DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

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

HEALTHCARE INSPECTION | REPORT #20-02368-202 | AUGUST 3, 2021

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Executive Summary

The VA Office of Inspector General (OIG) conducted this healthcare inspection at the Ralph H. Johnson VA Medical Center (facility) to determine the validity of allegations referred by Chairman Mark Takano, House Committee on Veterans' Affairs, regarding deficiencies in the mental health care provided for a high risk for suicide patient who died by suicide. Specifically, the OIG reviewed allegations of inadequate psychiatric monitoring and delays in psychiatric care due to procedures identified in the *Primary Care Service Agreement: Mental Health Integration and Mental Health Services* (service agreement), and a delay in placing the patient's high risk for suicide patient record flag.[1] The OIG also reviewed concerns that facility staff did not adequately (1) evaluate the patient's condition and treatment needs in a review of the patient's high risk for suicide patient record flag, (2) coordinate care, and (3) assess suicide risk. Additionally, staff failed to notify facility leaders of the patient's death by suicide.

Synopsis of Events

The patient was in their 20s at the time of death by suicide in fall 2019.[2] The patient initiated treatment with a facility primary care physician on a day in 2019 (day 1), and reported a history of anxiety disorder, major depressive disorder, and insomnia and treatment with an antidepressant and a mood stabilizer.[3] On day 49, a psychiatry resident physician admitted the patient to the facility's Inpatient Mental Health Unit. Five days later, the Suicide Prevention Coordinator placed a high risk for suicide patient record flag in the patient's electronic health record (EHR).[4] On day 56, the patient was discharged with two appointments for the following week. The patient intermittently engaged in outpatient mental health treatment from spring through late summer 2019.

On day 210, the outpatient social worker documented calling the patient in response to a voicemail message "hinting that [the patient] was not doing well." The patient's voicemail was not functional so the outpatient social worker was unable to leave a voicemail and documented a plan to call again. On day 229, the outpatient social worker recommended continuation of the

[1] Facility Mental Health Service Line, *Primary Care Service Agreement: Mental Health Integration and Mental Health Services*, November 9, 2017.

[2] The OIG uses the singular form of they (their) in this instance for privacy purposes.

[3] The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together.

[4] VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008. Deputy Under Secretary for Health for Operations and Management (10N) Memorandum, "Update to High Risk for Suicide Patient Record Flag Changes," January 16, 2020. VHA uses a high risk for suicide patient record flag to identify patients as high risk for suicide in their EHRs and requires intensive follow-up by providers while the patient remains flagged.

patient's high risk for suicide patient record flag and the Suicide Prevention Coordinator continued the patient's high risk for suicide patient record flag in the EHR.

On day 268, a facility medical records clerk responded to a release of information request for the patient's medical records from an Army Reserve investigating officer to uncover "any/all contributing factors towards the [patient's] decision to commit suicide." The Army Reserve investigating officer also provided a copy of the patient's death certificate.

Healthcare Inspection Results

The OIG did not substantiate that the service agreement procedures resulted in inadequate psychiatric monitoring of the patient or delays in psychiatric care for other primary care patients. Facility staff provided adequate psychiatric monitoring and the patient did not experience delays in psychiatric care due to service agreement procedures.

The OIG did not substantiate that facility staff delayed placement of the high risk for suicide patient record flag. The Suicide Prevention Coordinator placed a high risk for suicide patient record flag in the patient's EHR on day 54, two days prior to the patient's discharge from the Inpatient Mental Health Unit. The OIG found that facility staff did not adequately evaluate the patient's condition and treatment needs as part of a renewal review of the patient's high risk for suicide patient record flag. The Suicide Prevention Coordinator documented continuation of the patient's high risk for suicide patient record flag; however, facility leaders told the OIG that the patient's high risk for suicide patient record flag was continued unknowingly by staff on a date after the patient's death by suicide.[5]

The Suicide Prevention Supervisor told the OIG that, as of April 2020, additional monitoring procedures were implemented including a suicide prevention coordinator ensuring outreach to patients not engaged with mental health care in the prior 30 days; and monitoring of canceled mental health appointments for patients on the high risk for suicide list to ensure outreach when patients do not reschedule canceled appointments.

The OIG found that facility staff did not assign the patient a Mental Health Treatment Coordinator (MHTC) prior to discharge from the Inpatient Mental Health Unit, as required by the Veterans Health Administration (VHA).[6] The substance use disorder clinic social worker was assigned as the patient's MHTC day 71, 15 days after the patient's Inpatient Mental Health Unit discharge. At the time of the patient's care, the absence of a facility policy may have contributed to staff's lack of timely assignment of an MHTC for the patient. The Medical Director, Inpatient

[5] VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide,* July 18, 2008. VHA uses the High Risk for Suicide Patient Record Flag to alert staff of patients who are clinically determined to be at high risk for suicide.

[6] Deputy Under Secretary for Health for Operations and Management (10N) Memorandum, "Assignment of the Mental Health Treatment Coordinator, Attachments A, B, and C," March 26, 2012.

Mental Health Unit told the OIG that, at the time of the patient's admission, contrary to VHA policy, inpatient staff did not have to assign patients an MHTC. In spring 2019, leaders identified a deficit in MHTC assignment and in July 2020, established an MHTC standard operating procedure that outlined procedures meeting the VHA requirement.[7]

Both the acting Recovery Engagement and Coordination for Health–Veterans Enhanced Treatment (REACH VET) Coordinator and Provider completed required documentation.[8] However, the OIG found the REACH VET Provider documented discussing the patient's REACH VET status during an appointment that took place prior to the notification of the patient's REACH VET identification.[9] The OIG concluded that the REACH VET Provider did not discuss the patient's REACH VET status with the patient, as required.[10] Failure to engage in a collaborative discussion about the patient's identification as at increased statistical risk for adverse outcomes, may have contributed to a missed opportunity to discuss enhanced treatment opportunities.

The outpatient social worker completed one outreach attempt in response to a voicemail message in which the patient was "hinting that [the patient] was not doing well." However, the OIG found the outpatient social worker did not complete additional outreach as planned or document a rationale for discontinuing outreach. VHA provides guidance for staff to outreach to patients who no-show scheduled appointments but does not include specific procedures for other circumstances that warrant clinical judgment such as staff's response to telephone calls from patients unrelated to a scheduled appointment.[11]

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[7] Deputy Under Secretary for Health for Operations and Management (10N) Memorandum, "Assignment of the Mental Health Treatment Coordinator," March 26, 2012. Deputy Under Secretary for Health for Operations and Management (10N) Memorandum, "Assignment of the Mental Health Treatment Coordinator," *Attachments A, B, and C,* March 26, 2012.

[8] Acting Deputy Under Secretary for Health for Operations and Management (10N) Memorandum, "REACH VET: Recovery Engagement and Coordination for Health–Veterans Enhanced Treatment," August 10, 2016. VHA implemented the REACH VET program in 2016 using a statistical model to identify patients at increased risk for suicide behavior and other adverse outcomes. The REACH VET Coordinator is responsible for training appropriate staff of their responsibilities in the program and notifying providers of patients' REACH VET status.

[9] In an interview with the OIG, the acting REACH VET Coordinator reported serving in the acting role from spring 2019 to summer 2019 while the REACH VET Coordinator was on leave. On day 84, the REACH VET Coordinator notified the REACH VET Provider via email that the patient was at increased risk for suicide and requested outreach to the patient within one week.

[10] Acting Deputy Under Secretary for Health for Operations and Management (10N) Memorandum, "REACH VET: Recovery Engagement and Coordination for Health–Veterans Enhanced Treatment," August 10, 2016. VHA's Mental Illness Research, Education and Clinical Center, "REACH VET Providers," accessed June 24, 2020. http://vaww.mirecc.va.gov/reachvet/provider.asp (This is an internal VA website not publicly accessible). REACH VET Providers are responsible for reviewing the patient's clinical information, enhancing treatment as appropriate, outreaching the patient, and documenting patient outreach within one week of notification.

[11] VHA Notice 2019-09(2), *Minimum Scheduling Effort Required for Outpatient Appointments: Updates to VHA Directive 1230 and VHA Directive 1232(1)*, April 24, 2019, amended May 8, 2019.

Given the patient's high risk for suicide status, lack of engagement in mental health treatment, and voicemail message "hinting that [the patient] was not doing well," the OIG would have expected the outpatient social worker to follow through with the documented plan to complete additional outreach to "ascertain safety." In an interview with the OIG, the outpatient social worker explained not outreaching to the patient because of (1) the patient's treatment discontinuation in fall 2019, (2) respect for the patient's autonomy, and (3) no immediate safety concern. Although not done, the outpatient social worker acknowledged that the decision to not pursue contact with the patient should have been documented in an addendum to the day 210 progress note. The outpatient social worker's lack of additional outreach to the patient may have contributed to a failure to engage the patient in care and assess the patient's acute suicide risk and treatment needs.

The OIG found that facility staff did not comply with VHA suicide risk assessment procedures. Inpatient Mental Health Unit staff did not complete a secondary suicide risk screen within 24 hours prior to the patient's discharge, as required.[12] The psychiatry resident physician's supervisor told the OIG that comprehensive evaluation requirements were changing at the time of the patient's care and did not think a comprehensive evaluation was required then. The Medical Director, Inpatient Mental Health Unit told the OIG that prior to a November 2019 requirement to use a specified template, facility providers used a facility suicide risk assessment note to document the comprehensive evaluation and acknowledged that a comprehensive evaluation should have been completed prior to the patient's discharge.[13] Additionally, outpatient staff failed to complete the required comprehensive evaluation following the patient's positive secondary suicide risk screen. In an interview with the OIG, a substance use disorder clinic supervisor could not determine if the failure to complete an evaluation was due to a training issue but that additional training had been provided. Facility staff's failure to complete suicide risk screenings and comprehensive evaluations may have contributed to underestimating the patient's suicide risk and missed opportunities to establish a risk mitigation plan.

The OIG determined that facility staff did not notify facility leaders or suicide prevention staff of the patient's death by suicide. VHA Office of Mental Health and Suicide Prevention leaders informed the OIG that facility-level policy was expected to guide suicide notification processes. The Chief, Health Information Management Services told the OIG that at the time of the patient's death, facility leaders did not have a procedure in place to ensure that staff notified

[12] Deputy Under Secretary for Health for Operations and Management (10N) Memorandum, "Suicide Risk Screening and Assessment Requirements – Attachment B," May 23, 2018. The May 23, 2018 memorandum refers to a comprehensive assessment; however, later memoranda refer to a comprehensive evaluation.

[13] Acting Deputy Under Secretary for Health for Operations and Management (10N) Memorandum, "Eliminating Veteran Suicide: Update on Suicide Risk Screening and Evaluation," February 22, 2019. Deputy Under Secretary for Health for Operations and Management (10N) Memorandum, "Eliminating Veteran Suicide: Implementation Update on Suicide Risk Screening and Evaluation (Risk ID Strategy) and the Safety Planning for Emergency Department (SPED) Initiatives," October 17, 2019.

facility leaders or suicide prevention staff when they became aware of a death by suicide. In October 2020, Patient Administrative Services leaders told the OIG that a recently implemented process consisted of death certificates being directed to Decedent Affairs staff and Decedent Affairs staff then emailing the suicide prevention team of any death of a patient with a high risk for suicide patient record flag. Parallel to VHA's requirement for clinical staff to report all patient deaths by suicide through the suicide behavior and overdose report, the OIG would expect non-clinical staff to be required to notify facility leaders of patient deaths by suicide regardless of the patient's engagement in VHA mental health treatment.[14]

The OIG made five recommendations to the Facility Director related to high risk for suicide patient record flag reviews, MHTC assignment, REACH VET program requirements, suicide risk screening and assessment, and staff notification of patients' death by suicide.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with recommendations 1, 2, 4, and 5 and provided acceptable action plans (see appendixes B and C). Based on information provided, the OIG considers recommendations 2 and 5 closed. For the remaining open recommendations, the OIG will follow up on the planned and recently implemented actions to ensure that they have been effective and sustained. The Veterans Integrated Service Network and Facility Directors non-concurred with recommendation 3 that asked the Facility Director to review the patient's care for program adherence and appropriate outreach and take action as warranted. The OIG is disappointed that the Facility Director did not concur with the recommendation to review staff's failure to seize an opportunity to work collaboratively with a high-risk patient who was difficult to engage in treatment. See appendix B for the OIG's full response to the Directors' nonconcurrence.

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[14] Acting Deputy Under Secretary for Health for Operations and Management (10N) Memorandum, "Suicide Behavior and Overdose Report Computerized Patient Record System (CPRS) Note Template Implementation," April 8, 2019.

Contents

Abbreviations

EHR	electronic health record
MHTC	Mental Health Treatment Coordinator
OIG	Office of Inspector General
PC-MHI	primary care mental health integration
PTSD	posttraumatic stress disorder
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted this healthcare inspection at the Ralph H. Johnson VA Medical Center (facility) to determine the validity of allegations referred by Chairman Mark Takano, House Committee on Veterans' Affairs, regarding deficiencies in the mental health care provided for a high risk for suicide patient who died by suicide.

Background

The facility, part of Veterans Integrated Service Network (VISN) 7, is located in downtown Charleston, South Carolina, and operates six community-based outpatient clinics within South Carolina and Georgia. The facility served 77,779 unique patients from October 1, 2019, through September 30, 2020, and had a total of 136 operating beds, including 28 community living center beds. The facility provides specialty services including primary care, mental health, and subspecialty medical care; and has an academic affiliation with the Medical University of South Carolina.

Allegations and Concerns

On March 23, 2020, the OIG received a request from Chairman Mark Takano, House Committee on Veterans' Affairs, to review a complainant's allegations and subsequently identified related concerns:

1. Alleged inadequate psychiatric monitoring and delays in psychiatric care due to procedures identified in the *Primary Care Service Agreement: Mental Health Integration and Mental Health Services* (service agreement).[1]
2. Alleged delay in placing the patient's high risk for suicide patient record flag.
    - Further, the OIG identified a related concern that facility staff did not adequately evaluate the patient's condition and treatment needs in a review of the patient's high risk for suicide patient record flag.

Additionally, the OIG identified other concerns related to the patient's care, including

3. Inadequate care coordination,
4. Deficiencies in suicide risk assessment and evaluation, and
5. Failure to notify facility leaders of the patient's death by suicide.

[1] Facility Mental Health Service Line, *Primary Care Service Agreement: Mental Health Integration and Mental Health Services*, November 9, 2017.

On April 6, 2020, the OIG requested facility leaders review specific aspects of the patient's mental health care. The OIG determined that the Acting Facility Director's response did not adequately address the concerns, and on June 3, 2020, initiated a hotline inspection.

Scope and Methodology

The OIG conducted a virtual site visit from August 17, 2020, through August 20, 2020.[2]

The OIG interviewed the complainant and facility leaders and staff familiar with the patient's care and relevant processes. The OIG reviewed the 94 responses to a survey distributed to 141 providers and nurses from primary care, primary care mental health integration (PC-MHI), and mental health to evaluate staff experiences and concerns with the service agreement.[3]

The OIG reviewed the patient's electronic health record (EHR); Veterans Health Administration (VHA) directives, handbooks, and memoranda; facility policies and standard operating procedures; organizational charts; and a behavioral health autopsy related to the patient's care.[4] Per the OIG team's request, VHA Office of Mental Health and Suicide Prevention leaders provided information regarding relevant national policies and procedures related to high risk for suicide flags, suicide risk assessment, and continuity of care.

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

The OIG substantiates an allegation when the available evidence indicates that the alleged event or action more likely than not took place. The OIG does not substantiate an allegation when the available evidence indicates that the alleged event or action more likely than not did not take

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

[3] VHA Handbook 1101.10(1), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended May 26, 2017. PC-MHI is a mental health team that is integrated into primary care and coordinates with primary care providers to offer mental health services to patients.

[4] Deputy Under Secretary for Health for Operations and Management (10N) Memorandum, "Behavioral Autopsy Program Implementation," December 11, 2012. A behavioral health autopsy is a "standardized medical record review" utilizing a national template and submitted via an approved suicide prevention SharePoint portal.

place. The OIG is unable to determine whether an alleged event or action took place when there is insufficient evidence.

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

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

Patient Case Summary

The patient was in their 20s at the time of death by suicide in 2019.[5] The patient initiated treatment with a facility primary care physician on a day in 2019 (day 1), and reported a history of anxiety disorder, major depressive disorder, and insomnia and treatment with an antidepressant and a mood stabilizer.[6] The patient also reported cannabis use for chronic musculoskeletal pain. The primary care physician noted a plan for the patient "to establish care with mental health for further evaluation and treatment."

On the same day, a PC-MHI psychologist documented that the patient reported a history of sexual and physical abuse as a child. The patient reported "feeling empty," denied current suicidal and homicidal ideation, and the psychologist documented symptoms of loss of interest, poor focus, fatigue, purposeless, and sleep disturbances. The psychologist provisionally diagnosed recurrent major depressive disorder and anxiety disorder, and placed a consult to the facility's General Mental Health Clinic for medication management.

On day 33, a General Mental Health Clinic psychiatrist documented that the patient reported worsening anxiety since 2016 with daily recurring thoughts of childhood abuse and combat experiences, continued cannabis use, and difficulty maintaining employment due to problems with anger. The patient screened negative on the secondary suicide risk screen and the

[5] The OIG uses the singular form of they (their) in this instance for privacy purposes.

[6] The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together.

psychiatrist diagnosed the patient with anxiety disorder, increased the mood stabilizer medication dosage, and planned for the patient to return in four weeks.[7]

On day 48, the patient contacted the Veterans Crisis Line and reported suicidal ideation, a plan to either overdose on medications or use a knife, thoughts of killing family pets, and having written "a suicide letter."[8] The patient developed a safety plan with the Veterans Crisis Line responder and agreed to a suicide prevention program consult.[9]

The next day, the facility's Suicide Prevention Coordinator telephoned the patient who reported suicidal ideation with a plan to overdose on medications that were available in the home.[10] The Suicide Prevention Coordinator contacted the patient's spouse at work and the spouse agreed to transport the patient to the facility.

The patient arrived at the facility's Emergency Department and screened positive for suicide risk. A social worker met with the patient who reported a 2011 suicide attempt by overdose and having a "stockpile of muscle relaxers and sleep aids." The social worker also documented that "the obsessing and paranoia have been so bad that [the patient] has had thoughts of destroying all of their pictures, killing their animals, killing [the spouse], and [themselves]." The patient acknowledged "daily marijuana use to help with [the patient's] symptoms." The social worker evaluated the patient's acute suicide risk as high.

That day, a psychiatry resident physician admitted the patient to the facility's Inpatient Mental Health Unit. The psychiatry resident physician documented that the patient was "currently at high risk for suicide as [spouse] recently asked for a separation." On day 50, a social worker documented that the patient reported "a history engaging in self-injury by cutting [patient's] self on the arms, legs, and face with a razor blade." A psychiatrist documented that the patient reported not engaging in self-injurious behavior since 2011, as well as a history of two suicide attempts with the second one in 2011. The next day, an Inpatient Mental Health Unit nurse documented that the patient screened positive on the secondary suicide risk screen, notified the treatment team, and noted that the comprehensive evaluation would be completed in a separate note.

[7] Deputy Under Secretary for Health for Operations and Management (10N) Memorandum, "Suicide Risk Screening and Assessment Requirements," May 23, 2018. VHA implemented three phases for suicide risk screening and assessments: the primary suicide risk screen, secondary suicide risk screen, and a comprehensive suicide risk evaluation (comprehensive evaluation).

[8] VHA Directive 1503, *Operations of the Veterans Crisis Line Center*, May 26, 2020. VHA established the Veterans Crisis Line Center in 2007 to offer a toll-free crisis intervention hotline available 24/7 for veterans.

[9] VHA Directive 1503, *Operations of the Veterans Crisis Line Center*, May 26, 2020. Responders are staff who interact with individuals who contact the Veterans Crisis Line through chats, calls, and texts.

[10] Effective December 10, 2019, the facility's suicide prevention case manager positions were reclassified as suicide prevention coordinators. Therefore, in this report the OIG will use the title Suicide Prevention Coordinator.

On day 54, the Suicide Prevention Coordinator placed a high risk for suicide patient record flag in the patient's EHR.[11] On day 56, the social worker, psychiatry resident physician, psychiatry medical student, and the Suicide Prevention Coordinator met with the patient for a discharge and safety planning meeting. The social worker completed a suicide prevention safety plan with the patient. The psychiatry resident physician documented discharge diagnostic impressions including major depressive disorder; recurrent, severe, posttraumatic stress disorder (PTSD); cannabis use disorder; and alcohol use disorder. The patient was discharged with two appointments for the following week.

On day 57, an inpatient psychiatrist telephoned the patient and documented that the patient denied suicidal or homicidal ideation and planned to attend appointments the following week. On day 58, an outpatient psychiatrist returned the patient's telephone call from earlier that day and documented that the patient accidentally took too much medication and denied suicidal ideation.

On day 59, facility staff received a notification from a non-VA hospital that the patient presented with suicidal ideation.[12] Two days later, the patient was admitted to another non-VA hospital for a suicide attempt, and was discharged on day 69.

As scheduled by the Suicide Prevention Coordinator, a substance use disorder clinic psychiatry resident physician assessed the patient on day 70. The psychiatry resident physician documented that the patient did not want to take other mood stabilizers. The patient screened positive on the secondary suicide risk screen and the psychiatry resident physician noted that a comprehensive suicide risk evaluation (comprehensive evaluation) would be documented in a separate note.

On day 71, a substance use disorder clinic social worker was assigned as the patient's Mental Health Treatment Coordinator (MHTC).[13] On day 77, the MHTC documented that the patient denied suicidal ideation and did not report intent to act on suicidal ideation during the prior six months.

On day 78, the patient requested a same day mental health appointment to get work clearance. The following day, a psychologist documented that the patient denied current suicidal and

[11] VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008. Deputy Under Secretary for Health for Operations and Management (10N) Memorandum, "Update to High Risk for Suicide Patient Record Flag Changes," January 16, 2020. VHA uses a high risk for suicide patient record flag to identify a patient as high risk for suicide in their EHR and requires intensive follow-up by providers while the patient remains flagged.

[12] The OIG did not find documentation that explained the treatment provided by the first non-VA hospital.

[13] Deputy Under Secretary for Health for Operations and Management (10N) Memorandum, "Assignment of the Mental Health Treatment Coordinator," March 26, 2012. An MHTC is a mental health provider who is assigned as a point of contact for every patient receiving VHA mental health services. The role of the MHTC is to assist with coordination of care and ensure continuity of care.

homicidal ideation. The psychologist recommended group and individual dialectical behavior therapy, the patient agreed, and the psychologist placed a consult.

On day 83, the patient attended a therapy session with the MHTC. The next day, the Recovery Engagement and Coordination for Health–Veterans Enhanced Treatment (REACH VET) Coordinator documented the patient may benefit from enhanced treatment and assigned the MHTC as the REACH VET Provider.[14] On day 86, the MHTC documented, in a REACH VET Provider Note, that changes in the patient's care were not indicated and that on day 83, the patient was informed of being "identified as being at high statistical risk for suicide and other adverse outcomes."

On day 91, another social worker (outpatient social worker) completed a diagnostic assessment with the patient and noted that the patient's symptoms were consistent with borderline personality disorder. The patient reported recent suicidal thoughts with a plan to walk into the ocean with ankle weights, and wrist cutting. The patient attended five individual psychotherapy appointments with the outpatient social worker from day 105 to day 148.

During the patient's last appointment with the MHTC on day 141, the patient reported continued use of cannabis and being "very depressed." The patient expressed interest in continuing therapy with the outpatient social worker, and "an unwillingness" to attend recommended group therapy in the substance use disorder clinic. The same day, the patient reported having suicidal intent on day 135. The patient reported consuming alcohol and taking five sleep medication pills but discontinuing the behavior after calling a family member who dissuaded the patient. The Suicide Prevention Coordinator continued the patient's high risk for suicide patient record flag and the outpatient social worker completed a Suicide Behavior and Overdose Report.[15] On day 142, the outpatient social worker documented that during a telephone call, the patient denied suicidal ideation and they discussed safety planning.

[14] Acting Deputy Under Secretary for Health for Operations and Management (10N) Memorandum, "REACH VET: Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment," August 10, 2016. VHA implemented the REACH VET program in 2016 using a statistical model to identify patients at increased risk for suicide behavior and other adverse outcomes. The REACH VET Coordinator is responsible for training appropriate staff of their responsibilities in the program and notifying providers of patients' REACH VET status. VHA's Mental Illness Research, Education and Clinical Center, "REACH VET Providers," accessed June 24, 2020. http://vaww.mirecc.va.gov/reachvet/provider.asp. (This is an internal VA website not publicly accessible). REACH VET providers are responsible for reviewing the patient's clinical information, enhancing treatment as appropriate, outreaching to the patient, and documenting patient outreach within one week of notification.

[15] VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008. Acting Deputy Under Secretary for Health for Operations and Management, Suicide Behavior and Overdose Report Computerized Patient Record System (CPRS) Note Template Implementation, April 8, 2019. A Suicide Behavior and Overdose Report is entered into the EHR when a provider is informed of a patient's suicidal behaviors (an attempt, suicide death, preparation for suicide) and/or overdoses.

On day 145, the patient told a psychiatric resident physician about continued difficulty coping with upcoming divorce, cannabis use, depressed mood, and taking sleep medication in the morning and at night. The patient denied suicidal thoughts. The psychiatry resident physician instructed the patient to take the sleep medication only as needed at night and noted a plan to start the patient on an antidepressant medication. On day 148, the outpatient social worker documented that the patient agreed to attend evidence-based psychotherapy approximately weekly for 12 to 15 weeks.[16]

On day 162, the patient canceled appointments with the MHTC and the outpatient social worker and reported intent to reschedule. On day 167, and again three days later, the outpatient social worker attempted to contact the patient to reschedule the canceled appointment.[17] The patient canceled a day 175 scheduled appointment in the substance use disorder clinic. On day 181, the outpatient social worker contacted the patient by telephone in response to a voicemail message from the patient indicating a wish to discontinue therapy. The outpatient social worker documented that the patient "was not specific but implied that [the patient] was not in danger currently" and reported having "gone to a dark place." The patient agreed to contact the outpatient social worker the next day as the patient was not able to continue the call. The following day, the outpatient social worker called the patient who mentioned being in "some trouble" the previous weekend and being "drugged the one time I went out." The patient reported being unable to attend future appointments due to the patient's work schedule and inability to drive.

On day 210, the outpatient social worker documented calling the patient in response to a voicemail message "hinting that [the patient] was not doing well." The patient's voicemail was not functional so the outpatient social worker was unable to leave a voicemail and documented a plan to call again.

On day 229, the outpatient social worker recommended continuation of the patient's high risk for suicide patient record flag, documented that the patient remained "at significantly increased risk for suicidal behaviors," and a need for additional clinical assessment, and alerted the patient's MHTC. On the same day, the Suicide Prevention Coordinator continued the patient's high risk for suicide patient record flag in the EHR, and noted that a "new Safety Plan should be considered."

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[16] "Evidence-based Practice Program," VA, accessed October 29, 2020, https://www.va.gov/HEALTHCAREEXCELLENCE/about/organization/examples/evidence-based-practice-program.asp. Evidence-based practice refers generally to evidence-based treatment used within the VA health care system including evidence-based psychotherapy as a best practice for treating PTSD, substance use disorder, and other issues.

[17] VHA Handbook 1101.10(1), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended May 26, 2017. Secure messaging is a web-based VA means of electronic communication that allows veterans to send and receive messages to and from VA staff.

On day 268, a facility medical records clerk responded to a release of information request from an Army Reserve investigating officer for the patient's medical records to uncover "any/all contributing factors towards the [patient's] decision to commit suicide." The Army Reserve investigating officer also provided a copy of the patient's death certificate. In the day 321 Suicide Behavior and Overdose Report, the Suicide Prevention Coordinator wrote that the patient's spouse reported the patient "died by suicide" on day 214, and that the Charleston County Coroner confirmed the information.

Inspection Results

1. Alleged Inadequate Monitoring and Delays in Psychiatric Care Due to Service Agreement Procedures

The OIG did not substantiate that the service agreement procedures resulted in inadequate psychiatric monitoring of the patient or delays in psychiatric care for other primary care patients.

Service Agreement Three-Step Mental Health Care Model

The service agreement establishes a three-step mental health care model beginning with primary care treatment. In the first step, primary care providers are responsible to complete an initial assessment to identify symptoms and begin an "initial trial" of medication to treat depression, anxiety, anger, sleep impairment, or PTSD symptoms. Primary care providers may submit an electronic consult to request medication recommendations from the PC-MHI psychiatrist. Primary care providers are also responsible to refer patients for mental health services for

- Treatment of psychotic, manic symptoms, or attention deficit hyperactivity disorder symptoms,
- Management of a patient's risk of harm to self or others, and
- Medication management after an unsuccessful initial medication trial.[18]

PC-MHI treatment is the second step of the mental health care model. PC-MHI staff are co-located and provide enhanced mental health care access to primary care that can include same day assessment to offer diagnostic and treatment recommendations to primary care providers and medication recommendations via electronic consult.[19] PC-MHI staff may also provide

[18] Primary Care Service Agreement.

[19] VHA Handbook 1101.10(1), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended May 26, 2017. Primary Care Service Agreement.

- Care management to track a patient's symptoms and treatment needs,
- Brief psychotherapy,
- Medication management "following an initial trial started in primary care," or
- Referral to the appropriate care service within the General Mental Health Clinic.[20]

The General Mental Health Clinic is the third, and final, step in the mental health care model and provides "treatment and stabilization" for severe mental illness "without any duration limit."[21] The service agreement specifies the diagnoses of patients appropriate for General Mental Health Clinic referral that includes schizophrenia, schizoaffective disorder, bipolar disorder, dementia with psychosis or severe behavioral disturbance, suicidal or homicidal intent, and severe substance use disorder.[22]

The Patient's Psychiatric Care

The OIG found that the primary care physician referred the patient to PC-MHI for assessment and provision of the patient's initial medication management and subsequent engagement with a psychiatrist. The patient received continuous psychiatric medication management.

On day 1, the patient initiated treatment with a facility primary care physician and reported a history of anxiety, major depressive disorder, and insomnia. The physician documented the patient's treatment with medication for anxiety and depression, a mood stabilizer "for sleep," and a plan for the patient to "establish care with mental health for further evaluation and treatment." The same day, a PC-MHI psychologist completed an assessment and referred the patient to the General Mental Health Clinic for medication management.

On day 5, the patient reported being out of medication and the primary care physician refilled the patient's medications. On day 33, a General Mental Health Clinic psychiatrist increased the patient's mood stabilizer dosage, added a medication to treat sleep and anxiety symptoms, and placed a return to clinic order for four weeks.[23] The OIG concluded that facility staff provided adequate psychiatric monitoring and the patient did not experience delays in psychiatric care due to service agreement procedures.

[20] Primary Care Service Agreement.

[21] Primary Care Service Agreement.

[22] Primary Care Service Agreement.

[23] Facility staff scheduled the patient for a follow-up appointment on day 62. However, the patient was admitted to a non-VA hospital and the appointment was canceled.

Delays in Psychiatric Care Due to Service Agreement Procedures

Facility primary care, PC-MHI, and mental health leaders and staff interviewed by the OIG did not report that the service agreement contributed to delays in referrals for psychiatric treatment.[24] Further, facility leaders and staff that the OIG interviewed did not identify adverse events related to delays in patients receiving psychiatric care due to the service agreement.[25]

The OIG surveyed 141 primary care, PC-MHI, and mental health providers and nurses to further explore potential delays in psychiatric treatment due to the service agreement. As of November 12, 2020, 94 providers and nurses (67 percent) responded to the survey. Of the 94 respondents, 81 respondents (86 percent) denied concerns that service agreement procedures contributed to delays in patient referrals for psychiatric treatment. Four respondents reported knowledge of adverse patient outcomes as a result of delays in patient referrals for psychiatric treatment, but the OIG was unable to confirm the validity of these reports.[26]

2. Alleged Delay in Placing the Patient's High Risk for Suicide Patient Record Flag

The OIG did not substantiate that facility staff delayed placement of the high risk for suicide patient record flag. The Suicide Prevention Coordinator placed a high risk for suicide patient record flag in the patient's EHR on day 54, two days prior to discharge from the Inpatient Mental Health Unit.

In 2008, VHA established the high risk for suicide patient record flag to alert staff of immediate clinical safety concerns.[27] The facility suicide prevention coordinator, in collaboration with the patient's treating providers, is responsible for activating the high risk for suicide patient record

[24] The OIG interviewed the Chief and Assistant Chief of Primary Care, two Patient Aligned Care Team providers, two PC-MHI care managers, three PC-MHI psychologists, the Associate Chief of Staff of Mental Health, and an outpatient psychiatrist.

[25] VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018. VHA defines an adverse event as harmful or potentially harmful incident associated with care delivered by VA providers.

[26] One respondent declined to provide relevant patient information and the OIG informed the respondent about government investigative agencies including contact information. A second respondent did not reply to the OIG's outreach. The third respondent reported that in 2017, a patient died by suicide after referral to PC-MHI and that legal action was underway. The OIG determined that the patient's mental health care was not delayed, and the patient received services prior to death. However, the OIG was unable to confirm that the patient died by suicide. The fourth respondent denied knowledge of delays in care due to service agreement procedures in an interview with the OIG.

[27] VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008. VHA Directive 2010-053, *Patient Record Flags*, December 3, 2010, corrected copy February 3, 2011.

flag in the patient's EHR within 24 hours of determining that it is indicated.[28] VHA guidance states that high risk for suicide patient record flags "shall be placed" for patients admitted to an inpatient mental health unit following a suicide attempt or experiencing "strong suicidal ideations," to ensure adequate post-discharge follow up.[29]

On day 49, the patient presented to the facility's Emergency Department and a psychiatry resident physician admitted the patient to the Inpatient Mental Health Unit for suicidal and homicidal ideation. On day 54, the Suicide Prevention Coordinator, in collaboration with the patient's treating providers, determined the patient was high risk for suicide and placed a high risk for suicide patient record flag in the patient's EHR.[30] On day 56, a psychiatry resident physician discharged the patient home with a scheduled mental health treatment appointment the following week.

The OIG determined that the high risk for suicide patient record flag was placed in the patient's EHR two days prior to discharge from the Inpatient Mental Health Unit.

Related Concern: Inadequate High Risk for Suicide Patient Record Flag Review

The OIG found that facility staff did not adequately evaluate the patient's condition and treatment needs as part of renewal review of the patient's high risk for suicide patient record flag. The Suicide Prevention Coordinator documented continuation of the patient's high risk for suicide patient record flag; however, facility leaders told the OIG that the patient's high risk for suicide record flag was continued unknowingly by staff on a date after the patient's death by suicide.[31]

VHA policy states that the facility suicide prevention coordinator is responsible for (1) working with mental health providers to ensure ongoing monitoring and follow-up of patients, (2) collaborating with the patient's MHTC to ensure that mental health and medical needs are met, and (3) re-evaluating the high risk for suicide patient record flag at a minimum of every

[28] VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide,* July 18, 2008. The Suicide Prevention Coordinator is responsible for suicide prevention strategies and maintenance of high risk for suicide patient record flags at each VA medical center. Deputy Under Secretary for Health for Operations and Management (10N), *High Risk for Suicide Patient Record Flag Changes*, October 3, 2017.

[29] VHA Office of Mental Health and Suicide Prevention, *Suicide Prevention Coordinator Guide*, June 19, 2015.

[30] Effective December 10, 2019, the facility's suicide prevention case manager positions were reclassified as suicide prevention coordinators.

[31] VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide,* July 18, 2008. VHA uses the High Risk for Suicide Patient Record Flag to alert staff of patients who are clinically determined to be at high risk for suicide.

90 days.[32] The facility director is responsible for ensuring that the suicide prevention coordinator reviews high risk for suicide patient record flags every 90 days and deactivates patient record flags when a patient no longer presents an elevated risk.[33] A suicide prevention coordinator and the patient's MHTC should collaborate in the monitoring of high-risk patients "to ensure that both their suicidality and their mental health or medical conditions are addressed."[34] In March 2020, in response to an OIG report, VHA provided additional guidance related to the high risk for suicide patient record flag review process that requires suicide prevention coordinators (1) conduct a review of patients' clinical engagement, and (2) ensure monthly outreach for the remainder of the high risk for suicide patient record flag for patients not engaged in mental health treatment.[35]

The Suicide Prevention Coordinator initiated the patient's high risk for suicide patient record flag on day 54, a staff psychiatrist reviewed the high risk for suicide patient record flag within 90-days of initial placement, and the Suicide Prevention Coordinator continued the high risk for suicide patient record flag in the patient's EHR on day 141.[36] The patient continued in-person engagement in mental health treatment until day 148. From day 159, through day 210, the outpatient social worker sent the patient two secure messages, made four unsuccessful telephone attempts, and spoke to the patient by telephone three times. On day 229, two days before the 90-day review of the patient's high risk for suicide patient record flag was due, the outpatient social worker recommended continuing the patient's high risk for suicide patient record flag and the Suicide Prevention Coordinator continued the flag in the patient's EHR (see table 1.)

[32] VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008. VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015.

[33] VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008.

[34] VHA Office of Mental Health and Suicide Prevention, *Suicide Prevention Coordinator Guide*, June 19, 2015.

[35] VHA Notice 2020-13(1), *Inactivation Process for Category I High Risk for Suicide Patient Record Flags*, March 27, 2020, amended September 8, 2020. VA OIG, *Alleged Deficiencies in Mental Health Care Prior to a Death by Suicide at the VA San Diego Healthcare System, California*, No. 19-00501-175, August 7, 2019.

[36] VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008.

Table 1. Timeline of High Risk for Suicide Patient Record Flag Placement and Review

Date	Facility Staff's Action
Day 54	The Suicide Prevention Coordinator placed a high risk for suicide patient record flag in the patient's EHR.
Day 140	An outpatient psychiatrist documented support for continuing the patient's high risk for suicide patient record flag.
Day 141	The Suicide Prevention Coordinator continued the high risk for suicide patient record flag in the patient's EHR three days before the 90-day review was required.[37]
Day 210	The outpatient social worker made an unsuccessful telephone outreach attempt in response to the patient's voicemail message.
Day 229	The Suicide Prevention Coordinator asked by email if the patient's outpatient social worker "would you mind entering the [Mental Health] High Risk Suicide Flag Review note." The outpatient social worker responded by email that the patient was not engaged in treatment due to "no-shows/failure to respond to outreach" and recommended continuation of the patient's high risk for suicide patient record flag. The outpatient social worker documented a recommendation, in the patient's EHR, to continue the patient's high risk for suicide patient record flag due to the patient's "increased risk for suicidal behaviors" and need for "additional clinical assessment." The Suicide Prevention Coordinator continued the patient's high risk for suicide patient record flag two days before the 90-day review was required.

Source: VA OIG analysis of the patient's EHR and facility staff's emails.

The OIG found that facility staff reviewed the patient's high risk for suicide patient record flag every 90 days, as required.[38] However, facility staff did not adequately evaluate the patient's condition and treatment needs as part of the high risk for suicide patient record flag review on day 229. The Suicide Prevention Coordinator told the OIG that the decision to continue the high risk for suicide patient record flag was based on the outpatient social worker's documented recommendation and that it was expected that the outpatient social worker would have outreached to the patient. In an interview with the OIG, the outpatient social worker reported an expectation that the Suicide Prevention Coordinator would explicitly request outreach if warranted.

[37] VHA Directive 2008-036. *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008.

[38] VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008.

The Suicide Prevention Supervisor told the OIG that after assuming the role in spring 2020, additional monitoring procedures were implemented that included a suicide prevention coordinator ensuring outreach to patients not engaged with mental health care in the prior 30 days; and monitoring of canceled mental health appointments for patients on the high risk for suicide list to ensure outreach when patients do not reschedule canceled appointments.

Although the OIG found that facility staff completed outreach according to VHA policy at the time, the OIG would have expected staff to pursue contact with the patient between day 210 and day 229 given the patient's concerning voicemail in addition to high risk for suicide status, substance use, and barriers to in person treatment, as discussed below.[39]

3. Other Concern: Inadequate Care Coordination

The OIG found inadequate care coordination related to MHTC assignment, REACH VET procedures, and outreach to the patient.

Failure to Assign a MHTC

The OIG found that facility staff did not assign the patient an MHTC prior to discharge from the Inpatient Mental Health Unit. At the time of the patient's care, the absence of a facility policy may have contributed to staff's lack of timely assignment of an MHTC for the patient. However, in July 2020, facility leaders established an MHTC standard operating procedure to outline procedures that meets the VHA requirement.[40]

In 2012, VHA required that staff assign all patients an MHTC prior to discharge from an inpatient mental health unit.[41] The MHTC was required to maintain "regular contact" with the patient as clinically necessary, ensure communication with both the patient and the patient's designated family members or friends about the patient's treatment and any issues related to their care, and collaborate with the suicide prevention coordinator to ensure that high risk patients "are provided with increased monitoring and enhanced care."[42] VHA also required that each medical

[39] VHA Notice 2020-13(1), *Inactivation Process for Category I High Risk for Suicide Patient Record Flags*, March 27, 2020, amended September 8, 2020. VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008.

[40] Deputy Under Secretary for Health for Operations and Management (10N) Memorandum, "Assignment of the Mental Health Treatment Coordinator," March 26, 2012. Deputy Under Secretary for Health for Operations and Management (10N) Memorandum, "Assignment of the Mental Health Treatment Coordinator, Attachments A, B, and C," March 26, 2012. Facility Mental Health Service Standard Operating Procedure 116-20-05, *Mental Health Treatment Coordinator Assignment for Vulnerable Populations,* July 2020.

[41] Deputy Under Secretary for Health for Operations and Management (10N) Memorandum, "Assignment of the Mental Health Treatment Coordinator, Attachments A, B, and C," March 26, 2012.

[42] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015.

center establish a policy that guides identification of the MHTC to "ensure that the MHTC is identified early in the course of mental health care," and with consideration of multiple factors for MHTC assignments including where and how the patient entered into care.[43]

The substance use disorder clinic social worker was assigned as the patient's MHTC on day 71, 15 days after the patient's Inpatient Mental Health Unit discharge. The Assistant Chief, Mental Health told the OIG that patients should be assigned an MHTC upon discharge from the Inpatient Mental Health Unit. However, an inpatient psychiatrist told the OIG that, at the time of the patient's admission, there was not a facility requirement for Inpatient Mental Health Unit staff to assign the patient an MHTC. Contrary to VHA policy, the Medical Director, Inpatient Mental Health Unit told the OIG that, at the time of the patient's admission, inpatient staff did not have to assign patients an MHTC and in spring 2019, leaders identified a deficit in MHTC assignment and established an MHTC standard operating procedure in July 2020. The July 2020 MHTC standard operating procedure requires EHR documentation to assign an MHTC prior to a patient's Inpatient Mental Health Unit discharge or upon placement of a high risk for suicide patient record flag.[44]

At the time of the patient's care, the absence of a facility policy may have contributed to staff's lack of knowledge regarding the requirements and processes related to the identification and timely assignment of an MHTC for the patient. Facility staff's failure to assign an MHTC may have resulted in the patient not receiving support during the discharge process, which can be critical to a patient's successful transition to outpatient mental health treatment. The lack of an MHTC may have diminished the likelihood of the patient's engagement in care and post-discharge outreach for help.

Deficiencies in REACH VET Coordination

The OIG found that both the acting REACH VET Coordinator and Provider completed required documentation.[45] However, the REACH VET Provider documented discussing the patient's REACH VET status during an appointment that took place prior to the notification of the patient's REACH VET identification.

The REACH VET program identifies veterans currently using VA healthcare services who are statistically at elevated risk for adverse outcomes including suicide and overdoses. For each

[43] Deputy Under Secretary for Health for Operations and Management (10N) Memorandum, "Assignment of the Mental Health Treatment Coordinator," March 26, 2012. VHA Handbook 1160.01. In 2012, VHA replaced the term Principal Mental Health Provider with Mental Health Treatment Coordinator.

[44] Facility Mental Health Service Standard Operating Procedure 116-20-05, *Mental Health Treatment Coordinator Assignment for Vulnerable Populations,* July 2020.

[45] In an interview with the OIG, the acting REACH VET Coordinator reported serving in the acting role from spring to summer 2019 while the REACH VET Coordinator was on leave.

identified REACH VET patient, the REACH VET Coordinator assigns a REACH VET Provider to complete a comprehensive review of the patient's treatment plan to determine if enhanced treatment is needed.[46] Upon notification of a patient's REACH VET status, the REACH VET Provider must contact the patient to conduct a collaborative review of the patient's mental health care and other health care conditions.[47]

In an interview with the OIG, the REACH VET Provider speculated that the acting REACH VET Coordinator may have sent an email notification on or before day 83. However, the REACH VET Provider reported not saving the email. The acting REACH VET Coordinator told the OIG that REACH VET patients are identified on the second Wednesday of each month—which in this instance was day 84—and notification to the REACH VET Provider was not possible earlier than day 84 (see table 2).[48]

[46] Acting Deputy Under Secretary for Health for Operations and Management (10N) Memorandum, "REACH VET: Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment," August 10, 2016. VHA implemented the REACH VET program in 2016 using a statistical model to identify patients at increased risk for suicide behavior and other adverse outcomes. The REACH VET Coordinator is responsible for training appropriate staff of their responsibilities in the program and notifying providers of patients' REACH VET status. VHA's Mental Illness Research, Education and Clinical Center, "REACH VET Providers," August 11, 2017, accessed June 24, 2020. http://vaww.mirecc.va.gov/reachvet/provider.asp. (This is an internal VA website not publicly accessible). While not in the 2016 10N memorandum, the "REACH VET Provider Steps" identifies that the REACH VET providers are responsible for reviewing a patient's clinical information, enhancing treatment as appropriate, outreaching the patient, and documenting patient outreach within one week of notification.

[47] Acting Deputy Under Secretary for Health for Operations and Management (10N) Memorandum, "Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment," November 18, 2016.

[48] On day 84, the REACH VET Coordinator notified the REACH VET Provider via email that the patient was at increased risk for suicide and requested outreach to the patient within one week.

Table 2. Timeline of the Patient's REACH VET Identification and Actions

Date	REACH VET Action
Day 83	The MHTC documented an individual therapy appointment with the patient that did not include reference to the patient's REACH VET status.
Day 84	The acting REACH VET Coordinator documented the patient's identification through the REACH VET program and identified the MHTC as the REACH VET Provider in the patient's EHR and emailed instructions to complete an EHR review and outreach to the patient.
Day 86	The MHTC completed required REACH VET Provider documentation in the patient's EHR and noted that the patient's REACH VET status was discussed with the patient during the individual therapy appointment on day 83.

Source: VA OIG analysis of the patient's EHR and staff email correspondence.

The OIG concluded that the REACH VET Provider did not discuss the patient's REACH VET status with the patient, as required.[49] Failure to engage in a collaborative discussion about the patient's identification as at increased statistical risk for adverse outcomes, may have contributed to a missed opportunity to discuss enhanced treatment opportunities.

Inadequate Patient Outreach

The OIG found that the outpatient social worker completed one outreach attempt in response to a voicemail message in which the patient was "hinting that [the patient] was not doing well." However, the outpatient social worker did not complete additional outreach as planned or document a rationale for discontinuing outreach.

VHA provides guidance for staff to outreach to patients who no-show for scheduled appointments; however, does not include specific procedures for other circumstances that warrant clinical judgment such as staff's response to telephone calls from patients unrelated to a scheduled appointment.[50]

The OIG found that on day 210, the outpatient social worker completed one outreach attempt in response to the patient's voicemail and documented a plan to call again to determine the patient's safety (see table 3). In an interview with the OIG, the outpatient social worker explained not outreaching to the patient because of (1) the patient's treatment discontinuation in fall 2019, (2) respect for the patient's autonomy, and (3) no immediate safety concern. Although not done,

[49] Acting Deputy Under Secretary for Health for Operations and Management (10N) Memorandum, "REACH VET: Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment," August 10, 2016.

[50] VHA Notice 2019-09(2), *Minimum Scheduling Effort Required for Outpatient Appointments: Updates to VHA Directive 1230 and VHA Directive 1232(1)*, April 24, 2019, amended May 8, 2019.

the outpatient social worker acknowledged that the decision to not pursue contact with the patient should have been documented in an addendum to the day 210 progress note.

Table 3. Timeline of Patient Outreach

Date	Patient Outreach
Day 148	The patient attended an individual therapy appointment with the outpatient social worker.
Day 159	The outpatient social worker outreached the patient to confirm an individual therapy appointment on day 162.
Day 162	The patient contacted Patient Administrative Services staff to cancel the appointment with the MHTC. The patient called and canceled the individual therapy appointment with the outpatient social worker and expressed a plan to call again to reschedule.
Day 167	The outpatient social worker made two outreach attempts, a secure message and a telephone call, to the patient to reschedule an appointment.
Day 170	The outpatient social worker made two additional outreach attempts, a secure message and a telephone call, to reschedule an appointment.
Day 175	The outpatient social worker made an unsuccessful telephone contact attempt in response to the patient's voicemail that the patient "did not think [the patient] would continue in treatment."
Day 181	After a phone call with the patient, the outpatient social worker documented that the patient "now believes that [the patient] should be in therapy but getting to therapy now without the ability to drive would be very hard."
Day 182	In a telephone call with the patient, the outpatient social worker and patient "discussed options for trying to get [the patient] back into regular therapy." The patient described barriers including being "no longer allowed to drive."
Day 210	The outpatient social worker, upon returning from planned leave, received a voicemail message from the patient "hinting that [the patient] was not doing well."[51] The outpatient social worker made an unsuccessful telephone outreach attempt and documented a plan to "call again in an attempt to reach the veteran and ascertain safety."

Source: VA OIG analysis of the patient's EHR.

Given the patient's high risk for suicide status, lack of engagement in mental health treatment, and voicemail message "hinting that [the patient] was not doing well," the OIG would have expected the outpatient social worker to follow through with the documented plan to complete additional outreach to "ascertain safety." The outpatient social worker's lack of additional outreach to the patient may have contributed to a failure to engage the patient in care and assess the patient's acute suicide risk and treatment needs.

[51] The outpatient social worker told the OIG that the patient left a voicemail message approximately five days prior to receiving the message and outreaching the patient.

In a May 13, 2020, response to the OIG's initial request, the Acting Facility Director reported that on May 8, 2020, the Mental Health Service implemented a policy that required staff to follow up with four contact attempts for "patients on the high risk for suicide list that leave messages in any format."[52] However, Mental Health leaders informed the OIG that this procedure was not established because they determined that the "number of outreach attempts should be left to the clinical determination of the provider."

Facility leaders and staff told the OIG that, subsequent to the patient's death, procedures have been implemented to allow providers to opt out of having voicemail. The Assistant Chief, Mental Health told the OIG that most providers declined to have voicemail capability. Mental Health leaders told the OIG that as of April 2020, staff who chose to have voicemail capability "are required to forward their voicemails when out on planned leave to the covering provider. All section chiefs also have their voicemail PINs [personal identification numbers] so they can have the covering provider check the voicemail when the provider is out on sick leave."

4. Other Concern: Deficiencies in Suicide Risk Assessment and Evaluation

The OIG found that facility staff did not comply with VHA suicide risk assessment procedures. Inpatient Mental Health Unit staff did not complete a secondary suicide risk screen within 24 hours prior to the patient's discharge, as required.[53] Further, the OIG found that outpatient staff failed to complete the required comprehensive evaluation following the patient's positive secondary suicide risk screen.

In May 2018, VHA introduced a standardized three-stage suicide risk screening and assessment process that includes a primary suicide risk screen, secondary suicide risk screen, and a comprehensive evaluation.[54] The primary suicide risk screen is positive when the patient acknowledges thoughts of being better off dead or of hurting themself over the past two weeks. A positive primary suicide risk screen requires staff to complete the secondary suicide risk screen that includes more specific questions about the patient's past preparatory or suicidal

[52] The facility's Associate Director was the acting Medical Center Director from September 23, 2019, until June 7, 2020. VHA Directive 1232(2), *Consult Processes and Procedures*, August 24, 2016.

[53] Deputy Under Secretary for Health for Operations and Management (10N) Memorandum, "Suicide Risk Screening and Assessment Requirements–Attachment B," May 23, 2018. The May 23, 2018, memorandum refers to a comprehensive assessment; however, later memoranda refer to a comprehensive evaluation.

[54] Deputy Under Secretary for Health for Operations and Management (10N) Memorandum, "Suicide Risk Screening and Assessment Requirements," May 23, 2018. Deputy Under Secretary for Health for Operations and Management (10N) Memorandum, "Suicide Risk Screening and Assessment Requirements–Attachment B," May 23, 2018. The May 23, 2018, memorandum refers to a comprehensive assessment; however, later memoranda refer to a comprehensive evaluation.

behavior, current intent, and thoughts of a method and plan.[55] A positive secondary suicide risk screen prompts the comprehensive evaluation that asks more detailed information about the patient's suicidal ideation, warning signs, risk factors, protective factors, clinical impression of acute and chronic risk, and requires the provider to establish a risk reduction plan.[56] VHA requires inpatient mental health unit staff to complete the secondary suicide risk screen and the comprehensive evaluation, as indicated, "within 24 hours of admission and within 24 hours before discharge."[57]

On day 51, an Inpatient Mental Health Unit nurse documented that the patient screened positive on the secondary suicide risk screen, notified the treatment team, and noted that the comprehensive evaluation would be completed in a separate note. However, staff did not document a comprehensive evaluation. Additionally, Inpatient Mental Health Unit staff did not repeat the secondary suicide risk screen or update the comprehensive evaluation before the patient's discharge on day 56. The inpatient psychiatrist told the OIG that comprehensive evaluation requirements were changing at the time of the patient's care and did not think a comprehensive evaluation was required then. The Medical Director, Inpatient Mental Health Unit told the OIG that at the time of the patient's care, facility providers used a facility suicide risk assessment note to document the comprehensive evaluation.[58] The Medical Director, Inpatient Mental Health Unit also acknowledged that a comprehensive evaluation should have been completed prior to the patient's discharge.

On day 70, the patient screened positive on the secondary suicide risk screen at a scheduled outpatient appointment. A substance use disorder clinic psychiatry resident physician documented that the positive screen "requires same-day completion of a Suicide Risk Evaluation–Comprehensive" and "see separate Suicide Risk Evaluation–Comprehensive Note." The OIG found that staff did not complete a comprehensive evaluation in response to the day 70, positive secondary suicide risk screen. In an interview with the OIG, a substance use disorder

[55] Deputy Under Secretary for Health for Operations and Management (10N) Memorandum, "Suicide Risk Screening and Assessment Requirements," May 23, 2018; Deputy Under Secretary for Health for Operations and Management (10N) Memorandum, "Suicide Risk Screening and Assessment Requirements–Attachment A," May 23, 2018.

[56] Deputy Under Secretary for Health for Operations and Management (DUSHOM) (10N) Memorandum, "Eliminating Veteran Suicide: Implementation of Suicide Risk Screening and Evaluation," November 2, 2018. Deputy Under Secretary for Health for Operations and Management (10N) Memorandum, "High Risk for Suicide Patient Record Flag Changes," October 3, 2017.

[57] VHA Office of Mental Health and Suicide Prevention, Department of Veterans Affairs (VA) Suicide Risk Identification Strategy – Minimum Requirements by Setting, March 19, 2019.

[58] Deputy Under Secretary for Health for Operations and Management (10N) Memorandum, "Eliminating Veteran Suicide: Implementation Update on Suicide Risk Screening and Evaluation (Risk ID Strategy) and the Safety Planning for Emergency Department (SPED) Initiatives," October 17, 2019. As of November 16, 2019, VHA required use of the comprehensive evaluation national template.

clinic supervisor could not determine if it was a training issue and stated that subsequently, additional training has been provided.

The OIG found that Inpatient Mental Health Unit staff did not complete the required comprehensive evaluation in response to positive secondary suicide risk screen upon the patient's admission or a secondary suicide risk screen within 24 hours prior to the patient's discharge.[59] Additionally, the OIG found that outpatient staff failed to complete the required comprehensive evaluation in response to a positive secondary suicide risk screen on day 70. Facility staff's failure to complete suicide risk screenings and comprehensive evaluations may have contributed to underestimating the patient's suicide risk and missed opportunities to establish a risk mitigation plan.

5. Other Concern: Failure To Notify Facility Leaders of the Patient's Death by Suicide

The OIG determined that facility staff did not notify facility leaders or suicide prevention staff of the patient's death by suicide.

Facility policy in effect prior to December 2, 2019, required staff to report patient deaths by suicide to the Director's Office, Quality Management, and a Mental Health Service Line leader "within 24 hours of receiving the knowledge of a suicide."[60] The December 2, 2019, policy did not include the notification requirement and did not provide guidance for staff who learn of a patient's death by suicide.[61]

On day 229, Patient Administrative Services staff received a social security death notification that generated an EHR notification that the patient was deceased but did not identify that the patient died by suicide.[62] On day 267, an Army Reserve investigating officer submitted a release of information request to uncover "any/all contributing factors towards the [patient's] decision to commit suicide" and included a copy of the patient's death certificate, which noted the patient's day 214, manner of death as suicide. The Acting Facility Director told the OIG that the Medical Records staff who received the release of information request did not alert mental health staff.

According to an issue brief regarding this patient's death, a suicide prevention coordinator was notified on day 296, of the patient's suicide. In an interview with the OIG, the Suicide

[59] Deputy Under Secretary for Health for Operations and Management (10N) Memorandum, "Suicide Risk Screening and Assessment Requirements," May 23, 2018. Deputy Under Secretary for Health for Operations and Management (10N) Memorandum, "High Risk for Suicide Patient Record Flag Changes," October 3, 2017.

[60] Facility Policy 116-16-05, *Suicide Attempts: Assessment and Intervention Protocol*, June 27, 2016.

[61] Facility Policy 116-19-05, *Suicide Attempts: Assessment and Intervention Protocol*, December 2, 2019. This policy replaced the June 27, 2016 policy.

[62] Health Administration Service leaders described the notification process to the OIG.

Prevention Coordinator reported being notified by another member of the suicide prevention team, who accessed the patient's EHR and discovered the alert that the patient was deceased.

The OIG found that facility staff did not notify facility leaders or suicide prevention staff upon learning of the patient's death by suicide. While no VA policy was in place at the time of the patient's death, VHA Office of Mental Health and Suicide Prevention leaders informed the OIG that facility-level policy was expected to guide suicide notification processes.

The Chief, Health Information Management Services told the OIG that at the time of the patient's death, facility leaders did not have a procedure in place to ensure that staff notified facility leaders or suicide prevention staff when they became aware of a death by suicide. On May 13, 2020, the Acting Facility Director, in response to the OIG's inquiry, indicated that "to improve communication across departments" facility Medical Records staff would "immediately notify" the suicide prevention coordinator upon learning of a death by suicide.

In October 2020, Patient Administrative Services leaders told the OIG that a recently implemented process consisted of death certificates being directed to Decedent Affairs staff and Decedent Affairs staff then emailing the suicide prevention team of any death of a patient with a high risk for suicide patient record flag. In an interview with the OIG, the supervisor, suicide prevention team confirmed that Decedent Affairs staff notify the suicide prevention team when they learn of a death by suicide of a patient who was engaged in mental health treatment. Parallel to VHA's requirement for clinical staff to report all patient deaths by suicide through the suicide behavior and overdose report, the OIG would expect non-clinical staff to be required to notify facility leaders of patient deaths by suicide regardless of the patient's engagement in VHA mental health treatment.[63]

Conclusion

The OIG did not substantiate that the service agreement procedures resulted in (1) inadequate psychiatric monitoring of a patient who later died by suicide, or (2) delays in primary care referrals of other patients for psychiatric treatment. The OIG also did not substantiate that facility staff delayed placement of the high risk for suicide patient record flag. The Suicide Prevention Coordinator placed a high risk for suicide patient record flag in the patient's EHR on day 54, two days prior to the patient's discharge from the Inpatient Mental Health Unit.

Facility staff did not adequately evaluate the patient's condition and treatment needs as part of renewal review of the patient's high risk for suicide patient record flag. The Suicide Prevention Coordinator documented continuation of the patient's high risk for suicide patient record flag;

[63] Acting Deputy Under Secretary for Health for Operations and Management (10N) Memorandum, "Suicide Behavior and Overdose Report Computerized Patient Record System (CPRS) Note Template Implementation," April 8, 2019.

however, the patient's high risk for suicide record flag was continued unknowingly by staff on a date after the patient's death by suicide.[64] At the time of the patient's death, VHA guidance did not include clinical engagement review and patient outreach requirements for patients assigned high risk for suicide patient record flags. In March 2020, VHA implemented additional guidance that requires suicide prevention coordinators, as part of the high risk for suicide patient record flag review, to (1) conduct a review of patients' clinical engagement, and (2) ensure monthly outreach for the remainder of the high risk for suicide patient record flag for patients not engaged in mental health treatment.[65]

Facility staff did not assign the patient an MHTC prior to discharge from the Inpatient Mental Health Unit and facility leaders did not establish an MHTC policy, as required by VHA.[66] Facility staff's failure to assign an MHTC may have resulted in the patient not receiving support during the discharge process and diminished the likelihood of the patient's engagement and post-discharge outreach. At the time of the patient's care, the absence of a facility policy may have contributed to staff's lack of knowledge regarding the requirements and processes related to the identification and assignment of an MHTC.

The OIG found that both the acting REACH VET Coordinator and Provider completed required documentation. The REACH VET Provider documented discussing the patient's REACH VET status during an appointment prior to the patient's REACH VET identification. The OIG concluded that the REACH VET Provider did not discuss the patient's REACH VET status with the patient, as required.[67] Failure to engage in a collaborative discussion about the patient's identification as at increased statistical risk for adverse outcomes, may have contributed to a missed opportunity to discuss enhanced treatment opportunities.

Facility staff did not comply with VHA suicide risk-assessment procedures. Inpatient Mental Health Unit Staff did not complete a secondary suicide risk screen within 24 hours of the patient's discharge, as required.[68] Further, the OIG found that outpatient staff failed to complete the required comprehensive evaluation in response to a positive secondary suicide risk screen.

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[64] VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008.

[65] VHA Notice 2020-13(1), *Inactivation Process for Category I High Risk for Suicide Patient Record Flags*, March 27, 2020, amended September 8, 2020.

[66] Deputy Under Secretary for Health for Operations and Management (10N) Memorandum, "Assignment of the Mental Health Treatment Coordinator," March 26, 2012. Deputy Under Secretary for Health for Operations and Management (10N) Memorandum, "Assignment of the Mental Health Treatment Coordinator, Attachments A, B, and C," March 26, 2012.

[67] Acting Deputy Under Secretary for Health for Operations and Management (10N) Memorandum, "REACH VET: Recovery Engagement and Coordination for Health–Veterans Enhanced Treatment," August 10, 2016.

[68] Deputy Under Secretary for Health for Operations and Management (10N) Memorandum, "Suicide Risk Screening and Assessment Requirements – Attachment B," May 23, 2018.

The OIG determined that facility staff did not alert facility leaders or suicide prevention staff of the patient's death by suicide. The Chief, Health Information Management Services told the OIG that at the time of the patient's death, facility leaders did not have a procedure in place to ensure that staff notified facility leaders or suicide prevention staff when they became aware of a death by suicide.

Recommendations 1–5

1. The Ralph H. Johnson VA Medical Center Director ensures adherence to Veterans Health Administration policy in the renewal review of patients' high risk for suicide patient record flag, and monitors compliance.
2. The Ralph H. Johnson VA Medical Center Director evaluates compliance with Mental Health Treatment Coordinator assignment requirements, and takes action to address identified deficiencies as indicated.
3. The Ralph H. Johnson VA Medical Center Director reviews the patient's care to include staff's adherence to "Recovery Engagement and Coordination for Health–Veterans Enhanced Treatment" program requirements and appropriate outreach, consults with Human Resources and General Counsel Offices, and takes action as warranted.
4. The Ralph H. Johnson VA Medical Center Director ensures that Mental Health Service staff complete patients' suicide risk screenings and assessments as required by the Veterans Health Administration, and monitors compliance.
5. The Ralph H. Johnson VA Medical Center Director evaluates procedures for non-clinical staff to notify appropriate leaders of patient deaths by suicide, and takes action as needed.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: June 1, 2021

From: Interim Director, VA Southeast Network (VISN 7) (10N7)

Subj: Healthcare Inspection—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

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

1. I have had the opportunity to review the Draft Report, Deficiencies in Mental Health Care Coordination and Administrative Processes for a Patient Who Died by Suicide, Ralph H. Johnson VA Medical Center.
2. I concur with Ralph H. Johnson VA Medical Center's action plan and ongoing implementation for recommendation 4 and request for recommendations 1 and 4, and request for closure of recommendations 2 and 5. We non-concur with recommendation 3.
3. I appreciate the opportunity for this review as part of a continuing process to improve the care of our Veterans.
4. If you have any questions or require further information, please contact the VISN 7 Quality Management Officer.

(*Original signed by*:)

Maureen McCarthy, MD

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: May 28, 2021

From: Director, Ralph H. Johnson VA Medical Center (534/00)

Subj: Healthcare Inspection—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

To: Director, VA Southeast Network (10N7)

1. We are deeply saddened by the loss of this Veteran. The loss of any Veteran by suicide is a tragedy.
2. Thank you for the opportunity to review the first of two Inspector General draft reports involving this patient.
3. In this case, the appropriate resources regarding MH services with scheduled appointments were utilized in the care provided to this patient in alignment with VHA policy. The veteran received extensive care and was involved in several programs. While we agree that there are opportunities for improvement, Ralph H. Johnson provided quality care for this veteran utilizing appropriate resources.
4. I reviewed recommendations 1-5. I concur with recommendations 1, 2, 4 and 5. We began working on these recommendations prior to and during the site visit and request closure for recommendations 2 and 5 based upon the evidence provided. I non-concur with recommendation 3.

(*Original signed by*:)

Scott R. Isaacks, FACHE

Facility Director Response

Recommendation 1

The Ralph H. Johnson VA Medical Center Director ensures adherence to Veterans Health Administration policy in the renewal review of patients' high risk for suicide patient record flag, and monitors compliance.

Concur.

Target date for completion: December 1, 2021

Director Comments

Though we concur with the recommendation to ensure policy adherence and monitoring of compliance, in this case the Ralph H. Johnson VAMC adhered to VHA Directive 2008-036 at the time of the event. In [fall] 2019, within the required 90-day review period, the patient's High-Risk Flag was continued by the SPC [suicide prevention coordinator] with the collaboration of the assigned provider. The SPC received feedback from the patient's outpatient social worker recommending the flag be continued due to the patient's lack of engagement in treatment and the provider's inability to further assess risk of suicide due to the patient's lack of response to outreach attempts. The alternative would have been to remove the flag with no clinical evidence to support removal. The SPC's decision and action was in the patient's best interest and in compliance with VHA Directive 2008-036 as acknowledged within this report by OIG. The OIG referenced additional guidance, VHA Notice 2020-13(1), Inactivation Process for Category I High Risk for Suicide Patient Record Flags, March 27, 2020, amended September 8, 2020, which was not in effect during the time the patient was receiving care. The medical center will monitor renewal of patient's high risk for suicide patient record flags for $\geq$ 90% compliance for 6 consecutive months.

Recommendation 2

The Ralph H. Johnson VA Medical Center Director evaluates compliance with Mental Health Treatment Coordinator assignment requirements, and takes action to address identified deficiencies as indicated.

Concur.

Target date for completion: Completed, April 30, 2021

Director Comments

The Ralph H. Johnson VAMC concurs the facility did not document a Mental Health Treatment Coordinator (MHTC) within 24 hours of discharge; however, the patient's care was coordinated,

and [the patient] received appropriate outpatient services. The coordination of care was appropriate as evidenced by 13 encounters within 30 days, including multiple specialized mental health services to address [the patient's] mental health conditions and high-risk status. The assignment of the MHTC had no impact on the care of the patient. As documented, in the OIG report, the facility did develop a MHTC policy in July 2020 to ensure appropriate documentation of administrative processes. Audits conducted from November 2020 to April 2021 revealed greater than 90% compliance.

OIG Comment

The Facility Director provided sufficient supporting documentation, and the OIG considers this recommendation closed.

Recommendation 3

The Ralph H. Johnson VA Medical Center Director reviews the patient's care to include staff's adherence to "Recovery Engagement and Coordination for Health–Veterans Enhanced Treatment" program requirements and appropriate outreach, consults with Human Resources and General Counsel Offices, and takes action as warranted.

Non-Concur.

Target date for completion: N/A

Director Comments

The Ralph H. Johnson VAMC was in adherence with requirements outlined in VHA Memorandum 2016-08-10 at the time of the event. The patient was seen [on day 83]. Documentation from that visit indicates [the patient's] safety plan was reviewed, enhanced MH services were discussed, and appointments scheduled. The REACH VET Coordinator followed the process to notify the provider of the Veteran's status on [day 84]. The provider inadvertently documented in a REACH VET note [day 86], that the Veteran was told of the REACH VET status. In alignment with Just Culture and [High Reliability Organization] principles, the agency reviewed the care and responded accordingly. This patient was already identified as high risk and [the patient's] plan of care reviewed during the [day 83] visit as stated above. Based upon the documentation and the discussion with the patient [on day 83], the provider felt it would be inappropriate to repeat the same discussions. The purpose of REACH VET is to identify at-risk Veterans who are not currently engaged in services or may need enhanced services. This Veteran had been identified as a high-risk patient and the highest levels of care were being provided as detailed in the [day 83] note. Therefore, we met the full intent of the REACH VET initiative.

OIG Comment

The OIG is asking the Director to review the REACH VET Provider documentation irregularities related to the patient's notification of REACH VET status. In contrast to the Director's assertion that the provider did not think it appropriate to outreach the patient in the days after an outpatient appointment, the OIG found no evidence that the provider engaged in thoughtful decision-making to that end. In fact, the REACH VET Provider documented and told the OIG that the patient's REACH VET status was discussed with the patient on day 83, even though staff did not become aware of the patient's REACH VET status until day 84. On day 86, the REACH VET Provider documented, "During our appointment on [day 83], I took the following steps: Informed Veteran that [the patient had] been identified as being at high statistical risk for suicide and other adverse outcomes. Reviewed and collaboratively discussed: Care enhancement options." There is no evidence in the day 83 note of such a discussion.[1] In fact, in the day 83 note, the REACH VET Provider documented the patient articulated a "strong desire to engage in "treatment" with minimal definition of treatment beyond meeting daily." There is no documentation of any additional treatment services offered or discussed.

While the OIG agrees with the Director that one purpose of REACH VET is to identify at-risk veterans who are not engaged in services or may need enhanced services, the OIG also notes that VHA highlights REACH VET program goals to include (1) collaboration by offering providers an opportunity to contact patients "at heightened suicide and other adverse health outcome risks to collaboratively review their health care diagnoses, mental health conditions, and risk factors," and (2) outreach to patients that can strengthen the therapeutic relationship by reminding them that providers are there to provide support. The failure of the REACH VET Provider to seize the opportunity to work collaboratively with the patient upon awareness of the patient's REACH VET status was especially unfortunate since the patient was high risk and difficult to engage in treatment.

Recommendation 4

The Ralph H. Johnson VA Medical Center Director ensures that Mental Health Service staff complete patients' suicide risk screenings and assessments as required by the Veterans Health Administration, and monitors compliance.

Concur.

Target date for completion: October 31, 2021

[1] VHA Handbook 1907.01, *Health Information Management and Health Records,* March 19, 2015. The 2015 handbook was in effect at the time of the events in this report and was rescinded and replaced by VHA Directive 1907.01, *VHA Health Information Management and Health Records,* April 5, 2021. VHA requires that clinical staff's EHR documentation is complete, timely, accurate, and readily accessible.

Director Comments

The Ralph H. Johnson VAMC concurs with the recommendation, however appropriate care was provided for a patient identified as high risk. As noted throughout the above responses, the facility provided the Veteran numerous therapeutic resources to mitigate risk ([high risk flag], [Substance Treatment and Recovery] [dialectical behavior therapy], etc). In addition, a robust suicide prevention safety plan was created while on inpatient and reviewed in a multidisciplinary meeting with the patient on [day 56] and reviewed with [the patient] again on day 83. The purpose of suicide risk assessment is to ensure appropriate care is delivered to Veterans and we met that standard. The medical center will monitor all Psychiatry unit discharges for >90% compliance for 6 consecutive months.

Recommendation 5

The Ralph H. Johnson VA Medical Center Director evaluates procedures for non-clinical staff to notify appropriate leaders of patient deaths by suicide, and takes action as needed.

Concur.

Target date for completion: N/A

Director Comments

Though we concur with this recommendation to evaluate procedures for improved communication, the Ralph H. Johnson VAMC was in adherence with requirements outlined in VHA Directives and local policy at the time of the event. Facility medical records staff received an electronic notification from the social security office regarding the patient's death and followed the required process of documenting the patient's death in the medical record. As noted, there was no requirement at the time that they notify senior leadership. Although there is no requirement, our leadership took the opportunity to improve notification processes. In April 2020, an electronic process was implemented to notify the Suicide Prevention Team of all deaths by suicide as well as deaths of veterans engaged in mental health services via email. The facility has achieved 100% compliance with notifications to the Suicide Prevention Team and leadership. To further improve our processes, we are moving forward with an automated electronic system which will notify the SPC and appropriate leaders simultaneously. We request closure for this recommendation.

OIG Comment

The Facility Director provided sufficient supporting documentation, and the OIG considers this recommendation closed.

Glossary

To go back, press "alt" and "left arrow" keys.

alcohol use disorder. Habitual use of alcohol that can cause impairments in an individual's day to day functioning.[84]

anxiety disorder. Worry or fear that is persistent, gets worse over time, and can interfere with employment, school, and relationships.[85]

borderline personality disorder. A pattern of unstable behaviors based on an individual's perception of their experiences that can impact their emotions and cause impairment in social relationships.[86]

cannabis. The cannabis plant is the source for the psychoactive substance in marijuana.[87]

cannabis use disorder. A habitual use of cannabis that can cause impairments in an individual's day to day functioning.[88]

dialectical behavior therapy. A skills-based group and/or individual treatment for borderline personality disorder to teach an individual emotion regulation.[89]

insomnia. A sleep disorder that can make it hard to fall and stay asleep or cause an individual to wake up early and unable to fall back asleep.[90]

major depressive disorder. An episode of at least two weeks characterized by depressed mood or loss of interest or pleasure in activities, changes in sleeping and eating patterns, changes in energy, feelings of worthlessness or guilt, and thoughts of death.[91]

posttraumatic stress disorder. A trauma-related disorder that evolves after a person is exposed to serious injury, potential death, or sexual violence. PTSD is diagnosed after experiencing

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[84] Diagnostic and Statistical Manual of Mental Disorders, "Alcohol-Related Disorders," accessed October 28, 2020, https://dsm.psychiatryonline.org/doi/full/10.1176/appi.books.9780890425596.dsm16.

[85] National Institute of Mental Health, "Anxiety Disorders," accessed May 5, 2020, https://www.nimh.nih.gov/health/topics/anxiety-disorders/index.shtml.

[86] Diagnostic and Statistical Manual of Mental Disorders, "Personality Disorders," accessed October 28, 2020, https://dsm.psychiatryonline.org/doi/full/10.1176/appi.books.9780890425596.dsm18.

[87] Centers for Disease Control and Prevention, "What is Marijuana?," accessed October 28, 2020, https://www.cdc.gov/marijuana/faqs/what-is-marijuana.html.

[88] Diagnostic and Statistical Manual of Mental Disorders, "Cannabis-Related Disorders," accessed October 28, 2020, https://dsm.psychiatryonline.org/doi/full/10.1176/appi.books.9780890425596.dsm16.

[89] Mayo Clinic. "Borderline Personality Disorder, Psychotherapy," accessed October 29, 2020, https://www.mayoclinic.org/diseases-conditions/borderline-personality-disorder/diagnosis-treatment/drc-20370242.

[90] Mayo Clinic. "Insomnia," accessed October 28, 2020, https://www.mayoclinic.org/diseases-conditions/insomnia/symptoms-causes/syc-20355167.

[91] Diagnostic and Statistical Manual of Mental Disorders. "Depressive Disorders," accessed October 28, 2020, https://dsm.psychiatryonline.org/doi/full/10.1176/appi.books.9780890425596.dsm04.

symptoms for more than one month including recurrent intrusive symptoms associated with the event, avoidance of any potential reminders of the event, negative changes in mood and thought processes, and increased reactivity.[92]

[92] Diagnostic and Statistical Manual of Mental Disorders. "Trauma- and Stressor-Related Disorders," accessed October 28, 2020, https://dsm.psychiatryonline.org/doi/10.1176/appi.books.9780890425596.dsm07.

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