



DEPARTMENT OF VETERANS AFFAIRS  
**OFFICE OF INSPECTOR GENERAL**

*Office of Healthcare Inspections*

VETERANS HEALTH ADMINISTRATION

Deficiencies in the Mental  
Health Care of a Patient who  
Died by Suicide and Failure  
to Complete an Institutional  
Disclosure, VA Southern  
Nevada Healthcare System  
in Las Vegas



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## Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess allegations that a patient died by suicide the same day as discharge from the VA Southern Nevada Healthcare System (facility), Las Vegas Inpatient Mental Health Unit, and that facility leaders failed to complete an institutional disclosure, as required.<sup>1</sup> The inspection also evaluated OIG-identified concerns regarding the patient's outpatient and inpatient mental health care, including: suicide risk evaluation and monitoring; high risk for suicide patient record flag assignment; substance use disorder evaluation and referral; reconciliation of critical clinical information; deficiencies in mental health treatment coordinator (MHTC) assignment processes and care coordination; and response to the patient's complaints and requests.

The patient, who was over 70 years old at the time of death, had a medical history that included diagnoses of [post-traumatic stress disorder \(PTSD\)](#), [major depression](#), [mild neurocognitive impairment](#), high blood pressure, and [chronic kidney disease](#).<sup>2</sup> Beginning in summer 2013, the patient was prescribed [methylphenidate](#) for depression, and in spring 2016, the patient was additionally prescribed [mirtazapine](#) for depression, [trazodone](#) for sleep, and [lamotrigine](#) for mood stabilization. After approximately 15 years of mental health care at a California VA facility, the patient transferred care to the facility in spring 2019.

The OIG substantiated that the patient died by suicide the same day as discharge from the facility's Inpatient Mental Health Unit. The OIG found that in early and late summer 2019, outpatient mental health providers did not complete comprehensive evaluations with the patient following positive secondary suicide risk screens, as required by the Veterans Health Administration (VHA).<sup>3</sup> Outpatient mental health staff did not follow up with the patient to address incomplete comprehensive evaluations. The Chief of Behavioral Health reported that there was not the capability to obtain historical reports to determine whether the patient's comprehensive evaluations were identified as deficient. VHA Office of Mental Health and Suicide Prevention leaders reported to the OIG that the comprehensive evaluation deficiency

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<sup>1</sup> VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018. An institutional disclosure is a formal process for facility leaders and clinicians to inform the patient or patient's personal representative that an adverse event occurred during the patient's treatment that may have contributed to serious risk of future health issues or death. Adverse events are untoward incidents, injuries, or other occurrences of harm or potential harm directly associated with care or services delivered by VA staff.

<sup>2</sup> The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together.

<sup>3</sup> Deputy Under Secretary for Health for Operations and Management Memorandum, *Eliminating Veteran Suicide Implementation of Suicide Risk Screening and Evaluation*, November 2, 2018. This memorandum was in effect during the timeframe of the events discussed in this report; it was updated and superseded by Deputy Under Secretary for Health for Operations and Management Memorandum, *Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy)*, November 13, 2020.

reports for ambulatory settings provided information for the preceding two-week period, and not aggregate (historical) data.

Staff's failure to complete required comprehensive evaluations may have hindered identification of critical or new information regarding the patient's suicide risk, including warning signs and risk factors. Further, given that a comprehensive evaluation required a plan to mitigate risk, staff also failed to identify and reinforce the patient's coping strategies and protective factors. Additionally, the OIG found a [safety plan](#) reportedly provided to the patient to be unusable due to incomprehensible entries.

The OIG also found that the comprehensive evaluation completed by an Emergency Department social worker was incomplete, with "[[altered mental status](#)]" documented for most responses because the patient was unable to participate. The social worker told the OIG that the patient was disoriented and struggled to answer questions. Neither Inpatient Acute Medical Unit nor Inpatient Mental Health Unit staff completed another comprehensive evaluation with the patient until approximately one hour prior to the patient's discharge. The failure to obtain comprehensive evaluation information may have contributed to an incomplete understanding of the patient's risk factors including access to [lethal means](#), and thereby limited the effectiveness of the patient's discharge plan.

The OIG found that on the day of the patient's Inpatient Mental Health Unit discharge, the suicide prevention team did not assign the patient a high risk for suicide patient record flag, in spite of the patient's documented current psychosocial stressors and history of suicide behaviors.<sup>4</sup> Additionally, the suicide prevention team did not consult with the Inpatient Mental Health Unit treatment team as part of a consideration of assigning the patient a high risk for suicide patient record flag, as required.<sup>5</sup> The Suicide Prevention Coordinator told the OIG that the suicide prevention team did not think consultation with the Inpatient Mental Health Unit treatment team was needed. The Suicide Prevention Coordinator also told the OIG that a high risk for suicide patient record flag was not placed because the patient's electronic health record (EHR) indicated that the patient had suicidal ideation for a number of years without any suicide attempt, the patient reported suicide behaviors occurred 13–14 years prior, and the patient denied a current suicide plan or suicidal intent.

Further, the Suicide Prevention Coordinator was unable to definitively say whether or not the suicide prevention team reviewed the outpatient documentation in the patient's EHR. The outpatient documentation would have provided information related to the patient's difficulties and frustrations with outpatient mental health prescribers. Based on facility policy, the OIG

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<sup>4</sup> VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008. The primary purpose of the high risk for suicide patient record flag is to communicate to staff that a patient is at high risk for suicide and to include consideration of the risk in treatment decisions.

<sup>5</sup> VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008.

would have expected that the suicide prevention team place a high risk for suicide patient record flag due to the patient's active crisis and history of suicide behaviors.<sup>6</sup> Initiation of a high risk for suicide patient record flag would have included notification to Inpatient Mental Health Unit staff and may have affected treatment decisions, including the decision to discharge the patient from a brief, less than 24-hour, Inpatient Mental Health Unit admission.

The OIG found that during the patient's admission to the Inpatient Mental Health Unit, staff did not complete an adequate assessment of the patient's substance use or consider treatment options tailored to the patient's needs. The OIG found that Inpatient Mental Health Unit staff did not order laboratory tests to identify specific substances, such as illicit or prescribed medications, likely due to staff's diagnostic impression that the patient was abusing substances. The OIG would have expected the Inpatient Mental Health Unit staff to pursue a confirmatory drug screen to inform decisions regarding recommendations for the patient's substance use disorder diagnosis and treatment.<sup>7</sup>

Additionally, the OIG found that Inpatient Mental Health Unit staff did not request a formal or individualized substance use disorder assessment for the patient.<sup>8</sup> On the day of discharge, a psychologist attended the patient's interdisciplinary treatment team meeting and documented that the patient was "not considered a candidate" for residential substance use disorder treatment based on the patient's denial of illicit drug use. The admitting nurse practitioner told the OIG that the patient should have had an alcohol and drug treatment program consult placed prior to discharge; however, one was not placed. Inpatient Mental Health Unit staff told the OIG that substance use disorder assessment or treatment options outside of residential treatment were not considered because the patient denied substance use, became upset, and felt "treated like a subhuman" when residential or outpatient substance use disorder treatment options were discussed. The absence of the individual assessment may have contributed to staff's failure to enhance the patient's readiness to engage in substance use disorder treatment consistent with the patient's needs at the time.

The OIG found that Inpatient Mental Health Unit staff did not review or incorporate relevant outpatient mental health history into the patient's treatment plan and adequately address the patient's change in demeanor and concerning statements. Inpatient Mental Health Unit staff told the OIG that a review of the patient's outpatient mental health history was not conducted because of the patient's short admission time. The Inpatient Mental Health Unit staff's failure to review the patient's outpatient mental health treatment history may have contributed to the decision to

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<sup>6</sup> Facility Standard Operating Procedure 116-14, *Suicide Prevention Daily Operations*, October 2019.

<sup>7</sup> Karen Moeller, Kelly Lee, and Julie Kissack, "Urine Drug Screening: Practical Guide for Clinicians," *Mayo Clinic Proceedings* 83, no. 1 (January 2008): 66-76.

<sup>8</sup> VA/Department of Defense, *Clinical Practice Guideline for the Management of Substance Use Disorders*, 2015.

discharge that patient without addressing the patient's challenges in engaging in outpatient mental health care.

During the patient's Inpatient Mental Health Unit admission, the admitting nurse practitioner documented that the patient's family member reported receiving a text from the patient the previous day that stated, "maybe I should just die." When interviewed by the OIG, the patient's family member reported telling the Inpatient Mental Health Unit staff about the patient's text and requesting that the patient remain admitted after the Inpatient Mental Health Unit staff reported a plan to discharge the patient the following day. The patient's family member also told the OIG about notifying Inpatient Mental Health Unit staff of the patient's history, including that two family members had died by suicide, one of whom had had a [suicide pact](#) with the patient. Additionally, during a phone call with the family member and while the treatment team was present, the patient learned about not being able to return to live with the family member and stated, "My whole world has ended."

The inpatient social worker told the OIG that after the patient made the statement, Inpatient Mental Health Unit staff met with the patient, asked the patient to remain on the unit, asked the patient again about suicide intent that the patient denied, and expressed concern about the patient's depression. Inpatient Mental Health Unit staff reported not considering an involuntary hold of the patient because of the patient's long history of chronic suicidal ideation, denial of suicidal intent, the treatment team's recommendation for discharge, and the patient's request for discharge. Inpatient Mental Health Unit staff also told the OIG that a more thorough assessment of the patient did not occur because of the patient's brief length of stay.

The inpatient social worker completed the patient's safety plan, documented only the Veterans Crisis Line as the social contact for distraction, and did not identify anyone who could help the patient when in a crisis or with limiting access to lethal means. Additionally, the patient's discharge safety plan had not been modified for approximately eight months in spite of significant life changes including death of a family member, worsening depression, poor engagement with outpatient mental health treatment, Inpatient Mental Health Unit admission, and loss of a place to live.

Within less than 24 hours of admission, the patient was discharged from the Inpatient Mental Health Unit and after approximately two hours of returning to the family member's home, the patient died by gunshot wound to the head. The coroner listed the manner of death as suicide. The lack of comprehensive assessment of the patient, including staff's failure to review prior mental health treatment and response, and reconciliation of pertinent clinical information related to the patient's mental health condition may have contributed to Inpatient Mental Health Unit staff rendering treatment and discharge decisions based on incomplete and insufficient information about the patient.

The OIG found that facility leaders had not established a mental health treatment coordinator (MHTC) policy, as required by VHA.<sup>9</sup> An outpatient mental health nurse manager who supervised the MHTCs told the OIG that facility leaders were developing a MHTC policy that was not yet approved. Additionally, staff did not assign the patient an MHTC until the patient's tenth mental health visit and three months after the patient's initiation of care at the facility.<sup>10</sup> Further, staff changed the patient's assigned MHTC three additional times during the next six months, resulting in four MHTCs being assigned for the patient during nine months of care.

The OIG found that the assigned MHTCs did not maintain regular contact with the patient as clinically indicated to support treatment engagement or assist the patient with concerns with care. Further, staff inaccurately informed the patient about the assigned MHTC and that may have hindered the patient's ability to identify or contact the MHTC for support with concerns about care.

The OIG found that Inpatient Mental Health Unit staff did not communicate with a [geropsychologist](#), who the patient had seen for a total of nine outpatient appointments prior to the Inpatient Mental Health Unit admission, to coordinate care or discharge.<sup>11</sup> Additionally, the interdisciplinary treatment team meeting held on the day of discharge did not include the geropsychologist, although Inpatient Mental Health Unit staff recommended outpatient mental health aftercare following discharge.

As a result, information relevant to the patient's care and techniques for engaging the patient in care were not incorporated into the patient's care or discharge plan. The OIG also found that the patient's discharge follow-up appointments did not include an appointment with the patient's established outpatient mental health psychologist. Instead, the appointments included an appointment with a psychiatrist with whom the patient had a documented history of expressed concerns related to care.

The OIG found that leaders and staff did not effectively address the patient's expressed complaints and concerns submitted summer 2019 through early 2020 regarding difficulties obtaining medications as prescribed by staff at a California VA facility, engaging with mental health staff, and preference for a different primary care location (see appendix A for details about the patient's complaints). A registered nurse notified a geriatric psychiatrist, the Chief of Behavioral Health, and a medical support assistant about a secure message complaint from the patient but did not contact an immediate supervisor or a service level patient advocate liaison for

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<sup>9</sup> Deputy Under Secretary for Health for Operations and Management, *Assignment of the Mental Health Treatment Coordinator*, March 26, 2012.

<sup>10</sup> For purposes of this OIG report, the MHTC assigned in the EHR templated progress note is referred to as the assigned MHTC, although the formal assignment process was not completed.

<sup>11</sup> When interviewed by the OIG, the discharging Inpatient Mental Health Unit nurse practitioner reported seeing the patient for a few hours prior to discharge and was unable to speak with the geropsychologist prior to discharging the patient.

assistance with addressing the patient's unresolved concerns, as required.<sup>12</sup> The Chief of Behavioral Health did not sign the registered nurse's secure message note regarding the patient's complaint until approximately nine months after it was sent. When interviewed by the OIG, the Chief of Behavioral Health reported not seeing the additional signer request due to receiving hundreds of EHR alerts because of a system glitch.<sup>13</sup> The Chief of Behavioral Health told the OIG that it was not typical to get involved in a patient complaint unless a patient's concern is reported to the patient advocate or elevated through a supervisory chain.

A primary care nurse care manager did not provide a warm handoff when the patient sent another secure message to a primary care team that described concerns about not receiving a sleep medication, and advised the patient to contact the geriatric psychiatrist who prescribed the medication. It was not until the patient responded with additional frustration regarding the mental health care received that the primary care nurse care manager informed the patient that an MHTC was notified of the patient's concerns and advised that the patient either attend an upcoming scheduled psychiatry appointment or present as a walk-in to the outpatient mental health clinic to address the medication concern. The patient later canceled the scheduled psychiatry appointment. The OIG concluded that the ineffective response to the patient's complaints likely contributed to the patient's lack of confidence in facility staff, further disengagement from mental health treatment, and subsequent worsening psychiatric condition.

The OIG found that staff did not transfer the patient to a requested primary care location. The Assistant Chief of Primary Care told the OIG that the clinic location requested by the patient had a transfer wait list due to a high number of patient requests and internal patient transfers to the clinic. The Assistant Chief of Primary Care also told the OIG the patient's transfer request was made when the transfer-request process was changing from a form submission to the more trackable electronic waiting list system, which may have contributed to delays in transfer. Staff's lack of responsiveness to the patient's request for a primary care clinic transfer may have compounded the patient's dissatisfaction with care at the facility and potentially contributed to the patient's frustration.

The OIG substantiated that following awareness of the patient's death, facility leaders did not conduct an institutional disclosure, as required.<sup>14</sup> Facility leaders reported they did not conduct an institutional disclosure because treatment errors that would have contributed to the patient's death were not identified. However, VHA requires disclosure of sentinel events, including suicide within 72 hours of discharge from an inpatient care setting, regardless of whether or not

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<sup>12</sup> Facility Memorandum VE-16-01, *Patient Advocate and Patient Advocate Liaison Program*, November 2016.

<sup>13</sup> Clinical applications coordinators told the OIG that facility leaders were assigned as back-up signers when staff left the facility, which could result in them receiving numerous EHR alerts. The clinical applications coordinators told the OIG that the issue could be resolved by having an automated data processing application coordinator assign a surrogate signer for staff who were no longer employed at the facility.

<sup>14</sup> VHA Directive 1004.08, *Disclosures of Adverse Events to Patients*, October 31, 2018.

the event resulted from an error.<sup>15</sup> Facility leaders therefore failed to notify the patient's family member of rights and recourse following the patient's death, as required.<sup>16</sup> Additionally, the OIG concluded that the Chief of Staff erroneously defined the patient's death as a non-sentinel event.

The OIG made 10 recommendations to the Facility Director related to suicide evaluation and monitoring, substance use disorder evaluation and treatment referral, Inpatient Mental Health Unit staff's reconciliation and incorporation of critical clinical information into treatment and discharge planning, establishment of an MHTC policy, discharge coordination with outpatient treatment providers, patient complaint and request response, leaders' identification of sentinel events, and an institutional disclosure for the patient's care.

## Comments

The Veterans Integrated Service Network and Facility Directors concurred with the recommendations and provided an acceptable action plan (see appendixes B and C). The OIG will follow up on the planned actions until they are completed.



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<sup>15</sup> VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

<sup>16</sup> VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

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## Abbreviations

EHR	electronic health record
MHTC	Mental Health Treatment Coordinator
OIG	Office of Inspector General
PTSD	posttraumatic stress disorder
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



## Introduction

The VA Office of Inspector General (OIG) conducted an inspection to evaluate allegations that a patient died from suicide within two hours of discharge from the Inpatient Mental Health Unit at the VA Southern Nevada Healthcare System (facility) in Las Vegas and that facility leaders did not complete an institutional disclosure after the patient's death, as required.<sup>1</sup>

## Background

The facility, part of Veterans Integrated Service Network (VISN) 21, provides healthcare services to more than 45,000 patients yearly. The facility includes 90 inpatient beds with a 20-bed Inpatient Mental Health Unit, 4 outpatient clinics, and 2 community-based outpatient clinics. The facility provides a range of inpatient and outpatient medical, surgical, and mental health services.

## Allegations and Related Concerns

On May 4, 2020, the OIG received allegations that:

1. A patient died by suicide within two hours of discharge from the Inpatient Mental Health Unit.

The OIG identified the following concerns regarding the patient's outpatient and inpatient mental health care:

- Suicide risk evaluation and monitoring
  - High risk for suicide patient record flag assignment
  - Substance use disorder evaluation and referral
  - Reconciliation of critical clinical information
  - Mental health treatment coordinator (MHTC) assignment processes and care coordination
  - Response to the patient's complaints and requests
2. Facility leaders failed to complete an institutional disclosure, as required following a sentinel event.<sup>2</sup>

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<sup>1</sup> VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018. An institutional disclosure is a formal process for facility leaders and clinicians to inform the patient or patient's personal representative that an adverse event occurred during the patient's treatment that may have contributed to serious risk of future health issues or death. Adverse events are untoward incidents, injuries, or other occurrences of harm or potential harm directly associated with care or services delivered by VA staff.

<sup>2</sup> VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

## Scope and Methodology

The OIG initiated the healthcare inspection on May 26, 2020, and conducted a virtual site visit from July 27, 2020, through July 30, 2020.<sup>3</sup>

The OIG team interviewed leaders from the Veterans Health Administration (VHA) Care Management and Social Work Services, VISN 21, and the facility; as well as facility staff familiar with the patient's care and relevant processes; and a family member of the patient. Additionally, the OIG team obtained information from VHA Office of Mental Health and Suicide Prevention leaders regarding suicide risk assessment processes.

The OIG team reviewed relevant VHA directives, handbooks, and memoranda; facility policies, standard operating procedures, and organizational charts; The Joint Commission standards; American Psychiatric Association guidance; and Centers for Disease Control and Prevention literature. The OIG team also reviewed the patient's electronic health record (EHR); coroner, autopsy, and toxicology reports; and facility internal review documents related to the patient's care.

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

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 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,

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<sup>3</sup> The site visit was conducted virtually due to the coronavirus (COVID-19) pandemic. World Health Organization (WHO), "WHO Director-General's Opening Remarks at the Media Briefing on COVID-19," March 11, 2020, accessed November 10, 2020, <https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020>. Merriam Webster, *Definition of pandemic*, accessed November 10, 2020, <https://www.merriam-webster.com/dictionary/pandemic>. A pandemic is a disease outbreak over a wide geographic area that affects most of the population. The World Health Organization, *Naming the Coronavirus Disease (COVID-19) and the Virus that Causes It*, accessed November 10, 2020, [https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-\(covid-2019\)-and-the-virus-that-causes-it](https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it). COVID-19 is caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).

if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

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

## Patient Case Summary

The patient, who was over 70 years old at the time of death, had a medical history that included diagnoses of [posttraumatic stress disorder \(PTSD\)](#), [major depression](#), [mild neurocognitive impairment](#), high blood pressure, and [chronic kidney disease](#). In the early 1970s, the patient underwent a [resection](#) of a large component of the right [frontal lobe](#) of the brain to remove a [cyst](#). A California VA facility psychiatry resident physician documented that the patient’s major depression was “severe recurrent and [treatment resistant](#) likely contributed by [history of] frontal lobe resection.”

The patient was prescribed [methylphenidate](#) for depression in 2013, [lamotrigine](#) for mood stabilization in 2014, and in 2016, the patient was additionally prescribed [mirtazapine](#) for depression and [trazodone](#) for sleep. After approximately 15 years of mental health care at a California VA facility, the patient transferred care to the facility in June 2019.

From spring 2019 through early 2020, the patient regularly communicated to facility staff a need for medication refills through scheduled and walk-in visits and secure messages. The patient repeatedly informed facility staff of frustrations in attempts to obtain the antidepressant medication that was prescribed by the California VA facility providers. (Appendix A contains details about the patient’s care and staff response prior to the patient’s spring 2020 inpatient admission.)

In spring 2020, on day 1 at approximately 10:15 p.m., the patient presented to the facility Emergency Department and reported suicidal thoughts “almost everyday [*sic*]” and being unable to remember anything the patient did the previous two days. A nurse completed the secondary suicide risk screen and documented that the patient acknowledged thinking about how to “carry out” a plan to die by suicide and an intent to act on the suicidal thoughts within the past month.<sup>4</sup>

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<sup>4</sup> Deputy Under Secretary for Health for Operations and Management Memorandum, *Suicide Risk Screening and Assessment Requirements*, May 23, 2018. At the time of the patient’s care, VHA utilized the Patient Health Questionnaire (PHQ-9) as the primary suicide risk screen. When the primary screen was positive, staff were required to complete the Columbia–Suicide Severity Rating Scale, or the secondary suicide risk screen. When the secondary screen was positive, a licensed independent provider was required to complete a comprehensive suicide risk evaluation that included questions about suicidal ideation, plan, intent, behaviors, risk factors, protective factors, level of risk, and mitigation plan. This memorandum was in effect during the timeframe of the events discussed in this report; it was updated and superseded by Deputy Under Secretary for Health for Operations and Management Memorandum, *Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy)*, November 13, 2020.

A social worker noted that the patient “struggled to answer questions” and “would often response: [*sic*] I don’t know. I don’t remember.” The patient reported having suicidal ideation “all the time, every day, for years,” thought “about taking a knife” and “would not describe more details.” The social worker documented that the patient was “confused,” “struggled to recall past/present events,” and was unable to answer the comprehensive evaluation questions due to an [altered mental status](#).<sup>5</sup> The social worker assessed the patient’s acute and chronic risks of suicide as high and documented a suicide risk mitigation plan that included consideration of a high risk for suicide patient record flag and voluntary hospitalization.<sup>6</sup>

An Emergency Department physician documented that the patient reported “memory loss” but was not sure how long this had been occurring. The patient reported traveling to visit an ill family member the week prior and that earlier on day 1 another family member, with whom the patient resided, called the patient to inform them that the ill family member had died. The patient was unsure of the location at the time of the call but returned home, slept, and after awakening discovered purchases and cash withdrawals on a credit card. The patient reported that the family member called a friend to bring the patient to the Emergency Department. The patient reported a history of [traumatic brain injury](#) and denied drug use, gambling, and alcohol use. The physician documented that the patient had suicidal ideation and that the patient “has [history] of no plan.”

The patient’s vital signs were stable with slightly elevated blood pressure, consistent with the patient’s known diagnosis of high blood pressure. Laboratory tests revealed a low level of blood potassium that the physician noted may be related to the patient’s acute and chronic kidney disease as well as the patient’s report of chronic diarrhea. The patient’s drug screen was positive for [benzodiazepines](#) and [amphetamines](#), and the physician documented that the patient’s “regular medications does [*sic*] not include Benzodiazepines or Amphetamine.” The physician documented that the patient’s cognitive deficits may have been exacerbated by recent situational stresses and drug use. The patient was placed on one-to-one observation and treated with intravenous and oral potassium while in the Emergency Department.<sup>7</sup>

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<sup>5</sup> The social worker entered the comprehensive evaluation note in the patient’s EHR on day 2. Jin Han and Scott Wilber, “Altered Mental Status in Older Emergency Department Patients,” *Clinics in Geriatric Medicine* 29 no. 1 (February 2014):101-136, accessed November 30, 2020, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3614410/>. Altered mental status is brain dysfunction that may present as confusion, behavior change, psychosis, and disorientation. Altered mental status can be caused by an underlying medical condition.

<sup>6</sup> 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 Memorandum, *Update to High Risk for Suicide Patient Record Flag Changes*, January 16, 2020. VHA uses a Patient Record Flag Category I High Risk for Suicide to identify a patient as high risk for suicide in the EHR and requires intensive follow-up by providers while the patient remains flagged.

<sup>7</sup> Facility Policy 116-19-11, *Management of Veterans at High Risk for Suicide in the Non-Behavioral Acute Care Settings*, March 2019. One-to-one observation is “the constant observation of one patient by one staff.” One-to-one observation staff “should not be given additional responsibilities during one-to-one observation.”

The physician documented a plan to admit the patient to the facility on suicide precautions and if the patient “plans to leave,” the physician would place an “L2K.”<sup>8</sup> On day 2, a little after midnight, the physician ordered the patient’s admission to the acute medical unit to treat acute and chronic kidney disease, low potassium, suicidal ideation, and cognitive decline.

In the Emergency Department, an inpatient medicine physician completed a history and physical examination in preparation for the patient’s admission. The inpatient medicine physician documented that the patient had a history of treatment-resistant chronic depression, PTSD, and mild neurocognitive impairment. The patient acknowledged suicidal ideation, denied a plan, and reported being “always depressed and this [*sic*] no different.” The patient denied “ever doing drugs.” The inpatient medicine physician documented a plan to admit the patient for treatment of medical conditions, including methamphetamine intoxication, with intravenous fluids and cardiac monitoring. The inpatient medicine physician submitted an inpatient psychiatry consultation request to address “suicidal ideation, acute psychosis and Geri [geriatric] psych [psychiatric] decline. Positive amphetamine use.”

On day 2 at approximately 1:30 a.m., the patient was transferred to the Inpatient Acute Medical Unit. Upon arrival, a nurse administered the secondary suicide risk screen and documented that over the past month the patient wished to be dead or not wake up from sleep and had thoughts of suicide. The nurse documented that the patient denied drug use.

At approximately 5:40 a.m., an advance practice registered nurse completed the psychiatry consult with the patient by phone.<sup>9</sup> The patient reported “ongoing depressed mood, low energy, low motivation, feeling of hopelessness,” loss of interest in pleasurable activities, guilt, and sleep difficulties. The patient stated “[my] life is a mess,” reported discontinuing an antidepressant due to headaches, and explained that methylphenidate was prescribed for mood, not [attention deficit hyperactivity disorder](#). The patient reported being prescribed methylphenidate in combination with other effective medications in the past “but the psychiatrist [*sic*] here do not want to give it” and that methylphenidate was “the only thing that helped my depression.” The patient denied taking methylphenidate recently and when asked about the positive drug screen for

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<sup>8</sup> Facility Policy 116-19-11. Suicide precautions include “the provision and maintenance of a safe environment for those patients who are a suicide risk” and may include one-to-one observation. Facility Policy 116-19-09, *Emergency Psychiatric Evaluation – Legal 2000 Revised Hold (L2000R)*, April 2019. A Legal 2000 Revised Hold is used to involuntarily hold a patient in the hospital and requires completion of a Legal 2000 Revised Hold form. The Legal 2000 Revised Hold is an emergency psychiatric evaluation for patients with diminished capacity as a result of mental illness and who are a current, clear danger to self, others, or property. Department of Health and Human Services Nevada, Division of Public and Behavioral Health, *Clinical Behavioral Services Forms*, accessed November 30, 2020, [http://dpbh.nv.gov/Programs/ClinicalBehavioralServ/dta/Forms/Clinical\\_Behavioral\\_Services\\_Forms/](http://dpbh.nv.gov/Programs/ClinicalBehavioralServ/dta/Forms/Clinical_Behavioral_Services_Forms/). A Legal 2000 form is also referred to as an L2K.

<sup>9</sup> VHA Directive 1350, *Advanced Practice Registered Nurse Full Practice Authority*, September 13, 2017. An advanced practice registered nurse is a licensed independent provider who has clinical privileges in VA medical facilities. The nurse practitioner did not sign the EHR note until 11:15 p.m. on day 2.

benzodiazepine and amphetamine, the patient responded, “I don’t know.” The advance practice registered nurse confirmed that the patient last filled a prescription for the methylphenidate in fall 2019 through the Prescription Monitoring Program.<sup>10</sup>

The advance practice registered nurse documented that the patient reported being “non-compliant with medication” and was “a poor historian, needs to repeat questions frequently.” The advance practice registered nurse contacted the patient’s family member who reported suspicions that the patient was using methamphetamine, that the patient was missing for over a day prior to the patient’s admission, and that the patient was “not doing well mentally” and “needed help.”

The advance practice registered nurse diagnosed the patient with major depressive disorder, severe, without psychotic symptoms, and ruled out stimulant-induced mood disorder. The advance practice registered nurse recommended restarting mirtazapine for depression and sleep and trazodone for sleep, and transferring the patient to the Inpatient Mental Health Unit upon medical clearance.

Later that morning, the patient told another inpatient medicine physician about a history of “chronic depression for which [the patient] complained that mental health doctors here in the VA are not treating [the patient] with any medications which apparently worked for [the patient] in the past.” The patient reported that medications prescribed at the California VA facility, including trazodone and methylphenidate, “were all stopped by [the patient’s] mental health doctors here.” The patient reported suicidal ideation and denied homicidal ideation and “ongoing plans” of harming self or others. Morning laboratory studies revealed improvement in the patient’s potassium level and kidney function. The physician documented a plan that included continued intravenous fluids for hydration, potassium replacement therapy, and follow-up on psychiatry consultation.

Later that day, the physician spoke with the family member who reported suspecting that the patient was abusing methamphetamine and may have had a “manic episode.” The physician documented awaiting the psychiatry consult for recommendations and that the family member “prefers that patient receives further treatment as inpatient in the psychiatry unit, before being released home.”

The next morning, day 3 at approximately 10:00 a.m., the inpatient medicine physician documented that the patient reported “feeling better although still with depression and intermittent suicidal ideation.” The patient was started on mirtazapine the previous night and reported sleeping well and had decreased confusion. The physician documented stable vital signs with slightly elevated blood pressure, resolved acute kidney injury, and improved potassium

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<sup>10</sup> Nevada State Board of Pharmacy, “Prescription Monitoring Program,” accessed October 18, 2020, <https://bop.nv.gov/links/PMP/>. The Prescription Monitoring Program is a database of controlled substance prescriptions dispensed to patients in Nevada that is accessible to prescribers.

level. The inpatient medicine physician noted that the patient was “medically stable and cleared for transfer to psychiatry unit for further management.”

At approximately 2:30 p.m., the patient was voluntarily admitted to the Inpatient Mental Health Unit. A nurse documented that the patient stated “I asked to be admitted” and “I was lost a few days.” The patient denied homicidal ideation, reported daily suicidal ideation, and stated “I haven’t actively done [suicidal behavior] a long time [*sic*] and never again.” The nurse noted risk factors for suicide within the past six months including history of mental disorders, hopelessness, physical illness, and suicidal thoughts. The patient screened positive for suicide risk on depression and PTSD screens. The nurse informed the patient about the positive amphetamine and benzodiazepine drug screen results and the patient replied “I never did [methamphetamine] or drugs,” and “I take medications.”

At approximately 4:30 p.m., the inpatient mental health team met with the patient for treatment planning and the patient reported “I just want to leave.”<sup>11</sup> The patient stated “I need help with depression and PTSD,” and an inpatient social worker documented the patient’s diagnoses as PTSD and amphetamine-type substance use disorder, severe. The inpatient social worker documented a seven-day treatment plan.

At approximately 8:00 p.m., a nurse documented that the patient was irritable, denied suicidal and homicidal ideation, and “demand[ed] to be discharged.” The nurse noted that a psychiatric nurse practitioner (admitting nurse practitioner) told the patient that the treatment team would meet with the patient the next day to “decide if [the patient] is ready to go home,” and that the patient was “not happy.”

At approximately 9:18 p.m., the admitting nurse practitioner documented the patient’s admission evaluation and noted that the patient was “mildly cooperative,” asked to be discharged “routinely,” and stated “I hate the VA especially mental health.” The patient reported chronic suicidal ideation but did “not divulge current plan or intent,” and agreed to stay on the unit “through the night.” The admitting nurse practitioner assessed the patient as high risk for suicide, admitted the patient for “further stabilization,” and continued mirtazapine and trazodone.

With the patient’s consent, the admitting nurse practitioner spoke with the patient’s family member who reported finding illicit substances and paraphernalia in the patient’s belongings. The family member reported that two family members died by suicide, one of whom had a [suicide pact](#) with the patient. Further, the family member said that the patient sent a text message the night before that said “maybe I should just die.” The family member said that the patient “shuts down when mental health and substance use is brought up” and expressed hope for the patient to remain inpatient for treatment of methamphetamine use. The family member also said

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<sup>11</sup> Mental health treatment team participants included four advance practice nurses, a psychologist, three psychiatrists, three social workers, and a peer support specialist.

that the patient could return home but “if drug use persists [the patient] will not be allowed to live there.”

In the morning of day 4, the Suicide Prevention Coordinator reviewed the patient’s EHR and decided not to place a high risk for suicide patient record flag because the patient “reports chronic suicidal ideation with no plan or intent.” The Suicide Prevention Coordinator documented that the patient was at “Intermediate” acute and chronic risk of suicide.

Later that morning, the inpatient mental health treatment team met with the patient. A psychologist documented that the patient reported suicidal ideation “since the 70’s, so I don’t understand why I’m here.” The patient scored with moderately severe depressive symptoms on the primary suicide risk screen.<sup>12</sup> The psychologist documented the plan to continue inpatient treatment. Another psychologist also documented the treatment team meeting and noted that the patient denied substance use, reported “being treated like a subhuman,” and that based on the patient’s “self-report,” the patient was not a candidate for residential substance use treatment.

At approximately 11:00 a.m., the inpatient social worker and patient reviewed the patient’s early 2020 [safety plan](#) and the inpatient social worker documented that no changes to the safety plan were indicated and that the patient was provided with a copy of the safety plan.

A psychiatric nurse practitioner (discharging nurse practitioner) telephoned the patient’s family member with the patient and inpatient social worker. The family member stated that the patient could no longer live with the family member if the patient was unwilling to be honest about substance use. The family member offered to transport the patient from the facility to the family member’s home and assist the patient with moving out.

The inpatient social worker documented that the patient stated, “My whole world has ended,” and declined an offer to remain on the Inpatient Mental Health Unit. At approximately 12:30 p.m., the inpatient social worker updated a prior suicide risk evaluation and noted that the patient was at intermediate acute and chronic risk of suicide and did not have access to [lethal means](#). The updated suicide risk evaluation also included the patient’s protective factors of “access to and engagement in mental health care” and “pattern of help seeking.” The inpatient social worker completed a suicide risk mitigation plan that included alerting the Suicide Prevention Coordinator to consider a Patient Record Flag Category I High Risk for Suicide and providing lethal means safety counseling.

The discharging nurse practitioner noted that at the time of discharge, the “patient was not psychotic, manic, suicidal nor homicidal.” The discharging nurse practitioner documented that the patient declined referral to a substance use disorder treatment program. The patient was prescribed mirtazapine and agreed to outpatient mental health appointments with a social worker

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<sup>12</sup> The primary suicide risk screen score classifies symptoms in the following categories: minimal, mild, moderate, moderately severe, and severe depressive.

on day 6, a nurse on day 8, 2020, and a psychiatrist on day 19.<sup>13</sup> Immediately prior to discharge, the patient told a nurse, “I need to leave, this place is not for me, I’m not a meth head, but they already made up their minds.” At approximately 1:10 p.m., staff escorted the patient out of the unit.

The patient did not present for the day 6 appointment with the outpatient social worker. That same day, a nurse telephoned the patient for post-discharge follow-up, was unable to reach the patient, and left a message. On day 7, the nurse telephoned the patient’s number for another post-discharge follow-up call, and the patient’s family member answered and reported that the patient had died by suicide. The inpatient social worker and nursing supervisor called the patient’s family member who reported that the patient died by suicide using a gun. The family member stated, “I did not know [the patient] had a gun.”

The coroner investigator determined that the patient and family member returned home from the facility at approximately 2:45 p.m. on day 4, the day of discharge, and at approximately 3:15 p.m., the family member “heard a loud bang” and later discovered the patient “with a gun” and “blood about the face/head.”

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<sup>13</sup> The social worker’s and psychiatrist’s appointments were by telephone and the nurse’s appointment was through VA Video Connect, a live video through an internet connection. VA, *VA Video Connect*, accessed December 2, 2020, <https://mobile.va.gov/app/va-video-connect>.

## Inspection Results

### 1. Patient's Death by Suicide on Day of Discharge

The OIG substantiated that the patient died by suicide the same day as discharge from the facility's Inpatient Mental Health Unit. The coroner investigator pronounced the patient dead approximately three and a half hours after the patient and family member returned home from the facility. The medical examiner determined the patient's cause of death as "Gunshot wound of the head" and the manner of death as suicide.

The OIG identified deficiencies in the patient's outpatient and inpatient mental health care that may have contributed to the patient's death by suicide. The OIG found deficiencies in facility staff's completion of required suicide risk evaluation and monitoring, inadequate consideration of a high risk for suicide patient record flag, and inadequate substance use disorder evaluation and referral.<sup>14</sup> Additionally, the OIG found a failure to reconcile critical clinical treatment and discharge plan information, deficiencies in MHTC assignment processes and care coordination, and ineffective responses to the patient's complaints and requests.

#### Deficient Suicide Risk Evaluation and Monitoring

The OIG found that facility staff did not complete the patient's suicide risk evaluations as required by VHA. Two outpatient mental health staff members did not complete required comprehensive evaluations at the time of the patient's early summer and late summer 2019 visits.<sup>15</sup> Outpatient mental health staff did not follow up with the patient to address incomplete comprehensive evaluations. Additionally, the geriatric psychiatrist did not conduct a required secondary suicide risk screen or comprehensive evaluation and completed a safety plan with the patient that included multiple non-sensical word fragments. Further, a comprehensive evaluation completed in the Emergency Department was incomplete, and staff did not complete another comprehensive evaluation with the patient until approximately one hour prior to the patient's Inpatient Mental Health Unit discharge.

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<sup>14</sup> Deputy Under Secretary for Health for Operations and Management Memorandum, *Eliminating Veteran Suicide: Implementation of Suicide Risk Screening and Evaluation*, November 2, 2018. This memorandum was in effect during the timeframe of the events discussed in this report; it was updated and superseded by Deputy Under Secretary for Health for Operations and Management Memorandum, *Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy)*, November 13, 2020.

<sup>15</sup> Deputy Under Secretary for Health for Operations and Management Memorandum, *Eliminating Veteran Suicide Implementation of Suicide Risk Screening and Evaluation*, November 2, 2018. This memorandum was in effect during the timeframe of the events discussed in this report; it was updated and superseded by Deputy Under Secretary for Health for Operations and Management Memorandum, *Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy)*, November 13, 2020.

## *Suicide Risk Assessment*

In May 2018, VHA introduced a standardized three-stage suicide risk screening and assessment process that included a primary suicide risk screen, secondary suicide risk screen, and a comprehensive suicide risk evaluation (comprehensive evaluation).<sup>16</sup> A primary suicide risk screen was positive when a patient acknowledges being “bothered by thoughts” of being better off dead or of hurting themselves over the past two weeks. A positive primary suicide risk screen required staff to complete the secondary suicide risk screen that included more specific questions about the patient’s past preparatory or suicidal behavior, current intent, and thoughts of a method and plan. A positive secondary suicide risk screen prompted the comprehensive evaluation that asked more detailed information about the patient’s suicidal ideation, previous suicide attempts, warning signs, risk factors, protective factors, clinical impression of acute and chronic risk, and required the provider to establish a plan to mitigate risk, per The Joint Commission suicide risk-screening criteria.<sup>17</sup>

VHA designated which staff could have completed each screen. Generally, a broad range of licensed and unlicensed staff could have completed the primary suicide risk screen, licensed

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<sup>16</sup> Deputy Under Secretary for Health for Operations and Management, *Suicide Risk Screening and Assessment Requirements*, May 23, 2018; Deputy Under Secretary for Health for Operations and Management, *Suicide Risk Screening and Assessment Requirements – Attachment B*, May 23, 2018. This memorandum was in effect during the timeframe of the events discussed in this report; it was updated and superseded by Deputy Under Secretary for Health for Operations and Management Memorandum, *Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy)*, November 13, 2020. The new memorandum refers to a comprehensive evaluation rather than comprehensive assessment and changed the suicide risk screening and evaluation requirement to a two-stage process, eliminating the primary screen.

<sup>17</sup> Deputy Under Secretary for Health for Operations and Management, *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. The Joint Commission, *National Patient Safety Goal for Suicide Prevention*, November 27, 2018, updated November 20, 2019, accessed December 11, 2020, [https://www.jointcommission.org/-/media/tjc/documents/standards/r3-reports/r3\\_18\\_suicide\\_prevention\\_hap\\_bhc\\_cah\\_11\\_4\\_19\\_final1.pdf](https://www.jointcommission.org/-/media/tjc/documents/standards/r3-reports/r3_18_suicide_prevention_hap_bhc_cah_11_4_19_final1.pdf). The comprehensive evaluation uses an evidence-based approach for patients who screen positive for suicidal ideation or exhibit suicidal behavior including directly asking the patient about suicidal ideation, plan, intent, behaviors, risk factors, protective factors, assessing level of risk, developing a mitigation plan, using a classification system of low, intermediate, and high acute and chronic suicide risk.

clinicians could have completed the secondary suicide risk screen, and a healthcare provider must have completed the comprehensive evaluation.<sup>18</sup>

### *Outpatient Mental Health Settings*

In outpatient mental health settings, VHA required that staff complete the secondary suicide risk screen for all patients during intake evaluations and at least annually. VHA Office of Mental Health and Suicide Prevention leaders reported to the OIG that facility leaders were responsible for ensuring adherence to VHA suicide risk-screening requirements. Since October 2018, the Office of Mental Health and Suicide Prevention has tracked completion of comprehensive evaluations in ambulatory settings and shared deficiency reports with VISN and facility staff for quality oversight and improved implementation. Facility staff were responsible for following up with suicide risk-screening deficiencies. Staff follow-up may have included addressing trends that emerge, including repeated suicide risk-screening deficiencies by an individual staff member or for a particular patient. Facility leaders were responsible for utilizing local processes to ensure resolution of suicide risk-screening deficiencies.

The Chief of Behavioral Health told the OIG that facility leaders notified supervisors when staff members failed to complete suicide risk screens as required.<sup>19</sup> The Chief of Behavioral Health reported the expectation that supervisors educated staff with deficiencies about timely suicide risk screening completion and that staff should have contacted patients to attempt completion of the deficient suicide risk screening and document in the EHR if completed. The Chief of Behavioral Health reported the inability to obtain historical reports to determine whether the patient's comprehensive evaluations were identified as deficient. VHA Office of Mental Health and Suicide Prevention leaders reported to the OIG that deficiencies in the completion of the comprehensive evaluation were reported on a dashboard that included only information for the preceding two-week period, and not aggregate (historical) data.

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<sup>18</sup> Deputy Under Secretary for Health for Operations and Management Memorandum, *Suicide Risk Screening and Assessment Requirements*, May 23, 2018. Deputy Under Secretary for Health for Operations and Management Memorandum, *Suicide Risk Screening and Assessment Requirements – Attachment B*, May 23, 2018. This memorandum was in effect during the timeframe of the events discussed in this report; it was updated and superseded by Deputy Under Secretary for Health for Operations and Management Memorandum, *Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy)*, November 13, 2020. Department of Veterans Affairs (VA) *Suicide Risk Identification Strategy Staff Specific Guidance*, April 2, 2019. VHA allowed select non-independent practitioners including addiction therapists, registered nurses, and rehabilitation counselors to complete the secondary suicide risk screen. VHA allowed only licensed independent or advanced practice providers to complete the comprehensive evaluation, defined by VHA to include: physicians, licensed psychologists, clinical pharmacy specialists, licensed social workers, licensed mental health counselors, physician assistants, and advanced practice registered nurse.

<sup>19</sup> Facility staff provided multiple titles for this role, including Chief of Behavioral Health, Associate Chief of Staff for Behavioral Health, and Associate Chief of Staff, Behavioral Health Service. For purposes of this report, the OIG uses the title Chief of Behavioral Health.

### *Deficiencies in the Patient's Outpatient Suicide Risk Assessment*

In summer 2019, the patient presented to the outpatient mental health clinic. A nurse completed a primary and secondary suicide risk screen, both with positive results. The nurse notified a physician assistant of the positive secondary screen, and also included the physician assistant as an additional signer to a progress note containing the positive result. Approximately 30 minutes later, the physician assistant signed the nurse's progress note and documented "Safety plan in place as well as suicide risk evaluation done [one month prior]." The physician assistant did not complete a comprehensive evaluation.

In mid-July, the geriatric psychiatrist completed a primary screen, and the patient acknowledged thoughts of being better off dead or engaging in self-harm on several days of the previous two weeks. The geriatric psychiatrist did not conduct a secondary screen or comprehensive evaluation and completed a safety plan with the patient that included multiple non-sensical word fragments. For example, in response to the templated "Ways to make my environment safer and barriers I will use to protect myself from these potentially lethal means," the geriatric psychiatrist documented, "[the patient] has a thinking very seriously room so [the patient will] E Logan he cut treatable gun anything else to get get to resolve [*sic*]." The geriatric psychiatrist documented providing the patient with a copy of the safety plan.<sup>20</sup>

In summer 2019, the patient returned to the outpatient mental health clinic and screened positive on the primary and secondary screens. The nurse documented notifying a nurse practitioner of the positive secondary screen, but did not sign the note containing the positive secondary screen result until the following day, and included the nurse practitioner as an additional signer to the note. The nurse practitioner saw the patient the same day but did not complete a comprehensive evaluation and signed the nurse's progress note six days later. When interviewed by the OIG, the nurse practitioner suggested that the comprehensive evaluation may not have been completed because the nurse did not report the patient's positive secondary screen. The nurse practitioner did not recall receiving a subsequent notification that the patient was identified in the comprehensive evaluation deficiency report.

The OIG found that in early summer and late summer 2019, outpatient mental health providers did not complete comprehensive evaluations with the patient following positive secondary suicide risk screens, as required by VHA.<sup>21</sup> Staff's failure to complete required comprehensive evaluations may have hindered identification of critical or new information regarding the

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<sup>20</sup> An administrative staff member in the Office of the Director told the OIG that the geriatric psychiatrist retired in February 2020; therefore, the OIG was unable to speak with the provider to clarify why this occurred.

<sup>21</sup> Deputy Under Secretary for Health for Operations and Management Memorandum, *Eliminating Veteran Suicide Implementation of Suicide Risk Screening and Evaluation*, November 2, 2018. This memorandum was in effect during the timeframe of the events discussed in this report; it was updated and superseded by Deputy Under Secretary for Health for Operations and Management Memorandum, *Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy)*, November 13, 2020.

patient's suicide risk, including warning signs and risk factors. Further, given that a comprehensive evaluation requires a plan to mitigate risk, staff also failed to identify and reinforce the patient's coping strategies and protective factors. Additionally, the OIG found a safety plan reportedly provided to the patient to be unusable due to incomprehensible entries.

### *Deficiencies in the Patient's Inpatient Suicide Risk Assessment*

When same day completion of the comprehensive evaluation is not feasible or clinically appropriate, the comprehensive evaluation must be completed within 24 hours of the positive secondary suicide risk screen.<sup>22</sup> VHA policy specified that inpatient mental health staff were to complete a patient's suicide risk screening and assessment within 24 hours after admission and before discharge.<sup>23</sup> In June 2020, VHA issued additional guidance that when a patient is unable to participate in the comprehensive evaluation due to factors such as agitation, intoxication, or cognitive impairment, staff members are required to complete another comprehensive evaluation based on observation and objective data at a later time the same day.<sup>24</sup> Facility policy also required that staff enter pertinent documentation on the same day as the patient encounter.<sup>25</sup>

On day 1, the patient's secondary suicide risk screen was positive and an Emergency Department social worker completed a comprehensive evaluation. The social worker documented that the patient's suicidal ideation and suicidal behavior was "unknown or unclear" due to the patient's altered mental status. The social worker told the OIG that the patient was disoriented and struggled to answer questions. The social worker entered the comprehensive evaluation in the EHR the following day, approximately 16 hours after assessing the patient, precluding other staff from viewing the information until approximately 3:00 p.m. on day 2. The social worker told the OIG that the patient presented near shift end.

When the patient was transferred to the Inpatient Acute Medical Unit the next day, a nurse completed a primary suicide risk screen that was positive and a secondary screen that was

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<sup>22</sup> 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.

<sup>23</sup> Deputy Under Secretary for Health for Operations and Management, *Suicide Risk Screening and Assessment Requirements – Attachment B*, May 23, 2018. This memorandum was in effect during the timeframe of the events discussed in this report; it was updated and superseded by Deputy Under Secretary for Health for Operations and Management Memorandum, *Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy)*, November 13, 2020.

<sup>24</sup> VHA Guidance, *What to do if a Veteran is unwilling or unable to complete the VA Comprehensive Suicide Risk Evaluation*, June 16, 2020. The VHA guidance was issued after the patient's Inpatient Mental Health Unit admission and subsequent death.

<sup>25</sup> Facility Memorandum 136-19-22, *Health Records*, August 2019. This facility memorandum was in effect at the time of the events discussed above until it was rescinded on July 15, 2020. The new policy included similar language regarding the requirement that staff enter pertinent documentation on the same day as the patient encounter.

negative. The following day, upon the patient's transfer to the Inpatient Mental Health Unit, a nurse completed a primary screen that was positive but did not complete the secondary suicide risk screen. When interviewed by the OIG, the nurse reported possibly not completing the suicide risk screen because it was completed in the Emergency Department. The Nurse Executive told the OIG that the nurse should have completed the secondary suicide risk screen.

On the day of the patient's discharge, an inpatient mental health psychologist completed a primary suicide risk screen that was positive. Later that day, approximately 40 minutes prior to the patient's discharge, an inpatient social worker completed the secondary screen with a negative result. The inpatient social worker also completed a comprehensive evaluation that indicated intermediate acute and chronic risk for suicide. The inpatient social worker noted that the patient had "[suicidal ideation] since 70's but no attempts, has protective factors in place."

The OIG found that the comprehensive evaluation completed in the Emergency Department was incomplete, with "[altered mental status]" documented for most responses due to the patient's inability to participate.<sup>26</sup> Neither Inpatient Acute Medical Unit nor Inpatient Mental Health Unit staff completed another comprehensive evaluation with the patient until approximately one hour prior to the patient's discharge. The failure to obtain comprehensive evaluation information may have contributed to an incomplete understanding of the patient's risk factors including access to lethal means, and thereby limited the effectiveness of the patient's discharge plan.

### **Inadequate Consideration of High Risk for Suicide Patient Record Flag Assignment**

The OIG found that on the day of the patient's Inpatient Mental Health Unit discharge, the suicide prevention team did not assign the patient a high risk for suicide patient record flag, in spite of the patient's documented current psychosocial stressors and history of suicide behaviors.<sup>27</sup> Additionally, the suicide prevention team did not consult with the Inpatient Mental Health Unit treatment team as part of a consideration of assigning the patient a high risk for suicide patient record flag, as required.<sup>28</sup>

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<sup>26</sup> Facility staff conducted an internal review of the patient's care and as a result, provided Emergency Department and Inpatient Mental Health Unit social workers comprehensive evaluation trainings in July 2020. The Suicide Prevention Coordinator Supervisor also conducted an audit from July to November 2020 that did not reach a goal of 90 percent of comprehensive evaluations captured in detail. In December 2020, the audit was extended for an additional three months or until the 90 percent metric was reached.

<sup>27</sup> VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008. The primary purpose of the high risk for suicide patient record flag is to communicate to staff that a patient is at high risk for suicide and to include consideration of the risk in treatment decisions.

<sup>28</sup> VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008.

VHA requires that facility directors ensure a process to request, assign, and review patient record flags for patients at high risk for suicide.<sup>29</sup> Suicide prevention coordinators are required to assess a patient's risk of suicide "in conjunction with treating clinicians" and work "with clinicians, who refer potential high risk patients for flagging, to determine the advisability of the flag."<sup>30</sup> Facility policy requires that the suicide prevention team notifies the Inpatient Mental Health Unit treatment team when a high risk for suicide patient record flag has been placed for a patient on the Inpatient Mental Health Unit.<sup>31</sup> Facility policy also states that patients experiencing an active crisis with a history of suicide attempts or behaviors meet general criteria for inclusion on the high risk for suicide patient record flag list.<sup>32</sup> According to the Centers for Disease Control and Prevention, a combination of factors contribute to the risk of suicide, including family history of suicide; history of mental disorders, particularly clinical depression; history of substance abuse; barriers to accessing mental health treatment; loss, including relational or financial; and physical illness.<sup>33</sup>

On day 1, the Emergency Department social worker included "Alert Suicide Prevention Coordinator for consideration of a Patient Record Flag Category I High Risk for Suicide" as part of the patient's suicide risk mitigation plan. The Emergency Department social worker reported adding the EHR alert due to the patient's strained relationship with a family member and recent death of another family member and reported the expectation that the suicide prevention team would be notified as a result. When interviewed by the OIG, the Suicide Prevention Coordinator Supervisor reported the understanding that the Emergency Department social worker's documentation would not have alerted the suicide prevention team, and that the team reviewed the patient's EHR as a routine practice to consider all patients admitted to the Inpatient Mental Health Unit for a high risk for suicide patient record flag.

On day 3, the admitting inpatient mental health nurse documented that the patient's past suicide behavior included, "13-14 years ago, sleep [sic] one day in the car with my gun, ended up at the VA" and "from my window, saw a chef knife and a heater from my bathroom."<sup>34</sup> The admitting nurse practitioner also documented that two of the patient's family members died by suicide, one

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<sup>29</sup> VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008.

<sup>30</sup> VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008.

<sup>31</sup> VA Deputy Under Secretary for Health for Operations and Management Memorandum, *Standardized Suicide Nomenclature (Self-Directed Violence Classification System)*, April 19, 2010. Facility Standard Operating Procedure 116-14, *Suicide Prevention Daily Operations*, October 2019.

<sup>32</sup> Facility Standard Operating Procedure 116-14, *Suicide Prevention Daily Operations*, October 2019.

<sup>33</sup> Centers for Disease Control and Prevention, *Risk Factors for Suicide*, accessed October 18, 2020, <https://www.cdc.gov/violenceprevention/suicide/riskprotectivefactors.html>.

<sup>34</sup> A previous outpatient psychiatrist documented in the EHR that the patient considered sticking the knife into the electric heater.

of whom had a suicide pact 11 years prior with the patient. That same day, the inpatient social worker also added the Suicide Prevention Coordinator Supervisor to the patient's treatment plan as an additional signer.<sup>35</sup>

On day 4, a Suicide Prevention Coordinator documented,

After chart review and team consultation, it was decided to not flag this Veteran's chart as High Risk for Suicide. This flag is reserved for veterans who are high risk for suicide. Based on medical record documentation including notes from ER [emergency room] and inpatient providers, Veteran reports chronic suicidal ideation with no plan or intent. [Self-directed Violence] classification is Suicidal Ideation without Suicidal Intent. It appears Veteran is at Intermediate Acute Risk and Intermediate Chronic Risk.

The Suicide Prevention Coordinator told the OIG that the suicide prevention team did not meet with the patient on the Inpatient Mental Health Unit due to COVID-19 precautions, and based the flag determination on a suicide prevention team review, the VHA Suicide Prevention Manual, self-directed violence classifications, and clinical judgment.<sup>36</sup> The Suicide Prevention Coordinator also told the OIG that the suicide prevention team did not consult the with Inpatient Mental Health Unit treatment team regarding the patient's flag determination because the suicide prevention team did not think it was needed. The Suicide Prevention Coordinator was unable to definitively say whether or not the suicide prevention team reviewed the outpatient documentation in the patient's EHR. The outpatient documentation would have provided information related to the patient's difficulties and frustrations with outpatient mental health prescribers.

Two suicide prevention team members who participated in the review and determination not to place a high risk for suicide patient record flag for the patient told the OIG that the team was aware of a number of risk factors and recent crises that the patient was experiencing, including a positive drug screen result, memory loss, financial problems, and the recent death of a family member. The Suicide Prevention Coordinator told the OIG that a high risk for suicide patient record flag was not placed because the patient's EHR indicated that the patient had suicidal

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<sup>35</sup> Facility staff provided multiple titles for this role, including Suicide Prevention Program Manager, Suicide Prevention Coordinator Supervisor, Suicide Prevention Case Manager, and Suicide Prevention Coordinator. For purposes of this report, the OIG uses the title Suicide Prevention Coordinator Supervisor.

<sup>36</sup> VHA Manual, VA's Integrated Approach to Suicide Prevention: Ready Access to Quality Care, Suicide Prevention Coordinator Guide, June 19, 2015. VA Deputy Under Secretary for Health Operations and Management, Standardized Suicide Nomenclature (Self-Directed Violence Classification System), April 19, 2010. VHA requires that suicide prevention coordinators use a self-directed violence classification system, adopted from the Centers for Disease Control and Prevention, for improved communication among staff regarding risk levels and for specific recommendations for care at each point of classification.

ideation for a number of years without any attempt, the patient reported suicide behaviors occurred 13–14 years ago, and the patient denied current suicide plan or intent.<sup>37</sup>

The OIG found that the suicide prevention team did not communicate with Inpatient Mental Health Unit staff as required to inform the flag determination.<sup>38</sup> Further, despite awareness of the patient’s history of suicide behavior, recent crisis, and multiple risk factors for suicide, the suicide prevention team did not place a high risk for suicide patient record flag for the patient. Based on facility policy, the OIG would have expected that the suicide prevention team place a high risk for suicide patient record flag due to the patient’s active crisis and history of suicide behaviors.<sup>39</sup> Initiation of a high risk for suicide patient record flag would have included notification to Inpatient Mental Health Unit staff and may have affected treatment decisions, including the decision to discharge the patient from a brief, less than 24-hour, Inpatient Mental Health Unit admission.

### **Inadequate Substance Use Disorder Evaluation and Referral**

The OIG found that during the patient’s admission to the Inpatient Mental Health Unit, staff did not complete an adequate assessment of the patient’s substance use or consider treatment options tailored to the patient’s needs.

The Mayo Clinic advises that preliminary urine drug screens are presumptive only and a confirmatory drug screen is required before treatment decisions can be made on the basis of urine drug screens.<sup>40</sup> VHA requires assessment of patients with a positive drug screen or an indication of a substance use problem to determine the level of misuse and establish a diagnosis.<sup>41</sup> Patients in mental health settings may benefit from involvement of specialized program staff to assess and treat substance use disorders.<sup>42</sup>

Research on the transtheoretical model of addiction, also called stages of change, indicates that individuals in a pre-contemplative stage are typically unaware of and do not consider addictive

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<sup>37</sup> Facility staff provided multiple titles for this staff member, including Senior Social Worker, Social Worker Suicide Prevention, and Suicide Prevention Coordinator. For purposes of this report, the OIG used the title Suicide Prevention Coordinator.

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

<sup>39</sup> Facility Standard Operating Procedure 116-14, *Suicide Prevention Daily Operations*, October 2019.

<sup>40</sup> Karen Moeller, Kelly Lee, and Julie Kissack, “Urine Drug Screening: Practical Guide for Clinicians,” *Mayo Clinic Proceedings* 83, no. 1 (January 2008): 66-76.

<sup>41</sup> VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015.

<sup>42</sup> VHA Handbook 1160.04, *VHA Programs for Veterans with Substance Use Disorders (SUD)*, March 7, 2012.

behavior as a problem, although others readily identify the behaviors as destructive.<sup>43</sup> Individuals in pre-contemplative stage often reject advice for treatment or changes in behavior.<sup>44</sup>

Motivational interviewing is a technique used to strengthen the therapeutic relationship and should emphasize future treatment options for patients currently unwilling to engage in addictions-focused care.<sup>45</sup> VHA requires that substance use disorder assessment and treatment includes evidence-based psychotherapies, including motivational interviewing.<sup>46</sup>

On day 1, the patient denied amphetamine or benzodiazepine use when the inpatient medicine physician asked about the positive drug screen. The inpatient medicine physician ordered a psychiatry consult that an advance practice registered nurse conducted by telephone on day 2.<sup>47</sup> The advance practice nurse erroneously documented that the patient's drug screen was positive for methamphetamines, rather than amphetamines. The advance practice registered nurse also documented that the patient denied any drug use and included in the diagnoses for the patient, "[Rule-out] stimulant-induced mood [disorder]; Amphetamine use unspecified; Anxiolytic use unspecified."

When interviewed by the OIG, the advance practice registered nurse explained that verifying with the Prescription Monitoring Program confirmed that the patient's positive drug screen was not related to prescribed medications. However, the advance practice registered nurse acknowledged that methylphenidate, a medication previously prescribed to the patient, could result in a positive drug screen result for amphetamines.<sup>48</sup> The OIG found that Inpatient Mental Health Unit staff did not order laboratory tests to identify specific substances, such as illicit or prescribed medications, likely due to staff's diagnostic impression that the patient was abusing substances. The OIG would have expected Inpatient Mental Health Unit staff to pursue a

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<sup>43</sup> Jonathan Shaffer, "Stages-of-Change Model," in Marc Gellman and Rick Turner, *Encyclopedia of Behavioral Medicine*, (2013), accessed January 26, 2020, [https://doi.org/10.1007/978-1-4419-1005-9\\_1180](https://doi.org/10.1007/978-1-4419-1005-9_1180). The stages of change model is a framework that describes five phases, pre-contemplation, contemplation, preparation, action, and maintenance, that a patient may progress through when changing a behavior. The model includes assessment of a patient's readiness to change a behavior and includes strategies to guide the patient through the stages to facilitate change.

<sup>44</sup> Jonathan Shaffer, "Stages-of-Change Model," in Marc Gellman and Rick Turner, *Encyclopedia of Behavioral Medicine*, (2013), accessed January 26, 2020, [https://doi.org/10.1007/978-1-4419-1005-9\\_1180](https://doi.org/10.1007/978-1-4419-1005-9_1180).

<sup>45</sup> VA/Department of Defense, Clinical Practice Guideline for the Management of Substance Use Disorders, 2015.

<sup>46</sup> VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013. VHA Office of Mental Health and Suicide Prevention, *Motivational Interviewing Fact Sheet for Providers*, accessed October 17, 2020, [https://dvagov.sharepoint.com/sites/VACOMentalHealth/MI/Publications/MI\\_Factsheet\\_for\\_Providers.pdf](https://dvagov.sharepoint.com/sites/VACOMentalHealth/MI/Publications/MI_Factsheet_for_Providers.pdf). Motivational Interviewing is a practice employed when a veteran is ambivalent about making a change in behavior, such as addressing substance use disorders.

<sup>47</sup> The advance practice registered nurse told the OIG that the consult was conducted by telephone due to COVID-19 precautions.

<sup>48</sup> VA staff last prescribed the patient methylphenidate in September 2019. The OIG could not determine if the patient may have been in possession of remaining medication that could have affected the drug screen result.

confirmatory drug screen to inform decisions regarding recommendations for the patient's substance use disorder diagnosis and treatment.

On day 3, the admitting nurse practitioner documented "Illicit Drug Use: Yes current user: MildAmphetamine [*sic*]" and the family member's suspicions about the patient's substance use. When interviewed by the OIG, the admitting nurse practitioner reported that the assessment was based on the patient's drug screen and the family member's concerns.

On day 4, the day of discharge, a psychologist attended the patient's interdisciplinary treatment team meeting and documented that the patient was "not considered a candidate" for residential substance use disorder treatment based on the patient's denial of illicit drug use. That same day, another inpatient mental health nurse practitioner discharged the patient and included in the diagnoses, "Stimulant Use Disorder, methamphetamine subtype, unspecified; Anxiolytic Use Disorder, unspecified; and [Rule-out] Substance induced (methamphetamine) mood disorder." The discharging nurse practitioner told the OIG that the diagnoses were based on the patient's drug screen result and family member's report. In addition to not performing confirmatory laboratory testing, the OIG found that the admitting nurse practitioner and discharging nurse practitioner did not do a formal substance use disorder assessment, but rather relied on the family member's report to support the substance use diagnosis.<sup>49</sup>

The admitting nurse practitioner told the OIG that the patient should have had an alcohol and drug treatment program consult placed prior to discharge; however, one was not placed. The discharging nurse practitioner reported not placing a consult to outpatient substance abuse treatment because the patient was denying substance use. The inpatient social worker who evaluated the patient at discharge also told the OIG that substance use disorder assessment or treatment options outside of residential treatment were not considered due to the patient denying substance use.

The psychologist told the OIG that when a patient declined substance use disorder treatment in a treatment team setting, Inpatient Mental Health Unit staff typically place a consult for the psychologist to individually assess the patient, identify "stages of change," provide "a non-shaming environment," and engage the patient in the most suitable level of substance use disorder treatment. The psychologist told the OIG that an individual assessment of the patient's substance use was not completed because the patient denied use, became upset, and felt "treated like a subhuman" when residential or outpatient substance use disorder treatment options were discussed.

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<sup>49</sup> American Psychiatric Association, *From Planning to Publication: Developing DSM-5*, accessed October 18, 2020, [https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/DSM/APA\\_DSM-Development-of-DSM-5.pdf](https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/DSM/APA_DSM-Development-of-DSM-5.pdf). The Diagnostic and Statistical Manual of Mental Disorders (DSM) is a manual used by clinicians to accurately and consistently diagnose psychiatric disorders, including substance use disorders. DSM-5 is the most current version of the manual.

The OIG found that staff did not order confirmatory laboratory testing to identify the specific substance resulting in the patient's positive amphetamine drug screen, as the OIG would have expected.<sup>50</sup> Further, the OIG found that Inpatient Mental Health Unit staff did not request a formal or individualized substance use disorder assessment for the patient.<sup>51</sup> The absence of the individual assessment may have contributed to staff's failure to enhance the patient's readiness to engage in evidence-based substance use disorder treatment consistent with the patient's needs at the time.

## **Failure to Reconcile Critical Clinical Information**

The OIG found that Inpatient Mental Health Unit staff did not review or incorporate relevant outpatient mental health history into the patient's treatment plan and adequately address the patient's change in demeanor and concerning statements.

### *Inadequate Outpatient History Review*

The American Psychiatric Association recommends that the initial psychiatric evaluation of a patient include review of past psychiatric history, diagnoses, and treatments, including the patient's adherence and response.<sup>52</sup> Additionally, the American Psychiatric Association suggests that a staff member gain or corroborate information from prior medical records and other treating clinicians.<sup>53</sup>

The patient had a documented history of mental health care and diagnosis of [treatment-resistant depression](#) at the California VA facility, accessible to facility staff through the EHR. The patient's EHR included documentation of the patient's recent difficulty engaging with outpatient mental health prescribers at the facility and frustrations regarding denied requests for the previously prescribed methylphenidate. The inpatient social worker told the OIG that the patient's brief admission did not allow time to review the patient's outpatient mental health treatment history. When interviewed by the OIG, the discharging nurse practitioner also acknowledged having not reviewed the patient's outpatient mental health history. The discharging nurse practitioner told the OIG that additional information on the patient was not obtained due to seeing the patient for only a few hours and the patient requesting to leave. The Facility Director, Chief of Staff, and Inpatient Mental Health Unit Supervisor told the OIG that the expectation of Inpatient Mental Health Unit staff is to review past care.

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<sup>50</sup> Karen Moeller, Kelly Lee, and Julie Kissack, "Urine Drug Screening: Practical Guide for Clinicians," *Mayo Clinic Proceedings* 83, no. 1 (January 2008): 66-76.

<sup>51</sup> VA/Department of Defense, Clinical Practice Guideline for the Management of Substance Use Disorders, 2015.

<sup>52</sup> The American Psychiatric Association, "Practice Guidelines for the Psychiatric Evaluation of Adults," third edition, 2016, accessed December 7, 2020, <https://psychiatryonline.org/doi/pdf/10.1176/appi.books.9780890426760>.

<sup>53</sup> The American Psychiatric Association, "Practice Guidelines for the Psychiatric Evaluation of Adults," third edition, 2016, accessed December 7, 2020, <https://psychiatryonline.org/doi/pdf/10.1176/appi.books.9780890426760>.

The OIG found that Inpatient Mental Health Unit staff did not review the patient's outpatient mental health history reportedly because of the patient's short admission time. The Inpatient Mental Health Unit staff's failure to review the patient's outpatient mental health treatment history may have contributed to the decision to discharge that patient without addressing the patient's challenges in engaging in outpatient mental health care.

### *Inadequate Assessment of Changed Demeanor*

VHA requires that the configuration of an Inpatient Mental Health Unit promotes interaction between staff and patients to allow staff's identification and early intervention of changes in patient behavior.<sup>54</sup> Staff are required to monitor patients for changes in clinical condition that would warrant transition from a voluntary to involuntary admission.<sup>55</sup> The Joint Commission standards instruct organizations to reassess individuals served, as needed, to evaluate the patient's response to care and respond to a significant change in condition.<sup>56</sup>

On day 3, the admitting nurse practitioner documented that the patient's family member reported receiving a text from the patient the previous day that stated, "maybe I should just die." The nurse practitioner documented that the patient's family member would like the patient "to remain inpatient if possible and get treatment for [methamphetamine] use." When interviewed by the OIG, the patient's family member reported telling Inpatient Mental Health Unit staff about the patient's text and requesting that the patient remain admitted after the Inpatient Mental Health Unit staff reported a plan to discharge the patient the following day.

On day 4, the Inpatient Mental Health Unit interdisciplinary team met with the patient who continued to express a desire to be discharged and agreed to allow the team to contact the family member for collateral information. During a phone call to the patient's family member, the patient learned about not being able to return to live with the family member due to the patient not admitting to substance use. The patient then stated, "My whole world has ended." The inpatient social worker told the OIG that after the patient made the statement, the inpatient social worker, inpatient mental health nurse, and discharging nurse practitioner met with the patient. The inpatient social worker reported asking the patient to remain on the unit, asking the patient again about suicide intent that the patient denied, and expressing concern about the patient's depression. The inpatient social worker reported not considering an involuntary hold of the

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<sup>54</sup> VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013.

<sup>55</sup> VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013; Facility Memorandum 116-19-09, *Emergency Psychiatric Evaluation – Legal 2000 Revised Hold (L2000R)*, April 2019. Staff are required to follow Nevada State Law when determining a patient's admission status. Nevada Statute 433A, *Admission to Mental Health Facilities or Programs of Community-Based or Outpatient Services*, May 15, 2019.

<sup>56</sup> The Joint Commission Standard 02.02.07, Behavioral Health and Human Services, Care, Treatment, and Services, Effective March 15, 2020; The Joint Commission Standard 03.01.03, Behavioral Health and Human Services, Care, Treatment, and Services, Effective March 15, 2020.

patient because of the patient's long history of chronic suicidal ideation, denial of suicidal intent, and the treatment team's recommendation for discharge.

The inpatient social worker updated the comprehensive evaluation and documented the patient's risk level as "Intermediate ACUTE risk" and "Intermediate CHRONIC risk" based on the patient's reported history of suicidal ideation without attempts and identified protective factors. However, the inpatient social worker also told the OIG that an evaluation of the patient's recent stressors and change in demeanor after arriving to the Inpatient Mental Health Unit was not possible due to the patient's brief length of stay.

Additionally, the inpatient social worker completed the patient's safety plan and documented only the Veterans Crisis Line as the social contact for distraction, and did not identify anyone who could help the patient when in a crisis or with limiting access to lethal means. When interviewed by the OIG, the inpatient social worker reported having reviewed a January 2020 safety plan with the patient and not making changes. The inpatient social worker reported uncertainty about the patient's clinical changes over the preceding three months that might have warranted a discussion with the patient to update the safety plan. The inpatient social worker acknowledged that a more thorough safety plan could have been completed. Further, the OIG found that the inpatient social worker who documented the patient's early 2020 safety plan had duplicated the patient's summer 2019 safety plan and did not make any changes. As such, the patient's discharge safety plan had not been modified for approximately eight months in spite of significant life changes including death of a family member, worsening depression, poor engagement with outpatient mental health treatment, Inpatient Mental Health Unit admission, and loss of a place to live.

When interviewed by the OIG, the discharging nurse practitioner reported involvement in the patient's care for only a few hours prior to discharge, and noted that if the patient had been admitted for a longer period, the discharging nurse practitioner would have asked the patient more questions. The discharging nurse practitioner also told the OIG that the morning of discharge, the treatment team decided to discharge the patient and during a subsequent phone call, the patient's family member was concerned only about the patient's substance use, not the patient's suicide risk. The patient's family member told the OIG, however, about notifying Inpatient Mental Health Unit staff about the patient's history, including that two other family members died by suicide, one of whom had a suicide pact with the patient, and that the patient texted on day 2, "maybe I should just die." The family member also reported requesting that the patient remain admitted after Inpatient Mental Health Unit staff reported a plan to discharge the patient the following day.

The discharging nurse practitioner told the OIG that the patient did not meet criteria for involuntary hold because the inpatient mental health treatment team did not find the patient to be a danger to self; the treatment team recommended discharge; and the patient was requesting discharge. Within less than 24 hours of admission, at approximately 1:00 p.m., the patient was

discharged, and the discharging nurse practitioner documented that the patient participated in safety planning and did not meet criteria for involuntary hospitalization. The family member stated that the patient is welcome back into the home after discharge but “if drug use persists [the patient] will not be allowed to live there.” The patient returned to the family member’s home and died by gunshot wound of the head at approximately 3:15 p.m. The coroner listed the manner of death as suicide.

The OIG found that Inpatient Mental Health Unit staff did not adequately assess the patient’s change in demeanor within hours of admission and prior to discharge following the patient’s statement, “My whole world has ended.” The OIG also found that the inpatient social worker did not thoroughly review and update the patient’s safety plan at discharge that had not been modified since summer 2019, approximately eight months earlier, despite the patient experiencing significant psychosocial stressors and worsening depression. The lack of comprehensive assessment of the patient including staff’s failure to review prior mental health treatment and response, and reconciliation of pertinent clinical information related to the patient’s mental health condition may have contributed to Inpatient Mental Health Unit staff rendering treatment and discharge decisions based on incomplete and insufficient information about the patient.

## **Deficiencies in MHTC Assignment Processes and Care Coordination**

As of 2012, VHA requires that staff assign an MHTC early on in a patient’s mental health care, no later than the patient’s third outpatient mental health visit “over the previous 12 months.” The MHTC’s goal is to ensure continuity of care during care transitions, and assist a patient’s engagement in treatment.<sup>57</sup> VHA also requires that each medical center establish a policy that guides identification of the MHTC.<sup>58</sup>

MHTCs are expected to maintain regular contact with the patient as clinically indicated and communicate with the patient about problems or concerns with treatment. The MHTC should be aware of the overall goals of the patient’s mental health treatment to provide an enduring relationship and serves as a point of contact to the patient. VHA guidance states that changes in MHTC assignment “should be minimal and should not occur at every care transition” or “be predicated on administrative or workflow issues.” If changes in MHTC assignment need to

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<sup>57</sup> Deputy Under Secretary for Health for Operations and Management, *Assignment of the Mental Health Treatment Coordinator*, March 26, 2012.

<sup>58</sup> Deputy Under Secretary for Health for Operations and Management, *Assignment of the Mental Health Treatment Coordinator*, March 26, 2012. In 2012, VHA replaced the term Principal Mental Health Provider with Mental Health Treatment Coordinator.

occur, they should be planned in collaboration with the patient. The patient should be able to identify the currently assigned MHTC and have contact information.<sup>59</sup>

The OIG found that facility leaders had not established an MHTC policy, as required by VHA.<sup>60</sup> An outpatient mental health nurse manager who supervised the MHTCs told the OIG that facility leaders were developing an MHTC policy that was not yet approved. Additionally, staff did not assign the patient an MHTC until summer 2019, during the patient's tenth mental health visit and three months after the patient's initiation of care at the facility.<sup>61</sup> Further, staff changed the patient's assigned MHTC three additional times during the next six months, resulting in four MHTCs assigned for the patient during nine months of care.

The OIG found that the assigned MHTCs did not maintain regular contact with the patient as clinically indicated. During the patient's almost 11 months of care at the facility, the patient had contact with only one of the four MHTCs, as a result of the patient's two walk-in visits to the mental health outpatient clinic, and prior to the MHTC's assignment to the patient.<sup>62</sup> Additionally, the OIG did not find evidence in the patient's EHR that the MHTC assignment changes were planned in collaboration with the patient, as required.<sup>63</sup> Further, on three occasions, the patient was reportedly provided safety plans that identified a total of four staff members as the patient's MHTCs, only one of whom was ever assigned to the patient. The other three staff members identified in the patient's safety plans had no previous involvement in the patient's care.

The OIG found that facility leaders had not established an MHTC policy and staff did not assign the patient an MHTC at the beginning of the patient's mental health treatment, as required.<sup>64</sup> Additionally, the OIG found that staff changed the patient's MHTC assignment multiple times and did not find evidence that the assigned MHTCs had regular contact with the patient to support treatment engagement or assist the patient with concerns with care, as discussed below. Further, staff inaccurately informed the patient about the assigned MHTC and that may have

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<sup>59</sup> Deputy Under Secretary for Health for Operations and Management, *Assignment of the Mental Health Treatment Coordinator*, March 26, 2012.

<sup>60</sup> Deputy Under Secretary for Health for Operations and Management, *Assignment of the Mental Health Treatment Coordinator*, March 26, 2012.

<sup>61</sup> For purposes of the OIG report, the MHTC assigned in the EHR templated progress note is referred to as the assigned MHTC, although the formal assignment process was not completed.

<sup>62</sup> Facility Functional Statement, *Behavioral Health Interdisciplinary Program (BHIP) Mental Health Treatment Coordinator (MHTC)*. The facility employs registered nurses to serve as MHTCs in outpatient mental health clinics. The MHTCs also triage patients in the facility mental health walk-in clinics.

<sup>63</sup> Deputy Under Secretary for Health for Operations and Management, *Assignment of the Mental Health Treatment Coordinator*, March 26, 2012.

<sup>64</sup> Deputy Under Secretary for Health for Operations and Management, *Assignment of the Mental Health Treatment Coordinator*, March 26, 2012.

hindered the patient's ability to identify or contact the MHTC for support with concerns with care.

### *Deficiencies in Discharge Care Coordination*

The OIG found that Inpatient Mental Health Unit staff did not coordinate care with the patient's established [outpatient geropsychologist](#) at discharge.

VHA requires that Inpatient Mental Health Unit staff actively involve the program to which the patient is being discharged in the discharge process to facilitate patient engagement and timely follow-up. Additionally, discharge planning must include representation from the outpatient treatment team and direct communication between the patient and the outpatient staff member by in-person, video, or telephone communication.<sup>65</sup>

The patient saw a geropsychologist consistently for a total of nine appointments prior to the inpatient mental health admission. When interviewed by the OIG, the discharging Inpatient Mental Health Unit nurse practitioner reported seeing the patient for a few hours prior to discharge and was unable to speak with the geropsychologist prior to discharging the patient. Additionally, the geropsychologist was not included in the day of discharge interdisciplinary treatment team meeting, although Inpatient Mental Health Unit staff recommended outpatient mental health aftercare following discharge.

When interviewed by the OIG, the geropsychologist denied receiving any notification or contact from Inpatient Mental Health Unit staff related to the patient's admission. The OIG found that the patient's discharge follow-up appointments did not include an appointment with the geropsychologist. Instead, the appointments included an appointment with a psychiatrist with whom the patient had a documented history of expressed concerns related to care. The inpatient mental health psychologist who scheduled the appointments told the OIG that patients are usually asked for a preferred follow-up clinic but could not recall specifics related to the patient.

The OIG found that Inpatient Mental Health Unit staff members did not involve or communicate with the patient's assigned geropsychologist, as required.<sup>66</sup> As a result, information relevant to the patient's care and techniques for engaging the patient in care based on previous mental health treatment were not incorporated into the patient's care or discharge plan.

### **Ineffective Response to the Patient's Complaints and Requests**

The OIG found that leaders and staff did not effectively address the patient's expressed complaints and concerns regarding difficulty obtaining medications, engaging with mental health staff, and preference for a different primary care location.

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<sup>65</sup> VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013.

<sup>66</sup> VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013.

## *Outpatient Medication Management*

Facility policy encourages staff directly involved in patient care to identify and resolve a patient's complaints when possible.<sup>67</sup> When a patient's concerns cannot be resolved at the lowest level to the patient's satisfaction, staff are required to contact an immediate supervisor or a service level patient advocate liaison for assistance.<sup>68</sup>

Beginning in summer 2019, the patient notified facility staff of frustrations with the challenges in obtaining the medication as prescribed by staff at the California VA facility. (Appendix A contains details about the patient's complaints.) One month later, the patient sent a secure message expressing concern related to medications. A registered nurse included the patient's geriatric psychiatrist as an additional signer on the patient's message. Two days later, in another secure message, the patient expressed difficulty engaging with the geriatric psychiatrist in the past, and requested that the registered nurse notify hospital administration of the patient's concerns. The registered nurse added the Chief of Behavioral Health, and a medical support assistant as additional signers to the patient's message.<sup>69</sup>

When interviewed by the OIG, the registered nurse reported rarely adding the Chief of Behavioral Health as additional signer to secure messages but had done so with the intention that the Chief of Behavioral Health or other facility leaders would intervene because the patient was very upset. The registered nurse did not recall receiving a response from the Chief of Behavioral Health or other facility mental health leaders related to the patient's concerns. The registered nurse told the OIG that staff may have tried to contact the patient, because the patient was assigned a different psychiatrist following the messages. However, the registered nurse was unable to provide documentation of outreach to the patient regarding the concerns.

Two weeks after notification of the secure message, the geriatric psychiatrist responded that the "methylphenidate for depression" would be renewed at the appointment scheduled two weeks later. Additionally, the Chief of Behavioral Health did not sign the registered nurse's secure message note regarding the patient's complaint until approximately nine months after it was sent. When interviewed by the OIG, the Chief of Behavioral Health reported not seeing the additional

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<sup>67</sup> Facility Memorandum VE-16-01, *Patient Advocate and Patient Advocate Liaison Program*, November 2016. A complaint is defined as a gap between a patient's expectations and actual service experience. Patients may express complaints verbally or in written form to any staff member.

<sup>68</sup> Facility Memorandum VE-16-01, *Patient Advocate and Patient Advocate Liaison Program*, November 2016.

<sup>69</sup> VA Human Resources Management Letter No. 05-12-03, *Identification of Employees Performing Medical Support Assistant Duties*, March 2, 2012. This letter was in effect at the time of the events discussed above until it was rescinded on January 14, 2020. Medical support assistants are VHA staff members who support direct patient care medical staff by performing a range of administrative and technical duties, including managing clinic schedules.

signer request due to receiving hundreds of EHR alerts and because of a system glitch.<sup>70</sup> The Chief of Behavioral Health told the OIG that it was not typical to get involved in a patient complaint unless a patient's concern is reported to the patient advocate or elevated through a supervisory chain.

When interviewed by the OIG, the outpatient mental health nurse manager who supervised the registered nurse denied being notified of the patient's concerns. The outpatient mental health nurse manager reported the expectation that a staff member serving in the role of MHTC would notify the outpatient mental health nurse manager of a patient's complaints prior to notifying the Chief of Behavioral Health. The Chief of Outpatient Psychiatry was uncertain if facility leaders were aware of the patient's complaints and told the OIG that the Chief of Outpatient Psychiatry role did not exist at the time of the patient's complaint and the position was later developed to address such needs.<sup>71</sup>

In early 2020, the patient sent another secure message to the primary care team that described concerns about not receiving a sleep medication. A primary care nurse care manager advised the patient to contact the geriatric psychiatrist who prescribed the medication. It was not until the patient responded with additional frustration regarding the mental health care received that the primary care nurse care manager informed the patient that an MHTC was notified of the patient's concerns and advised that the patient either attend an upcoming scheduled psychiatry appointment or present as a walk-in to the outpatient mental health clinic to address the medication concern. The patient later canceled the scheduled psychiatry appointment.

The Assistant Chief of Primary Care told the OIG that the expectation would be that a nurse care manager would have reached out to the prescribing provider about the concern and attempted to perform a warm handoff.<sup>72</sup> If the prescribing provider was unavailable, the Assistant Chief of Primary Care reported that the nurse care manager should have alerted the patient's primary care team to help.

The OIG found that facility leaders and staff did not effectively respond to the patient's multiple secure message complaints submitted summer 2019 through early 2020. Further, staff did not contact an immediate supervisor or a service level patient advocate liaison for assistance with addressing the patient's unresolved concerns, as required.<sup>73</sup> The OIG concluded that the

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<sup>70</sup> Clinical applications coordinators told the OIG that facility leaders are assigned as a back-up signer when staff leave the facility, which could result in receiving numerous EHR alerts. The clinical applications coordinators told the OIG that the issue could be resolved by having an automated data processing application coordinator assign a surrogate signer for staff who were no longer employed at the facility.

<sup>71</sup> Facility staff provided multiple titles for this role, including Outpatient Lead Psychiatrist, Chief of Psychiatry, and Chief of Outpatient Psychiatry/Psychiatry Program Manager. For purposes of this report, the OIG uses the title Chief of Outpatient Psychiatry.

<sup>72</sup> Facility Memorandum PS-16-04, *Hand-off Communication*, October 2016. Hand-off communication occurs when patient care is transferred from one care provider to another to ensure that pertinent patient information is relayed.

<sup>73</sup> Facility Memorandum VE-16-01, *Patient Advocate and Patient Advocate Liaison Program*, November 2016.

ineffective response to the patient's complaints likely contributed to the patient's lack of confidence in facility staff, further disengagement from mental health treatment, and subsequent worsening psychiatric condition.

### *Primary Care Clinic Reassignment*

VHA requires that established patients who request to transfer care to a different site within the same facility service area are placed on an electronic waiting list and remain assigned to the current site and provider until capacity is available at the requested location. Once capacity is available, staff are required to remove the patient from the waiting list and schedule an appointment for the patient at the requested location.<sup>74</sup>

In summer 2019, the patient sent a secure message to staff regarding an upcoming primary care appointment and reported having made a request to be transferred to a more convenient primary care location. The primary care nurse care manager replied that the upcoming appointment was with the current primary care provider and advised the patient to keep the appointment if the patient had not received a transfer approval letter.

The OIG found that the patient's request to transfer to a more convenient primary care clinic location was entered into the facility's electronic waiting list in midsummer 2019. In late summer, 2019, staff documented that a voicemail was left for the patient regarding the transfer request.

In early 2020, the patient remained scheduled at the original primary care clinic location and a transfer was not reflected in the patient's appointments. The Assistant Chief of Primary Care told the OIG that the clinic location requested by the patient had a transfer wait list due to a high number of patient requests and internal patient transfers to the clinic. The Assistant Chief of Primary Care also told the OIG the patient's transfer request was made when the transfer request process was changing from a form submission to the more trackable electronic waiting list system that may have contributed to delays in transfer.

The OIG found that staff did not transfer the patient to the requested primary care location. Staff's lack of responsiveness to the patient's request for a primary care clinic transfer may have compounded the patient's dissatisfaction with care at the facility and potentially contributed to the patient's frustration.

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<sup>74</sup> VHA Directive 1230(2), *Outpatient Scheduling Processes and Procedures*, July 15, 2016, amended January 22, 2020.

## 2. Failure to Complete an Institutional Disclosure

The OIG substantiated that following awareness of the patient's death, facility leaders did not conduct an institutional disclosure, as required.<sup>75</sup> Additionally, the OIG found that the Chief of Staff erroneously defined the patient's death as a non-sentinel event.

An institutional disclosure is a formal process for facility leaders and clinicians to inform a patient or patient's personal representative of events during the patient's care that resulted in death or serious injury and to provide information about rights and recourse. The institutional disclosure must be completed regardless of when the adverse event is discovered. VHA requires that an institutional disclosure of sentinel events occur, regardless of whether they resulted from an error.<sup>76</sup> The Joint Commission defines a sentinel event as an unexpected occurrence involving actual or risk of death or serious physical or psychological harm. The Joint Commission defines a patient's death by suicide within 72 hours of discharge from an Inpatient Mental Health Unit as a sentinel event.<sup>77</sup>

Three days after the patient's discharge from the Inpatient Mental Health Unit, the patient's family member notified a nurse that the patient died by suicide on the day of discharge.

The Facility Director told the OIG that the patient's death was a sentinel event but that Quality Management staff did not identify gaps in facility processes and did not assess the event as meeting criteria for an institutional disclosure. When interviewed by the OIG, the Chief of Staff reported that the patient's death was not a sentinel event and told the OIG that the patient's death did not warrant an institutional disclosure because additional time on the Inpatient Mental Health Unit or medication changes may not have prevented the patient's death. The Chief Officer of Quality, Safety, Value told the OIG that the patient's death was a sentinel event and prompted internal reviews, but that an institutional disclosure was not completed because the event happened after discharge and the family member was already aware of the patient's death.

Facility leaders reported they did not conduct an institutional disclosure because treatment errors were not identified that would have contributed to the patient's death. However, VHA requires disclosure of sentinel events, including a suicide within 72 hours of discharge from an inpatient care setting, regardless of whether or not the event resulted from an error.<sup>78</sup> Facility leaders therefore failed to notify the patient's family member of rights and recourse following the patient's death, as required.<sup>79</sup> Additionally, the OIG concluded that the Chief of Staff erroneously defined the patient's death as a non-sentinel event.

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<sup>75</sup> VHA Directive 1004.08, *Disclosures of Adverse Events to Patients*, October 31, 2018.

<sup>76</sup> VHA Directive 1004.08, *Disclosures of Adverse Events to Patients*, October 31, 2018.

<sup>77</sup> VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.

<sup>78</sup> VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

<sup>79</sup> VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

## Conclusion

The OIG substantiated that the patient died by suicide the same day as discharge from the facility's Inpatient Mental Health Unit. Deficiencies in the patient's outpatient and inpatient mental health care may have contributed to the patient's death by suicide. Facility staff were deficient in completion of required suicide risk evaluation and monitoring. In early summer and late summer 2019, outpatient mental health providers did not complete comprehensive evaluations with the patient following positive secondary suicide risk screens, as required by VHA. Staff's failure to complete required comprehensive evaluations may have hindered identification of critical or new information regarding the patient's suicide risk, including warning signs and risk factors. Further, given that a comprehensive evaluation requires a plan to mitigate risk, staff also failed to identify and reinforce the patient's coping strategies and protective factors. Additionally, a safety plan reportedly provided to the patient was unusable due to incomprehensible entries.

The suicide prevention team inadequately considered a high risk for suicide patient record flag. The suicide prevention team did not communicate with Inpatient Mental Health Unit staff as required to inform the flag determination and despite awareness of the patient's history of suicide behavior, recent crisis, and multiple risk factors for suicide, did not place a high risk for suicide patient record flag for the patient. Based on facility policy, the OIG would have expected that the suicide prevention team place a high risk for suicide patient record flag due to the patient's active crisis and history of suicide behaviors. Initiation of a high risk for suicide patient record flag would have included notification to Inpatient Mental Health Unit staff and may have impacted treatment decisions, including the decision to discharge the patient from a brief, less than 24-hour, Inpatient Mental Health Unit admission.

Inpatient Mental Health Unit staff did not complete an adequate assessment of the patient's substance use or consider treatment options tailored to the patient's needs. Staff did not order confirmatory laboratory testing to identify the specific substance resulting in the patient's positive amphetamine drug screen, as the OIG would have expected. Further, the Inpatient Mental Health Unit staff did not request a formal or individualized substance use disorder assessment for the patient. The absence of the individual assessment may have contributed to staff's failure to enhance the patient's readiness to engage in substance use disorder treatment consistent with the patient's needs at the time.

Inpatient Mental Health Unit staff did not adequately assess the patient's change in demeanor within hours of admission and prior to discharge following the patient's statement, "My whole world has ended." Additionally, the inpatient social worker did not thoroughly review and update the patient's safety plan at discharge, which had not been modified since summer 2019, approximately eight months earlier, despite the patient experiencing significant psychosocial stressors and worsening depression. The lack of comprehensive assessment of the patient including staff's failure to review prior mental health treatment and response, and reconciliation

of pertinent clinical information related to the patient's mental health condition may have contributed to Inpatient Mental Health Unit staff rendering treatment and discharge decisions based on incomplete and insufficient information about the patient.

Staff did not assign the patient a MHTC at the beginning of the patient's mental health treatment, as required, and did not find evidence that the assigned MHTC had regular contact with the patient to support treatment engagement. Staff also referred to multiple staff members as the patient's MHTC in the patient's EHR that may have resulted from the program analyst's failure to enter the patient's MHTC assignment into the software program for staff to clearly identify. As a result, staff provided the patient inaccurate MHTC information that may have hindered the patient's ability to identify or contact the MHTC for support with concerns with care, as discussed below.

Facility leaders had not established an MHTC policy and staff did not assign the patient an MHTC at the beginning of the patient's mental health treatment, as required. Additionally, staff changed the patient's MHTC assignment multiple times and did not find evidence that the assigned MHTCs had regular contact with the patient to support treatment engagement or assist the patient with concerns with care. Further, staff inaccurately informed the patient about the assigned MHTC and that may have hindered the patient's ability to identify or contact the MHTC for support with concerns with care, as discussed below.

Inpatient Mental Health Unit staff members did not involve or communicate with the patient's assigned geropsychologist, as required. As a result, information relevant to the patient's care and techniques for engaging the patient in care based on previous mental health treatment were not incorporated into the patient's care or discharge plan.

Leaders and staff did not effectively address the patient's expressed complaints and concerns regarding difficulty obtaining medications, engaging with mental health staff, and preference for a different primary care location. Further, staff did not contact an immediate supervisor or a service level patient advocate liaison for assistance with addressing the patient's unresolved concerns, as required. The ineffective response to the patient's complaints likely contributed to the patient's lack of confidence in facility staff, further disengagement from mental health treatment, and subsequent worsening psychiatric condition.

The OIG substantiated that following awareness of the patient's death, facility leaders did not conduct an institutional disclosure, as required. Facility leaders reported they did not conduct an institutional disclosure because treatment errors were not identified that would have contributed to the patient's death. However, VHA requires disclosure of sentinel events, including a suicide within 72 hours of discharge from an inpatient care setting, regardless of whether the event resulted from an error. Facility leaders therefore failed to notify the patient's family member of rights and recourse following the patient's death, as required. Additionally, the Chief of Staff erroneously defined the patient's death as a non-sentinel event.

## Recommendations 1–10

1. The VA Southern Nevada Healthcare System Director ensures completion of suicide risk screening and evaluation in accordance with Veterans Health Administration requirements.
2. The VA Southern Nevada Healthcare System Director makes certain that Inpatient Mental Health Unit staff collaboratively develop and update safety plans with patients to reflect the patient's current risk and protective factors.
3. The VA Southern Nevada Healthcare System Director ensures adherence to Veterans Health Administration requirements and VA Southern Nevada Healthcare System Standard Operating Procedure 116-14, *Suicide Prevention Daily Operations*, October 2019, in the consideration of high risk for suicide patient record flags.
4. The VA Southern Nevada Healthcare System Director evaluates substance use disorder diagnostic and treatment referral processes for patients on the Inpatient Mental Health Unit and takes action as warranted.
5. The VA Southern Nevada Healthcare System Director reviews current practices to ensure Inpatient Mental Health Unit staff reconcile and incorporate critical clinical information into treatment and discharge planning.
6. The VA Southern Nevada Healthcare System Director expedites the establishment of mental health treatment coordinator policy in accordance with Veterans Health Administration requirements.
7. The VA Southern Nevada Healthcare System Director makes certain that Inpatient Mental Health Unit staff coordinate discharge plans with outpatient treatment providers, in accordance with Veterans Health Administration requirements.
8. The VA Southern Nevada Healthcare System Director ensures patient complaints and requests are addressed in accordance with Veterans Health Administration requirements.
9. The VA Southern Nevada Healthcare System Director promotes leaders' accurate identification of sentinel events consistent with The Joint Commission definition and Veterans Health Administration requirements.
10. The VA Southern Nevada Healthcare System Director conducts a full review of the patient's care, determines whether an institutional disclosure is warranted, and takes action as indicated.

## Appendix A: Case Summary Prior to the Patient's Inpatient Admission

In spring 2019, the patient presented to a primary care clinic to establish care at the facility, address dizziness and nausea, and transfer medications from the California VA facility. The primary care physician referred the patient to [primary care mental health integration](#). That same day, a primary care mental health integration psychologist documented that “a week ago” the patient moved to the area to reside closer to family. The psychologist documented that the patient planned to go to the mental health outpatient clinic as a walk-in for medication refills. The patient did not present to the mental health outpatient clinic that day.

The following day, the patient went to the Emergency Department and requested medication refill for methylphenidate. The nurse practitioner initially advised the patient to follow up with the mental health clinic for the refill and documented that the patient reported being advised to go to the Emergency Department for the refill and was upset. About an hour later, the nurse practitioner documented speaking with a pharmacist, noted the patient's methylphenidate regimen from the California VA facility, and ordered a three-day supply of medication. The pharmacist documented that the patient described being “tossed around between pharmacy, [Emergency Department] and Mental health for over 3 hours,” and the pharmacist noted confirmation of this time frame.

The next day, the patient sent a secure message to a former California VA facility psychologist and stated:

roadblocks to things like my meds, I had at [the California VA facility]; especially the 1 scheduled drug, prescribed for a few years, that I've been taking for depression. I was told, by some that there was no history – at all – regarding the methylphenidate.<sup>80</sup>

The patient requested a summary of the history of the methylphenidate prescription. The psychologist responded that a provider “noted [in spring 2019] that your methylphenidate should be continued” and that facility providers “should have access to all of your notes, including that one.”

That same day, the patient presented as a walk-in to the mental health outpatient clinic for treatment of depression and the patient reported having “suicidal thoughts since the 1970s” but denied “actual attempt.” The psychiatrist prescribed a 28-day supply of methylphenidate. The following day, an outpatient mental health nurse documented a historical suicide prevention safety plan that noted the patient did not have access to firearms.

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<sup>80</sup> VA Secure Messaging is an online tool for patients to communicate privately with their VA healthcare team.

Eighteen days after establishing care, at a scheduled outpatient mental health clinic intake appointment, a social worker documented that the patient had two previous inpatient mental health hospitalizations for suicidal ideation, most recently 14 years prior. With the patient's agreement, the social worker submitted a consult request to the outpatient geriatric mental health services and the patient was scheduled with a geropsychologist 19 days later.

Five days prior to the scheduled appointment with a geropsychologist, the patient presented as a walk-in to the mental health outpatient clinic to request a methylphenidate refill.<sup>81</sup> The patient screened positive on the secondary suicide risk screen, and the nurse documented that the patient reported current suicidal ideation with "a plan but with no intent to act on it at the present time."<sup>82</sup> The nurse informed a physician assistant about the patient's positive secondary suicide risk screen. The physician assistant reviewed the patient's EHR and documented that the patient was prescribed methylphenidate starting in 2005, with the last prescription approximately one month prior to this appointment. The physician assistant prescribed a five-day supply of methylphenidate "For continuity of care" and noted that the patient's EHR did not include an [attention deficit disorder](#) or attention deficit hyperactivity disorder diagnosis.

Three days after the walk-in visit to the mental health outpatient clinic, the patient sent a secure message to facility primary care in which the patient explained the insufficiency of the amount of methylphenidate prescribed and wrote:

I don't understand the confusion over the methylphenidate that I've been taking for years.... How can we finally, get this situation resolved. My whole 2 month history at this facility has been one frustration and anxiety-inducing process after another. I haee [*sic*] never experienced such ridiculous care at the VA. It needs to end.

Two days later, the geropsychologist documented that the patient "expressed motivation for treatment." Six days later, a geriatric psychiatrist documented that the patient denied medication side effects and reported having tried seven different antidepressants in the past and found that methylphenidate 40 milligrams twice daily was beneficial.<sup>83</sup> The geriatric psychiatrist renewed only the patient's sleep medication and completed a suicide

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<sup>81</sup> The patient's 28-day prescription was started two days after the prescription was written. The patient would have completed the methylphenidate on the day of this walk-in visit, and the patient's next scheduled psychiatric appointment was 11 days after this walk-in visit.

<sup>82</sup> As part of the secondary suicide risk screen, the nurse documented that the patient did "Intend to carry out" a suicide plan.

<sup>83</sup> Prescribers' Digital Reference, *Methylphenidate Hydrochloride - Drug Summary*, accessed November 5, 2020, <https://www.pdr.net/drug-summary/Ritalin-LA-methylphenidate-hydrochloride-1003>. The maximum recommended dosage for treatment of treatment-resistant depression in geriatric patients is 100 milligrams per day for extended release and 60 milligrams per day for all other oral formulations.

prevention safety plan. The patient continued individual therapy with the geropsychologist approximately once or twice a month until the final session on spring 2020.

Approximately five weeks after the walk-in visit to the mental health outpatient clinic, the patient sent a secure message to the patient's assigned mental health team with "I HATE THIS PLACE." in the subject line and the message "Once again, ACTIONS SPEAK LOUDER THAN WORDS. Meds are still a hill that can't be climbed with you people." The next morning, a staff member who served as an MHTC replied that methylphenidate "was refilled yesterday," and that the patient's concerns were being forwarded to the geriatric psychiatrist. Two days later, in a secure message, the patient noted "about 20 years" of "Chronic PTSD" and "treatment resistant Major Depression" and that the geriatric psychiatrist did not "have a clue about what my [*sic*] treatment needs." The patient also wrote:

Further, my med situation is simply deadly. The meds that I currently take, I have been taking for years. They are what has helped more than a long list of others that have been attempted. Here, that studied process is being questioned at every turn.

In a secure message response four days later, a nurse apologized to the patient, suggested that the patient could change providers, and added the Chief of Behavioral Health and a medical support assistant as additional signers on the EHR secure message.<sup>84</sup> The patient canceled an appointment with the geriatric psychiatrist for later that month and requested another provider.

Seventeen days after the nurse's secure message response, the patient "presented to the walk-in clinic for medication refill" and the patient screened positive on the secondary suicide risk screen. A nurse completed a safety plan with the patient. A nurse practitioner documented that the patient reported a last dose of methylphenidate the day prior and that it was "the only medication effective" for the patient's depression. The nurse practitioner documented that the Prescription Monitoring Program report "did not indicate aberrant or inappropriate findings for the prescribed controlled substance," and prescribed a 14-day supply of methylphenidate, and "Instructed Veteran to follow up with primary mental health prescriber as soon as possible."

Two weeks later, another outpatient psychiatrist documented that the patient "has been seen by so many different [Mental Health] Providers here," appeared depressed, and was "barely audible." The psychiatrist documented telling the patient that the methylphenidate doses were "way too high and are all wrong," and that "Before a tapering off dose was offered to patient [the patient] got angry and left abruptly." The psychiatrist did not provide a prescription or order a follow-up appointment to be scheduled.

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<sup>84</sup> The Chief of Behavioral Health acknowledged receipt of the secure message notification approximately nine months later.

The next day, the psychiatrist documented calling the patient “because of [instant message] sent by Front Desk.” In the call, the psychiatrist again recommended a lower methylphenidate dose to safely taper the medication. The psychiatrist documented that the patient’s speech was “garbled,” and that the patient was crying. The psychiatrist ordered a “slightly lower dose of Methylphenidate for [STAT](#) mailing.”

The patient met with the geropsychologist for individual therapy six weeks later and again six weeks after that. Three days later, the patient met with a neuropsychologist for cognitive testing at the request of the primary care provider due to “concern for changes in mental status. The patient reported discontinuation of antidepressant medications because of “conflict over need and bureaucracy” and denied using any recreational or illicit drugs. The neuropsychologist completed a secondary suicide risk screen with the patient that had a positive result, and then, completed a comprehensive evaluation. The neuropsychologist deferred the cognitive testing for the patient to walk-in to the mental health clinic for medication management of depressive symptoms. In the mental health clinic, the patient agreed to a one-month trial of an antidepressant that the patient had a documented history of trying at the California VA facility with “no response” to the medication. The physician assistant also ordered a follow-up appointment for approximately one month later, with a psychiatrist that was later discontinued.<sup>85</sup> Fifteen days after the patient met with the neuropsychologist, the neuropsychologist completed the cognitive testing.

Six days later, the patient presented to the Emergency Department for a cough and was positive on the secondary suicide risk screen. A social worker documented that the patient’s secondary suicide risk screen “was unchanged from mid-December and [patient’s] Comprehensive suicide risk was low.” The social worker also documented that the patient “has chronic depression and is not currently taking [mental health] medications.” The patient reported meeting with “5-6” mental health prescribers who did not prescribe what “worked the best.” The social worker noted that the patient had refills for psychiatric medications for two more months, but the patient did not want to fill the prescriptions since the patient “has not found a prescriber that will refill them once [the date of the last refill] comes.” The social worker encouraged the patient to present to the mental health walk-in clinic.

Two days later, the patient presented to the walk-in mental health clinic and requested a refill of the previously prescribed antidepressant. A nurse offered services to address the patient’s expressed concerns about medications and “providers, VA,” including information about the patient advocate and requesting a change in provider. A physician assistant ordered a refill of the antidepressant and instructed the patient to return to the clinic for medication management in four weeks. The patient had individual therapy with the geropsychologist 13 days later, and again 15 days later.

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<sup>85</sup> In early 2020, two days after the patient was seen in the mental health walk-in clinic, a staff member discontinued the order for the follow-up appointment.

Approximately one month after the completion of the cognitive testing, the neuropsychologist provided the patient with feedback regarding the neuropsychological evaluation results. The neuropsychologist noted mild neurocognitive deficits, that “depression and anxiety likely contribute to the observed cognitive impairments,” and recommended that the patient’s depression “be closely monitored.” Both the geropsychologist and the psychiatrist (with whom the patient was scheduled in spring 2020) acknowledged receipt of the report that day.

Approximately one month later, the patient sent a secure message to the primary care clinic requesting a refill of trazodone. A primary care nurse responded that since the medication was prescribed by a psychiatrist, the patient should contact the mental health provider for a refill. The patient replied:

given my history with the [Mental Health] department in Las Vegas, I don't currently have a mental health provider that I trust. This situation has been deteriorating since spring, 2019 and I have no faith in any resolution... I have never been treated this badly in this system. Pointing me to such a non-solution is asking me to go away.

The nurse responded that the patient’s MHTC requested that the patient keep the psychiatry appointment scheduled for the following week to discuss the patient’s concerns and that the patient “can always walk in for a same day mental health appointment.”

Two days after the patient sent the secure message requesting a refill of trazodone, the patient canceled the appointment with the geropsychologist that scheduled for the following week. Two days later, the patient canceled the upcoming psychiatric appointment.

Approximately six weeks after the patient canceled the geropsychology and psychiatry appointments, a primary care social worker contacted the patient in response to the patient’s request to the primary care provider to update the patient’s [advance directive](#). The patient reported the plan to submit the required form with changes one week later, when the patient planned to be there for a radiology appointment.

## Appendix B: VISN Director Memorandum

### Department of Veterans Affairs Memorandum

Date: June 10, 2021

From: Director, Sierra Pacific Network (10N21)

Subj: Healthcare Inspection—Deficiencies in the Mental Health Care of a Patient who Died by Suicide, VA Southern Nevada Healthcare System in Las Vegas

To: Executive in Charge, Office of the Under Secretary for Health (10)

1. I have reviewed the draft report and responses provided by the VA Southern Nevada Healthcare System in Las Vegas. I concur with the Healthcare System Director's responses.
2. If you have additional questions or need further information, please contact the VISN 21 Accreditation Program Manager.

*(Original signed by:)*

John Brandecker, MBA, MPH  
Network Director, VISN 21

## Appendix C: Facility Director Memorandum

### Department of Veterans Affairs Memorandum

Date: June 10, 2021

From: Director, VA Southern Nevada Healthcare System (593/00)

Subj: Healthcare Inspection—Deficiencies in the Mental Health Care of a Patient who Died by Suicide, VA Southern Nevada Healthcare System in Las Vegas

To: Director, Sierra Pacific Network (10N21)

1. We appreciate the opportunity to review the draft report of recommendations from the OIG Health Care virtual Inspection conducted at the VA Southern Nevada Healthcare System from July 27, 2020-July 30, 2020.
2. Please find the attached response to each recommendation included in the report. We have completed, or in the process of completing, actions to resolve these issues.

*(Original signed by:)*

William J. Caron, PT, MHA, FACHE  
Medical Center Director/CEO  
VA Southern Nevada Healthcare System

## Facility Director Response

### Recommendation 1

The VA Southern Nevada Healthcare System Director ensures completion of suicide risk screening and evaluation in accordance with Veterans Health Administration requirements.

Concur.

Target date for completion: 9/1/20

### Director Comments

The VA Southern Nevada Healthcare System Director will continue to ensure completion of suicide risk screening and evaluation in accordance with Veterans Health Administration requirements.

The Suicide Prevention Coordinator conducted scenario/simulations trainings using potential mental health events including the identification of risk factors that would place a Veteran at a higher level of risk for suicide. The trainings also included education about documentation standards for Veterans who are unwilling or unable to complete the Comprehensive Suicide Risk Evaluation (CSRE).

Trainings occurred in the following areas on the below dates/times:

Emergency Department (ED) Social Workers trained on 7/7/20 and 7/10/20

ED nurses trained on 9/1/20

Acute Mental Health staff trained on 7/14/20 and 7/27/20

New employees also receive training on suicide risk screening and evaluation

VASNHS will continue to monitor the National Suicide Screening Process Fallout database weekly and provide additional education to staff when opportunities are identified. Additionally, Quality Patient Safety staff will continue to monitor admissions and discharges daily to ensure appropriate suicide risk screenings and evaluations are performed and provide notification and additional education to staff when opportunities are identified. The program will have executive governance oversight monitoring for effectiveness and action planning if warranted.

### OIG Comment

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

## Recommendation 2

The VA Southern Nevada Healthcare System Director makes certain that Inpatient Mental Health Unit staff collaboratively develop and update safety plans with patients to reflect the patient's current risk and protective factors.

Concur.

Target date for completion: 10/29/21

### Director Comments

The VA Southern Nevada Healthcare System Director will continue to make certain that Inpatient Mental Health Unit staff collaboratively develop and update safety plans with patients to reflect the patient's current risk and protective factors.

Thirty inpatient Mental Health unit safety plans will be audited monthly until 90% is achieved for 3 months for collaborative development and updates to safety plans which reflect Veteran's current risk and protective factors. The audits will be monitored in governance oversight committee.

## Recommendation 3

The VA Southern Nevada Healthcare System Director ensures adherence to Veterans Health Administration requirements and VA Southern Nevada Healthcare System Standard Operating Procedure 116-14, *Suicide Prevention Daily Operations*, October 2019, in the consideration of high risk for suicide patient record flags.

Concur.

Target date for completion: 6/2/21

### Director Comments

The VA Southern Nevada Healthcare System Director will continue to ensure adherence to Veterans Health Administration requirements and VA Southern Nevada Healthcare System Standard Operating Procedure 116-14, *Suicide Prevention Daily Operations*, October 2019, in the consideration of high risk for suicide patient record flags. Additionally, VASNHS Suicide Prevention Team will continue to review the appropriateness of high-risk suicide patient record flags daily to ensure the general criteria are being followed. Program effectiveness will be monitored in executive governance oversight.

### OIG Comment

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

## **Recommendation 4**

The VA Southern Nevada Healthcare System Director evaluates substance use disorder diagnostic and treatment referral processes for patients on the Inpatient Mental Health Unit and takes action as warranted.

Concur.

Target date for completion: 9/30/21

### **Director Comments**

VASNHS Substance Use Disorder Program Manager will evaluate current processes for substance use disorder diagnostic and treatment referral and present findings to the Director and Executive Leadership Team as well as the VISN Mental Health Chief Officer for review and evaluation. Any recommended modifications will be discussed, and actions will be taken accordingly.

## **Recommendation 5**

The VA Southern Nevada Healthcare System Director reviews current practices to ensure Inpatient Mental Health Unit staff reconcile and incorporate critical clinical information into treatment and discharge planning.

Concur.

Target date for completion: 10/29/21

### **Director Comments**

The VA Southern Nevada Healthcare System Director will review current practices to ensure Inpatient Mental Health Unit staff reconcile and incorporate critical clinical information into treatment and discharge planning.

Thirty inpatient Mental Health unit treatment and discharge plans will be audited monthly until 90% is achieved for 3 months to ensure staff are reconciling and incorporating critical clinical information into treatment and discharge planning. The audits will be monitored in governance oversight committee.

## **Recommendation 6**

The VA Southern Nevada Healthcare System Director expedites the establishment of mental health treatment coordinator policy in accordance with Veterans Health Administration requirements.

Concur.

Target date for completion: 3/8/21

### **Director Comments**

This policy was completed on 3/8/21.

### **OIG Comment**

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

### **Recommendation 7**

The VA Southern Nevada Healthcare System Director makes certain that Inpatient Mental Health Unit staff coordinate discharge plans with outpatient treatment providers, in accordance with Veterans Health Administration requirements.

Concur.

Target date for completion: 10/29/21

### **Director Comments**

The VA Southern Nevada Healthcare System Director will continue to make certain that Inpatient Mental Health Unit staff coordinate discharge plans with outpatient treatment providers, in accordance with Veterans Health Administration requirements and patient preference.

Thirty inpatient Mental Health unit treatment and discharge plans will be audited monthly until 90% is achieved for 3 months to ensure staff are coordinating discharge plans with outpatient treatment providers in accordance with Veterans Health Administration requirements. The audits will be monitored in governance oversight committee.

### **Recommendation 8**

The VA Southern Nevada Healthcare System Director ensures patient complaints and requests are addressed in accordance with Veterans Health Administration requirements.

Concur.

Target date for completion: 1/12/21

### **Director Comments**

The VA Southern Nevada Healthcare System Director will continue to ensure patient complaints and requests are addressed in accordance with Veterans Health Administration requirements.

Mental Health staff were re-educated on the appropriate process for handling patient complaints and requests on 10/20/20 and 1/12/21. Also included was Standard Operating Procedure 116-08 Change of Behavioral Health Service Provider Request which outlines the process for Veteran requests to change providers. Process for handling change of provider requests will be added to new hire orientation. Program effectiveness will be monitored in executive governance oversight.

### **OIG Comment**

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

### **Recommendation 9**

The VA Southern Nevada Healthcare System Director promotes leaders' accurate identification of sentinel events consistent with The Joint Commission definition and Veterans Health Administration requirements.

Concur.

Target date for completion: 9/30/21

### **Director Comments**

The Patient Safety Manager will provide a presentation at a monthly Director Staff meeting on Sentinel Events which will include how to accurately identify a sentinel event using The Joint Commission definition and Veterans Health Administration requirements. New hires continue to receive information on Sentinel Events at orientation.

### **Recommendation 10**

The VA Southern Nevada Healthcare System Director conducts a full review of the patient's care, determines whether an institutional disclosure is warranted, and takes action as indicated.

Concur.

Target date for completion: 8/31/21

### **Director Comments**

Executive Leadership will conduct further analysis of this case to determine if an institutional disclosure is warranted and will take appropriate action. If indicated, Executive Leadership will consult with VISN and National Risk Management Leadership.

## Glossary

**advance directive.** A legal document used to inform a patient’s providers and family of treatment and end-of-life care preferences should the patient lack ability to express their wishes.<sup>86</sup>

**altered mental status.** A brain dysfunction that may present as confusion, behavior change, psychosis, and disorientation. Altered mental status can be caused by an underlying medical condition.<sup>87</sup>

**amphetamines.** Drugs that can be obtained legally through prescription to treat health problems such as attention problems and weight concerns.<sup>88</sup>

**attention deficit disorder.** Past terminology used to refer to attention deficit hyperactivity disorder.<sup>89</sup>

**attention deficit hyperactivity disorder.** A mental health disorder with persistent symptoms that may include inattention, hyperactivity, and impulsivity and can lead to problems such as difficulty maintaining relationships, issues at school or work, and decreased self-esteem.<sup>90</sup>

**benzodiazepine.** A sedative medication used to treat anxiety, insomnia, and seizure disorders.<sup>91</sup> Benzodiazepines can be addictive and have abuse potential.<sup>92</sup>

**chronic kidney disease.** The gradual loss of kidney function.<sup>93</sup>

**cyst.** A liquid-filled growth that forms in or on the body.<sup>94</sup>

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<sup>86</sup> MedlinePlus, *Advance Directives*, updated August 20, 2019, accessed December 9, 2020, <https://medlineplus.gov/advancedirectives.html>.

<sup>87</sup> Jin Han and Scott Wilber, “Altered Mental Status in Older Emergency Department Patients,” *Clinics in Geriatric Medicine* 29 no. 1 (February 2014):101-136, accessed November 30, 2020, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3614410/>.

<sup>88</sup> MedLinePlus, “Substance use – amphetamines,” accessed October 18, 2020, <https://medlineplus.gov/ency/patientinstructions/000792.htm>.

<sup>89</sup> Children and Adults with Attention-Deficit/Hyperactivity Disorder, *Glossary of Terms – ADD*, accessed December 11, 2020, <https://chadd.org/about-adhd/glossary-of-terms/>.

<sup>90</sup> Mayo Clinic, “Adult attention-deficit/hyperactivity disorder (ADHD),” accessed December 11, 2020, <https://www.mayoclinic.org/diseases-conditions/adult-adhd/symptoms-causes/syc-20350878>.

<sup>91</sup> United States Drug Enforcement Administration, “Benzodiazepines,” accessed June 11, 2020, <https://www.dea.gov/factsheets/benzodiazepines>

<sup>92</sup> Lance Longo and Brian Johnson, “Addiction: Part I. Benzodiazepines – Side Effects, Abuse Risk and Alternatives,” *American Family Physician* 61 no. 7 (April 1, 2000):2121-2128.

<sup>93</sup> Mayo Clinic, “Chronic Kidney Disease,” accessed October 28, 2020, <https://www.mayoclinic.org/diseases-conditions/chronic-kidney-disease/symptoms-causes/syc-20354521>.

<sup>94</sup> Merriam-Webster Dictionary, “Definition of cyst,” accessed October 28, 2020, <https://www.merriam-webster.com/dictionary/cyst>.

**frontal lobe.** A part of the brain that is important for thinking and controlling voluntary movements or activity.<sup>95</sup>

**geropsychology.** A specialty of psychology. Geropsychologists specialize in understanding and providing services, such as mental health treatment, to older adults.<sup>96</sup>

**lamotrigine.** A medication used to stabilize mood in the treatment of bipolar disorder. Lamotrigine can also be used to treatment some seizure disorders.<sup>97</sup>

**lethal means.** Objects such as medications, firearms, or sharp items that can be used in suicide attempts or other self-directed violence. Lethal means safety planning is a critical component of suicide prevention.<sup>98</sup>

**major depression.** A disorder characterized by a period of at least two weeks with depressed mood and/or loss of pleasure or interest in activities. Symptoms must be present much of the day nearly every day during the two-week period. Symptoms must be a marked change from one's prior functioning and not better explained by a medical condition.<sup>99</sup>

**methamphetamines.** Illicit amphetamines obtained without a prescription for a mood-altering effect, with slang terms such as "crystal," "ice," and "meth."<sup>100</sup>

**methylphenidate.** A medication used to treat attention deficit hyperactivity disorder.<sup>101</sup> Methylphenidate can also be prescribed for treatment-resistant depression in adult and geriatric populations and due to toxic effects in overdose, should only be prescribed when absolutely necessary and periodically reevaluated for usefulness. Side effects may include mood or behavior changes, tremor, sleep problems, increased blood pressure, headache, or gastrointestinal symptoms.<sup>102</sup>

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<sup>95</sup> Mayo Clinic, "Brain Lobes," accessed December 11, 2020, <https://www.mayoclinic.org/brain-lobes/img-20008887>.

<sup>96</sup> American Psychological Association. "Geropsychology," accessed December 1, 2020, <https://www.apa.org/ed/graduate/specialize/geropsychology>.

<sup>97</sup> National Alliance on Mental Illness, "Lamotrigine (Lamictal)," accessed February 4, 2021, [https://www.nami.org/About-Mental-Illness/Treatments/Mental-Health-Medications/Types-of-Medication/Lamotrigine-\(Lamictal\)](https://www.nami.org/About-Mental-Illness/Treatments/Mental-Health-Medications/Types-of-Medication/Lamotrigine-(Lamictal)).

<sup>98</sup> VA Mental Illness Research, Education, and Clinical Center, Center of Excellence, *Lethal Means Safety & Suicide Prevention*, updated February 1, 2018, accessed December 11, 2020, <https://www.mirecc.va.gov/lethalmeanssafety/>.

<sup>99</sup> Diagnostic and Statistical Manual of Mental Disorders. "Major Depressive Disorder," accessed October 28, 2020, <https://dsm.psychiatryonline.org/doi/full/10.1176/appi.books.9780890425596.dsm04>.

<sup>100</sup> MedLinePlus, "Substance use – amphetamines," accessed October 18, 2020, <https://medlineplus.gov/ency/patientinstructions/000792.htm>.

<sup>101</sup> Mayo Clinic, "Methylphenidate (Oral Route)," accessed October 28, 2020, <https://www.mayoclinic.org/drugs-supplements/methylphenidate-oral-route/description/drg-20068297>.

<sup>102</sup> Prescribers' Digital Reference, *Methylphenidate Hydrochloride - Drug Summary*, accessed November 5, 2020, <https://www.pdr.net/drug-summary/Ritalin-LA-methylphenidate-hydrochloride-1003>.

**mild neurocognitive impairment.** The stage between expected cognitive decline of normal aging and dementia that is characterized by problems with memory, language, thinking, or judgment.<sup>103</sup>

**mirtazapine.** A medication used to treat depression.<sup>104</sup>

**posttraumatic stress disorder (PTSD).** A disorder defined by exposure to a traumatic event followed by the development of characteristic symptoms. Symptoms of posttraumatic stress disorder may include fear-based emotional and behavioral reactions, loss of pleasure in activities and negative cognitions, heightened arousal and externalizing behavior, and dissociative symptoms.<sup>105</sup>

**primary care mental health integration.** Consists of mental health teams integrated into primary care clinics to coordinate and provide mental health care for patients with a diagnosis of depression, anxiety, PTSD, or substance use.<sup>106</sup>

**resection.** A surgical procedure done to remove a portion of an organ or structure.<sup>107</sup>

**safety plan.** A document that identifies coping strategies and sources of support for patients who are at high risk for suicide to use before or during a crisis. The safety plan should be concise and comprehensible, and patients should be included in its development.<sup>108</sup>

**stat.** Refers to immediately.<sup>109</sup>

**suicide pact.** An agreement between two or more people to die by suicide at the same time.<sup>110</sup>

**traumatic brain injury.** May result from a violent blow or jolt to the head or body or penetration of brain tissue. Signs and symptoms of mild traumatic brain injury are wide ranging,

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<sup>103</sup> Mayo Clinic, “Mild Cognitive Impairment (MCI),” accessed October 28, 2020, <https://www.mayoclinic.org/diseases-conditions/mild-cognitive-impairment/symptoms-causes/syc-20354578>.

<sup>104</sup> Mayo Clinic, “Mirtazapine (Oral Route),” accessed December 1, 2020, <https://www.mayoclinic.org/drugs-supplements/mirtazapine-oral-route/description/drg-20067334>.

<sup>105</sup> Diagnostic and Statistical Manual of Mental Disorders. “Posttraumatic Stress Disorder,” accessed October 28, 2020, <https://dsm.psychiatryonline.org/doi/10.1176/appi.books.9780890425596.dsm07#BABJAEHE>.

<sup>106</sup> VA Patient Care Services, *Primary Care – Mental Health Integration (PC-MHI)*, updated August 1, 2016, accessed December 9, 2020, <https://www.patientcare.va.gov/primarycare/PCMHI.asp>.

<sup>107</sup> Merriam-Webster, “Definition of resection,” accessed December 11, 2020, <https://www.merriam-webster.com/dictionary/resection>.

<sup>108</sup> VA Safety Plan Quick Guide for Clinicians. “What is a Safety Plan?” accessed February 3, 2021, <http://vaww.mentalhealth.va.gov/docs/VASafetyPlanColor.pdf>.

<sup>109</sup> Merriam-Webster, “Definition of Stat,” accessed October 29, 2020, <https://www.merriam-webster.com/dictionary/stat>.

<sup>110</sup> Merriam-Webster, “Definition of suicide pact,” accessed May 19, 2021, <https://www.merriam-webster.com/dictionary/suicide%20pact>.

and can include headache, fatigue, sleep problems, dizziness, memory or concentration difficulties, mood changes, and depression or anxiety.<sup>111</sup>

**trazodone.** A medication for depression that can also be used for sleep problems.<sup>112</sup>

**treatment-resistant depression.** A depression for which standard treatments such as antidepressant medication and psychotherapy do not resolve the symptoms.<sup>113</sup>

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<sup>111</sup> Mayo Clinic, “Traumatic Brain Injury,” accessed December 1, 2020, <https://www.mayoclinic.org/diseases-conditions/traumatic-brain-injury/symptoms-causes/syc-20378557>.

<sup>112</sup> MedlinePlus. *Trazodone*, accessed December 1, 2020, <https://medlineplus.gov/druginfo/meds/a681038.html>.

<sup>113</sup> Mayo Clinic, “Treatment-resistant depression,” accessed October 28, 2020, <https://www.mayoclinic.org/diseases-conditions/depression/in-depth/treatment-resistant-depression/art-20044324>.

## OIG Contact and Staff Acknowledgments

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