accurate and timely mental health treatment coordinator assignment, including patient centered management module entry and notification for the assigned staff and applicable patient.

5. The Under Secretary for Health evaluates the effectiveness of dedicated mental health treatment coordinators in enhancing patient engagement in outpatient mental health care following discharge from an inpatient mental health unit, and takes action as appropriate.

6. The Under Secretary for Health considers establishing written guidance regarding expectations for mental health unit staff to schedule patients' post-discharge mental health care appointments.

7. The Under Secretary for Health determines supportive factors that contribute to patients' attendance at outpatient mental health appointments following discharge from an inpatient mental health unit, including self-motivation enhancement and family and friend involvement, and takes action to integrate such factors into discharge planning procedures.

8. The Under Secretary for Health considers establishing a process for patient orientation to the behavioral health interdisciplinary team to facilitate patient awareness of, and accessibility to, team members, and takes action as appropriate.

Appendix A: Facility Responses to MHTC Policy Request

Of the 106 facilities with established mental health units, 93 (88 percent) responded to the OIG's initial request for a facility MHTC policy.

Of the 93 responses, 9 (10 percent) facilities reported using national written guidance and 6 facilities provided a policy other than an MHTC policy that did not include the relevant MHTC information. Of the remaining 78 facility MHTC policies provided, 54 (69 percent) included an effective date prior to July 13, 2021, and 24 (31 percent) were undated or had an effective date later than July 13, 2021.

In January 2022, the OIG again requested MHTC policies with effective dates prior to July 13, 2021, from 43 facilities that included the

- 6 that provided a policy other than an MHTC policy;
- 24 that provided an undated policy, or a policy dated later than July 13, 2021; and
- 13 that did not respond to the OIG's initial request.

A total of 102 of 106 facilities with mental health units responded to the OIG's initial or follow-up request for an MHTC policy.[103] Ultimately, of the 106 facilities, 71 (67 percent) provided MHTC policies with an effective date prior to July 13, 2021.

[103] The following four facilities failed to respond to the OIG's initial or follow-up request for MHTC policies: Oklahoma City VA Health Care System, Sheridan VA Medical Center, VA Central Western Massachusetts Healthcare System, and VA Salt Lake City Health Care System.

Appendix B: Identification of VISN Chief Mental Health Officers, Associate Chief of Staff of Mental Health, and MHTC Interview Sites

Table B.1. Interview Sites Selected Based on Number of Patients Assigned MHTCs and with a Policy in Place

VISN	Medical Center Site	Patients Assigned MHTC of Total Reviewed Patients	MHTC Policy in Place
16	Michael E. DeBakey VA Medical Center, Houston, Texas	7 of 7	No
19	VA Salt Lake City Health Care System, Utah	4 of 4	Yes
7	Atlanta VA Healthcare System, Georgia	4 of 4	No
8	West Palm Beach VA Medical Center, Florida	3 of 3	Yes
8	VA Caribbean Healthcare System, San Juan, Puerto Rico	3 of 3	No
22	West Los Angeles VA Medical Center, California	1 of 4	Yes
5	Washington DC VA Medical Center	1 of 5	No
12	Jesse Brown VA Medical Center, Chicago, Illinois	0 of 3	Yes
21	VA Palo Alto Health Care System, California	0 of 3	Yes

Source: OIG analysis of MHTC assignments and VHA-provided facility policies

Appendix C: Office of the Under Secretary for Health Memorandum

Department of Veterans Affairs Memorandum

Date: November 4, 2024

From: Under Secretary for Health (10)

Subj: Office of Inspector General (OIG) Draft Report, Deficiencies in Inpatient Mental Health Suicide Risk Assessment, Mental Health Treatment Coordinator Processes, and Discharge Care Coordination

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on OIG's draft report on inpatient mental health processes including suicide risk assessments, coordinator process and discharge care coordination. The Veterans Health Administration (VHA) concurs with recommendations 1-6 and 8 and concurs in principle with recommendation 7. VHA provides an action plan to address the recommendations in the attachment.

2. Initiated in 2018, VHA's implementation of universal suicide risk screening, across all healthcare settings, is the largest known implementation of suicide risk screening and evaluation in the nation. While this standardized process of identifying suicide risk, known as VA Suicide Risk Identification Strategy, has been associated with increased mental health treatment follow-up, particularly for those Veterans not previously engaged in mental health services in the prior year (Gujral, Bahraini, Brenner LA, et al. 2023 - PubMed (nih.gov)), there is more to do. VHA appreciates the recommendations provided by the OIG, as the shared goal is to strengthen screening and evaluation processes to mitigate the risk of suicide.

3. VHA has engaged in an iterative process to examine implementation and improve uptake of the VA Suicide Risk Identification Strategy. VHA is actively driving improvements in processes and implementation through strategic partnerships and data-driven initiatives. VHA is focused on enhancing performance measurement, refining policies, and implementing targeted strategies to increase screening and evaluation rates.

4. Suicide prevention and high-quality mental health treatment for Veterans remains one of VHA's top priorities and VHA appreciates OIG's ongoing collaboration in evaluating and identifying areas of opportunity as further refinements of VHA strategies aimed at enhancing Veteran care coordination and suicide prevention continue.

5. Comments regarding the contents of this memorandum may be directed to the GAO OIG Accountability Liaison Office at vha10oicgoalaction@va.gov.

(Original signed by:)

Shereef Elnahal M.D., MBA

[OIG comment: The OIG received the above memorandum from VHA on November 8, 2024.]

VETERANS HEALTH ADMINISTRATION (VHA)
Action Plan

OIG Draft Report, Deficiencies in Inpatient Mental Health Suicide Risk Assessment, Mental Health Treatment Coordinator Processes, and Discharge Care Coordination
(OIG Project Number 2021-02389-HI-1177)

Recommendation 1. The Under Secretary for Health monitors inpatient mental health unit adherence to suicide risk identification processes and identifies and addresses barriers.

VHA Comments: Concur

VHA will monitor suicide risk screening and evaluation adherence for inpatient mental health settings and will provide evidence that reflects enhancements to monitoring for inpatient mental health suicide risk screening and evaluation requirements. In addition, VHA will review barriers that impact adherence to suicide risk screening and evaluation requirements and will provide evidence that reflects a plan to address barriers of adherence to suicide risk screening and evaluation.

Status: In progress Target Completion Date: February 2026

Recommendation 2. The Under Secretary for Health ensures inpatient mental health unit staff complete suicide prevention safety plans as expected, and monitors compliance.

VHA Comments: Concur

VHA will monitor compliance with offering Veterans the opportunity to develop or update safety plans during inpatient mental health treatment and will provide evidence that reflects enhancements to monitoring inpatient mental health safety planning requirements.

Status: In progress Target Completion Date: February 2026

Recommendation 3. The Under Secretary for Health clarifies requirements for facility-level written guidance regarding the processes for mental health treatment coordinator identification, assignment, and care coordination, and monitors compliance.

VHA Comments: Concur

VHA agrees that the original mental health treatment coordinator (MHTC) 1.0 requirements, that were in place at the time that these data were collected, were not clear or effective. To begin addressing this gap, the fiscal year (FY) 2022 Expanded Implementation of Outpatient Behavioral Health Interdisciplinary Program-Collaborative Chronic Care Model (BHIP-CCM) Team-Based Care memorandum outlined the need for each BHIP team to have a dedicated care coordinator, with a staffing ratio of 1.0 FTE care coordinator for every 1,000 Veterans served and required sites complete the BHIP-CCM Enhancement Guide Process Summary (n = 27 processes) and BHIP Implementation Checklist, which includes developing local, written processes for MHTC

2.0 identification, assignment, and care coordination. The Informational: Mental Health Treatment Coordinator (MHTC) 2.0 Operational Guidance memorandum outlining expectations and tools for the MHTC 2.0 Care Coordinator role was released in March 2024, with national virtual training held in late June 2024, further delineating national guidelines for MHTC 2.0 identification, assignment, and care coordination.

The Office of Mental Health (OMH) BHIP National Program Office will request all sites complete the MHTC 2.0 Implementation Checklist by the fourth quarter of FY 2026. Compliance with the updated requirements for MHTC identification, assignment, and care coordination will be monitored through the completion of BHIP-CCM Enhancement Guide Process Summaries and BHIP Implementation Checklists, completion of the MHTC 2.0 Implementation Checklist, and monitoring of new MHTC metrics, which are under development.

Status: In progress Target Completion Date: July 2025

Recommendation 4. The Under Secretary for Health ensures accurate and timely mental health treatment coordinator assignment, including patient centered management module entry and notification for the assigned staff and applicable patient.

VHA Comments: Concur

VHA agrees. To streamline the process, a national note template has been designed and required for use by the MHTC 2.0 Care Coordinator, or designee, to document MHTC 2.0 assignment, reassignment, or assignment removal and to facilitate communication with the Veteran. VHA will develop a process to monitor utilization of the MHTC 2.0 assignment note templates.

Status: In progress Target Completion Date: July 2025

Recommendation 5. The Under Secretary for Health evaluates the effectiveness of dedicated mental health treatment coordinators in enhancing patient engagement in outpatient mental health care following discharge from an inpatient mental health unit, and takes action as appropriate.

VHA Comments: Concur

As a learning organization and a health system committed to providing world-class mental health care to Veterans and preventing Veteran suicide, we acknowledge and have identified multiple opportunities to improve since implementation of the original MHTC guidance. These important lessons learned have been incorporated this into the revised guidance (MHTC 2.0) that was released in March 2024, with a focus on addressing care coordination gaps.

During the development of MHTC 2.0, VHA reviewed evidence-based best practices, such as the integration of a dedicated discharge planner or coordinator. These approaches have been proven to significantly improve post-discharge engagement and care continuity (Schmidt et al., 2022). The primary goal of MHTC 2.0 is not only to sustain current levels of post-discharge engagement but also to improve care coordination across the mental health continuum of care and proactive population

management, ensuring Veterans experience seamless transitions between different levels of care.

The MHTC 2.0 Operational Guidance was released to the field in March 2024. The Office of Mental Health is currently tracking and will continue to track, monitor, and evaluate the implementation of this new role to ensure its effectiveness. VHA remains committed to continuously developing and enhancing its infrastructure to optimize post-discharge engagement and overall care coordination for Veterans.

Schmidt, E. M., Wright, D., Cherkasova, E., Harris, A. H. S., & Trafton, J. (2022). Evaluating and improving engagement in care after high-intensity stays for mental or substance use disorders. *Psychiatric Services, 73*(1), 18–25. https://doi.org/10.1176/appi.ps.202000287

Status: Complete Completion Date: March 2024

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

Recommendation 6. The Under Secretary for Health considers establishing written guidance regarding expectations for mental health unit staff to schedule patients' post-discharge mental health care appointments.

VHA Comments: Concur

VHA Office of Mental Health reviewed the need for written guidance regarding expectations for mental health unit staff to schedule patients' post-discharge mental health care appointments and determined that this written guidance will be added to VHA Directive 1160.06, Standard Operating Procedure for Core Clinical Processes on Inpatient Mental Health Units. The MHTC 2.0 Operational Guidance specifies the originating inpatient unit staff should connect the Veteran to a BHIP team/MHTC to promote care continuity.

Status: In progress Target Completion Date: December 2024

Recommendation 7. The Under Secretary for Health determines supportive factors that contribute to patients' attendance at outpatient mental health appointments following discharge from an inpatient mental health unit, including self-motivation enhancement and family and friend involvement, and takes action to integrate such factors into discharge planning procedures.

VHA Comments: Concur in principle

Motivational interviewing is part of therapeutic programming requitements for inpatient mental health units (please see VHA Directive 1160.06.3, Standard Operating Procedure for Inpatient Mental Health Core Clinical Programming Requirements Under VHA Directive 1160.06). Additionally, OMH has initiated development of an educational program for frontline inpatient mental health staff that emphasizes staff communication skills to enhance patients' self-motivation for treatment. With the Veteran's permission, family involvement in care is included as a responsibility of the Interdisciplinary Treatment Team in VHA Directive 1160.06, and if the Veteran agrees, family involvement is included in the patient's treatment plan which guides treatment during

hospitalization, including discharge planning. VHA Directive 1160.06 also includes a section on visitation, and states "Visitation with a Veteran's social support network should be encouraged (in-person or by virtual means) during hospitalization. The VA uses a broad understanding of family, including anyone whom the patient or resident considers to be family."

Status: Complete Completion Date: September 2023

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

Recommendation 8. The Under Secretary for Health considers establishing a process for patient orientation to the behavioral health interdisciplinary team to facilitate patient awareness of, and accessibility to, team members, and takes action as appropriate.

VHA Comments: Concur

VHA will establish a process for patient orientation to BHIP while on the mental health inpatient unit. This may include brochures or psychoeducational material that can be used by MHTC 2.0 Care Coordinators and/or mental health inpatient staff to orient Veterans to the BHIP team, explain the role of the MHTC 2.0 Care Coordinator, and provide clear information about how care transitions and follow-up will be managed.

Status: In progress Target Completion Date: December 2025

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